THE SCOTTISH OFFICE

NHS: MEL(1994)91

National Health Service in Scotland
Management Executive

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5400

13 September 1994

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COMMON SERVICES AGENCY
RECEIVED: 15 SEP 1994
FILE No.

REFERRED TO	ACTION TAKEN

Dear Colleague

REPORTS OF THE HEALTH SERVICE COMMISSIONER

Summary

1. Enclosed are

   1.1 the Health Service Commissioner's annual report for 1993-94;

   1.2 his report of selected cases (October 1993 - March 1994);

   1.3 epitomes of the selected cases;

   1.4 a special report by the Commissioner on failure to provide long-term NHS care for a brain-damaged patient.

2. Although the Commissioner's criticisms stem from his investigation of a very small proportion of the total number of cases treated by the NHS, there is clearly no room for complacency. Public respect for the NHS and their appreciation of the care provided by NHS staff is particularly high. We must not allow a limited number of shortcomings to undermine this confidence, and the Commissioner's reports contain useful lessons to be learned by all NHS bodies and not just those identified in them.

Action

3. General Managers and Chief Executives are asked to

   3.1 distribute the reports as widely as possible;

   3.2 provide me by 5 December 1994 with a note of action taken to improve procedures in the light of the reports, and to increase the awareness of staff and the public of the Commissioner's work.

Yours sincerely

DAVID R STEEL
Director of Corporate Affairs

Recycled

NHS/HSC.R (1993-94)

Health Service Commissioner

Second Report for Session 1993–94

Failure to provide long term NHS care for a brain-damaged patient

Presented to Parliament pursuant to Section 119(4) of the National Health Service Act 1977, as amended by the Health Services Act 1980.

Ordered by The House of Commons *to be printed*
2 February 1994

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National Health Service Act 1977

In June 1993 I agreed to investigate a complaint which had been referred to me by the chief officer of Leeds Community Health Council on behalf of a woman whose husband was discharged to a private nursing home when he no longer needed acute hospital care. Her complaint was that she had been placed under an obligation to pay for continuing care which should have been provided free of charge by Leeds Health Authority.

I consider that my investigation has raised issues of general public interest. I have therefore decided to make a report on the case, to the Secretary of State for Health, to be laid before both Houses of Parliament in accordance with Section 119 (4)(b) of the National Health Service Act 1977.

An epitome of the case is provided on page 1. The ensuing pages contain the full text of my investigation report but with the identity of the complainant anonymised in order to preserve confidentiality.

January 1994

W K REID

Health Service Commissioner for England

FAILURE TO PROVIDE LONG TERM NHS CARE FOR A BRAIN-DAMAGED PATIENT—CASE NO: E.62/93–94

Matters considered

Statutory framework and policy context—provision for long term care.

Summary of case

A man suffered a brain haemorrhage and was admitted to a neuro-surgical ward in the General Infirmary at Leeds. He received surgery but did not fully recover. After 20 months in hospital he was in a stable condition but still required full time nursing care. Since nothing more could be done, the consultant decided that he should no longer stay in the ward. The man's wife was told that he would be discharged and that she should find a suitable nursing home for his future needs. Despite her misgivings she agreed to the discharge and he moved to a local nursing home in September 1991. The next year the man's wife — with assistance from her local community health council — complained to Leeds Health Authority (the body responsible for purchasing health care for Leeds residents) that they had not met their responsibilities towards her husband. Despite further correspondence and a meeting no resolution was found, and the woman complained to me in 1993. The complaint which I investigated was that the woman had been obliged to pay for her husband's continuing nursing care, which should have been provided through Leeds Health Authority free of charge under the NHS.

Findings

No one disputed that the man was in a seriously incapacitated condition or that he needed full-time nursing care. The National Health Service Act 1977 places a general duty upon the Secretary of State to meet 'all reasonable requirements'. However, in connection with an earlier investigation of mine, the chief executive of the NHS Management Executive had explained that, while a duty existed where a doctor judged such care to be necessary on clinical grounds, authorities had an overriding duty to determine their priorities within the financial resources available — which meant that an individual patient might never receive treatment. Leeds Health Authority's policy was to make no provision for the continuing care of patients with neurological conditions; also, the man's age (he was 55 years at the time of his discharge) meant that he was not able to gain access either to the services for elderly people or to a unit for the younger disabled. Not only were there no suitable hospital beds for the man's continuing care but no provision had been made for such care in a nursing home under a contractual arrangement. In my opinion that situation amounted to a failure in service and I upheld the complaint. (I liken this case to one—W.478/89–90—involving a woman who suffered a severe head injury, which was published in the Selected Case volume for October 1990—March 1991.) While they were not formally the subject of my investigation, I found that aspects of the discharge arrangements had been unsatisfactory. None of the Infirmary's staff was aware of the Department of Health guidance which required them to set out in writing, before discharge, whether the Health Authority would pay the nursing home fees. Although the man's wife agreed to pay those fees herself, I considered in the circumstances that that had been inequitable.

Remedy

Leeds Health Authority, and the Trust which manage the Infirmary, apologised for the shortcomings which my report identified. Leeds Health Authority accepted all my recommendations, which were that they should make an *ex gratia* payment to the complainant for the nursing home costs which she had already incurred; that the man's future nursing care should be provided at the expense of the NHS; that they review provision of services for patients such as the complainant's husband; and that they remind their service providers of the need to follow Department of Health guidance on discharge procedures.

Failure to provide long term NHS care for a brain-damaged patient—Case No: E.62/93–94

Background and complaint

1. In December 1989 the complainant's husband suffered a brain haemorrhage and was admitted to ward 5 at the General Infirmary at Leeds (which is administered by the United Leeds Teaching Hospitals NHS Trust). On 6 August 1991 the senior ward sister told the complainant that nothing more could be done for her husband, that his bed was needed for other patients and that she should find a nursing home placement for him. She objected, believing that a nursing home could not provide the range of care which her husband required and that her own financial position would be damaged. In September the patient was discharged to a local nursing home, where he remains.

2. On 16 September 1992 the local Community Health Council (the CHC) complained on the complainant's behalf to Leeds Health Authority, which is the relevant health authority responsible for purchasing provision in the area, that they had not met their responsibility to provide for her husband's care needs. Leeds Health Authority replied on 20 January 1993 and wrote again on 8 March after a meeting on 11 February. The complainant remained dissatisfied with their refusal to meet the cost of her husband's nursing home fees.

3. The complaint which I investigated was that the patient was obliged to pay for continuing nursing care which should have been provided through Leeds Health Authority free of charge under the National Health Service.

Investigation

4. The summary of complaint for my investigation was issued on 2 June 1993. I explained to the complainant that some of the decisions of the staff concerned might relate, in my opinion, to the exercise of their clinical judgment taking them statutorily outside my jurisdiction. I obtained the comments of Leeds Health Authority and examined relevant papers including the patient's clinical and nursing records. My officer took evidence from the complainant, Health Authority staff and staff at the Infirmary. Although they are not within my jurisdiction, my officer also took evidence from the chief officer of the CHC, two social workers employed by the local Social Services Department and the matron of the nursing home. I have not put into this report every detail investigated but I am satisfied that no matter of significance has been overlooked. My investigation was not concerned directly with the circumstances of the patient's discharge from the Infirmary to the nursing home or whether the Trust had carried out their responsibilities in accordance with Department of Health guidance. Some references to the patient's discharge are included, however, to provide background information and the context in which the complainant and the CHC have pursued the complaint.

Statutory framework and policy context

5. The provision of health services in England and Wales is governed by the National Health Service Act 1977, which states in section 3(1) that:

> 'It is the Secretary of State's duty to provide .... , to such extent as he considers necessary to meet all reasonable requirements—
>
> (a) hospital accommodation;
>
> (b) other accommodation for the purpose of any service provided under this Act;
>
> (c) medical, dental, nursing and ambulance services;
>
> ....
>
> (e) such facilities for .... the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service;
>
> ....'

6. In connection with another investigation I was undertaking at the time the chief executive of the NHS Management Executive wrote to me in 1991, about the provision of care by health authorities:

> '....If in a doctor's professional judgment a patient needs NHS care, then there is a duty upon the Health Service to provide it without charge .... this can be done by providing community nursing care to the patient's own home, by providing in-patient care or by a contractual arrangement with an independent sector home (ie paid for in full by the health authority). The level of service provided overall is a matter for individual health authorities in the light of local circumstances and priorities.'

and:

> '....
>
> a. there is no general duty on a health authority to provide in-patient medical or nursing care to every person who needs it. Legal precedents have established that the Secretary of State's duty under section 3 of the Act is qualified by an understanding that he should do so "within the resources available".... Thus
>
> b. in any particular case the provision of such care may be deferred so that cases may be dealt with, in order of clinical priority, within the resources available; and
>
> c. consideration of clinical priority may mean that a particular patient may never be provided with in-patient nursing care.
>
> Further
>
> d. where a person is receiving private care, in a nursing or residential home, the Health Authority has no power to make "top up payments" to cover any shortfall between the charges of the home and any income support .... health authorities have, financially, an "all or nothing" responsibility for patients
>
> ....'

7. The Department of Health issued guidance (circular (HC(89)5)) in February 1989 about the discharge of patients from hospital. It states:

> 'The [discharge] procedures should provide for:
>
> '....
>
> 'ii. liaison with social services .... about alternative arrangements, if it appears likely the patient will not be able to return to his/her current place of residence .... Such arrangements must be made in good time and be acceptable to the patient and, where appropriate, the patient's relative or carers .... Where a person moves from hospital to a private nursing home, it should be made quite clear to him/her in writing before the transfer whether or not the health authority will pay the fees, under a contractual arrangement. No NHS patient should be placed in a private nursing or residential care home against his/her wishes if it means that he/she or a relative will be personally responsible for the home's charges.'

Failure to provide long-term care

8. The complainant told my officer that her husband had been admitted to the hospital on 8 December 1989 and had had surgery for a brain haemorrhage. In 1990 the consultant in charge of her husband's care indicated that eventually he would have to move from the ward. On 6 August 1991 the senior ward sister asked her to find an alternative placement because her husband's bed was needed for other patients. She asked if her husband could stay in the hospital, even if not in ward 5, but was told that there was no point in that. Another nurse took her to visit three nursing homes but the nurse thought that they might not be able to meet all her husband's needs at that time. On, she thought, 22 August 1991 the continuing care facilitator (a senior nurse who assessed elderly patients and facilitated their transfer to private nursing homes) and a social worker spoke separately to her about the discharge arrangements. She told them that she

feared that a nursing home would not be able to provide sufficient care. She also expressed disquiet that she might not be able to afford the fees and that she might have to sell the family home. There was little discussion about the financial issues but the continuing care facilitator said that only nursing homes with medical beds, of which there were only a few in the area, would be suitable. Later, the complainant visited two of those homes and chose the one where he now resides; her husband was discharged from the Infirmary and moved there on 20 September. Before his discharge the senior ward sister presented her with a 'discharge form' which she refused to sign because she did not agree with the discharge.

9. The complainant said that the care provided at the nursing home was generally acceptable. Her husband remained totally dependent on the nurses for his every need. He was doubly incontinent, had no mobility, had to be fed and could not communicate. (The home's matron confirmed that in separate evidence to my officer.) He also had a kidney tumour and cataracts in both eyes and had occasional epileptic fits for which he received medication. The nursing home fees had been £1,224 every four weeks but had risen to £1,344. Her husband had received relevant benefits from the Department of Social Security which offset the cost of the fees, but an annual shortfall of over £6,000 remained. An occupational health scheme to which he belonged did not provide financial assistance for those with chronic conditions.

10. After reading a newspaper article in March 1992 about the loss of hospital beds in Leeds for patients requiring long term care, the complainant contacted the CHC chief officer who said that she had good reason to complain about having to pay for nursing care. The CHC chief officer wrote to the Health Authority in a letter dated 16 September about her concerns. (The CHC chief officer told my officer that the letter might not have been sent until October.) The Authority's chief executive replied in January 1993 (see paragraph 12). The complainant remained dissatisfied and a meeting took place on 11 February with the CHC chief officer, the Authority's chief executive and the headquarters services manager. Four main issues were raised: the pressure applied on her to agree to her husband's discharge from the Infirmary; the failure to be informed of her right to refuse the discharge and the payment of the nursing home fees; the failure to be provided with written information about who would pay the nursing home fees; and the duty of Leeds Health Authority to provide her husband's nursing care free of charge. She had not been satisfied with the headquarters services manager's letter dated 8 March to the CHC (see paragraph 12). She could not reconcile her husband's condition with being told that he did not meet the criteria for NHS care. If his care could not be provided in a hospital the cost of his care in the nursing home should in her opinion have been met by Leeds Health Authority.

11. The CHC chief officer told my officer that the meeting on 11 February had been amicable and had lasted about an hour and a half. The chief executive and the headquarters services manager had appeared sympathetic to the complainant's view that her husband should have continued to receive NHS care. They had said that 'their hands were tied' by national policy in respect of providing long term nursing care and they had been more willing to discuss the discharge arrangements than issues concerning their responsibility to provide care. Their letter dated 8 March had set out fairly the questions raised at the meeting, although the central question of whether the NHS had a responsibility for providing continuing care had not really been addressed. Over recent years there had been a reduction in the provision of long term care beds in Leeds; *the public had become conditioned to that and now rarely complained.* Although Leeds Health Authority intended to provide community services for people with learning difficulties or mental illness, there was no provision for the continuing care of brain-damaged patients. She believed that the Act (paragraph 5) placed on authorities an obligation to provide such care. Discussions were taking place in Leeds about the future of neurosurgical services but the results had not been

disclosed. (I have seen that the Leeds CHC's Annual Report for 1991–92 highlighted issues about the discharge of patients into private nursing homes and the extent to which continuing care was, or should be, available under the NHS.)

12. Relevant extracts from the letters to which I have referred in paragraph 10 are as follows:

(i) The chief executive's letter of 20 January 1993 to the CHC:

> 'You will know that within the NHS in general over recent years there has been a tendency to reduce the number of continuing care beds in hospitals, concentrating on offering acute and rehabilitative medical services. This has reflected the national policy of providing continuing nursing care services within a community setting, with social security benefits being tailored towards meeting the cost of such services provided within private nursing homes ....
>
> 'It has not been the Authority's policy to "top up" Social Security payments for individual people being cared for in private nursing homes. In a different context, advice from the NHS Chief Executive is that such an arrangement is not possible. Against this background I am afraid that the Authority is not able to consider meeting the cost of [this patient's] nursing home fees.
>
> 'From 1 April 1993 I understand that it will be possible for [the complainant] to approach the Local Authority .... to ask for financial support in this respect. [They] will have discretion to offer such financial support, having regard to the means of the applicant.'

(ii) The headquarters services manager's letter of 8 March 1993 to the CHC:

> '[With regard to the patient's discharge from the Infirmary] I am told that it is documented that [the complainant] stated she did not wish her husband to be discharged ...., but it was a clinical decision by the medical team that [her husband] would not benefit further from acute clinical care. Staff at the Infirmary believe that [his] discharge was handled appropriately and with sensitivity ....'
>
> '[Regarding continuing care] .... it has not been the Authority's policy to [enter into contractual arrangements with nursing homes] in relation to the requirement for individual patients needing continuing nursing care .... [The letter then restated the position described by the chief executive and quoted in (i) above].
>
> 'There have been occasions where the Authority has agreed to meet the cost of continuing care for a limited period when specialist services were required .... This has been done because this was felt to be clinically necessary .... In [the patient's] case, there were four nursing homes locally which were able to meet his care requirements ....'

(iii) The chief executive's formal response to me about this complaint:

> '.... There is very little which can be added to the letters which have been written on this matter, and .... they form the basis of my official response ....'

13. The consultant responsible for the patient's care while he was at the Infirmary told my officer that even when he was discharged his condition had still been very poor. He had severe neurological damage and a renal tumour and had had a heart attack. He needed full nursing care and could not have returned home. However, his condition was stable and no further active treatment could have been given. Ward 5 was intended to provide only acute treatment. It had been difficult to find an alternative placement for him because the complainant was worried that a nursing home would not be able to provide the quality of care required. (I have seen an entry in the patient's clinical records dated 6 August 1991, which stated: '[seen by the senior registrar] start investigating placement? [another nursing home]'.) If she had not agreed to her husband's discharge he

would have had to stay longer in the ward. The consultant sympathised with the complainant's complaint that the cost of her husband's continuing care should be met by Leeds Health Authority; in his view, that was their duty but it might lead to the rationing of other services. There had been five or six other long stay patients in the ward at that time and they also had been discharged to nursing homes. There appeared to him to be a service gap for patients requiring continuing care. (I have seen the contract documentation for neurosurgical services, for 1991–92, between Leeds Health Authority and the United Leeds Teaching Hospitals NHS Trust. It relates to the 'surgical management of disease and injuries of the nervous system and its covering', including subarachnoid haemorrhage. It states that 'inpatient .... facilities are provided at [the Infirmary]' and that there is 'a full [multi-disciplinary] team .... who work together .... to ensure rapid inpatient rehabilitation and a rapid and smooth progress to discharge and continued outpatient care'. There is no reference to continuing residential care.) The consultant said that he was not aware of the requirements of the guidance (paragraph 7) and considered that it was not the responsibility of medical staff to ensure that patients were notified about who would pay nursing home fees (a matter which I as Health Service Commissioner find remarkable in the light of other investigations I have undertaken).

14. The senior registrar in the consultant's team told my officer that the consultant's decision to discharge the patient had been supported by all members of the multidisciplinary team. Ward 5 was not a suitable place for providing long term care (patients now stayed there no longer than about six months). Before his discharge he had asked a consultant geriatrician whether the patient could be offered a geriatric bed but he had been told that he was too young to be eligible for that (the patient was then aged 55 years). There was no provision for patients who were too young for geriatric care and yet not suitable for admission to a disability unit for younger people. Discharge to a nursing home had been the only realistic option. There had been no discussion with the complainant about who would pay for the nursing home fees and he had assumed that the cost would be met by Leeds Health Authority. In his view the care of someone as disabled as the complainant's husband should be met by the NHS and he was sympathetic to her complaint.

15. My officer interviewed separately the senior ward sister and a junior ward sister from ward 5 and the continuing care facilitator. Their evidence about the patient's clinical condition, his total dependence on nursing care and the decision to discharge him did not differ materially from that given by the consultant and senior registrar. The senior sister said that the discussions and preparations for the patient's discharge had begun in May and had continued until his discharge in September. She could not recall presenting a discharge form to the complainant; if she had refused to accept her husband's discharge, that would have been recorded. The continuing care facilitator said that it was not the Infirmary's policy to put in writing who would pay the nursing home fees; the complainant had agreed, however, to pay them.

16. The Trust's chief executive told my officer that, on the basis of the information available to him, it seemed that, while some points of detail might have been overlooked, it had not been an option for the patient to stay in ward 5 and, if his wife had not agreed to his discharge, he would probably have been sent to a [unspecified] long stay institution because there was no other suitable ward at the Infirmary. Leeds Health Authority had not been aware of, or involved in, the patient's discharge plan. The staff at the Infirmary had been better placed to know about alternative placement options than the staff at Leeds Health Authority.

17. For his part the chief executive of Leeds Health Authority told my officer that he first knew about the complaint when the CHC wrote to him in October 1992 (paragraph 10). When a clinician decided that active treatment in hospital could no longer be justified, the patient's discharge had to be arranged. He had

wondered how much information had been given to the complainant at the time of her husband's discharge to the nursing home. At the meeting on 11 February she had said that she had agreed to her husband's discharge although she had been unhappy about it. If, however, the discharge procedures had not been followed correctly, that was a matter for both Leeds Health Authority and the Trust. (The contract documentation provides that 'where the complainant holds the Purchaser [that is, Leeds Health Authority] responsible in respect of its procurement of services, the Purchasers shall respond ....'. The Provider (that is, the Trust), 'shall ensure that its staff are properly .... instructed with regard to all its policies and procedures'. The Trust's revised discharge policy, dated April 1993, states that where a patient requires placement in a nursing home the social worker and continuing care facilitator will 'ensure resources are available and can be committed': there is no reference to making clear in writing whether the NHS will pay the fees involved.) The Trust's duty was to ensure that the discharge was planned and implemented in an acceptable way, and Leeds Health Authority monitored the services provided. The purchaser/provider relationship was a positive one and it was in the interests of both that nationally-agreed procedures and guidelines were followed.

18. The chief executive said that Leeds Health Authority could not meet every health need. Present policy was for shorter inpatient stays with continuing care being provided in the community. The Authority did not provide for any long stay medical beds in hospital or have any contractual arrangements for such beds in private nursing homes. They were no different in that respect from most other health authorities. There were many residents receiving care in private nursing homes; if Leeds Health Authority were expected to pay nursing home fees they would soon become financially overstretched. He sympathised with the complainant's position and felt that the issues her complaint raised needed to be addressed nationally. He believed that the Authority had acted reasonably in this case. He stood by what he had said in his reply to the complaint.

19. The headquarters services manager told my officer that, while the 1977 Act appeared to place a general requirement on Leeds Health Authority to provide for all healthcare needs, that could not be held to be absolute since there had to be discretion so that account could be taken of financial limits and clinical priorities. The Authority were expected to provide continuing care in community settings. The Yorkshire Regional Health Authority had issued in May 1990 a guidance document on services for elderly people. (I have seen an extract which states that 'Requirements for long term care to be local, homely, small in scale and delivered according to a social rather than a medical model mean that long-stay wards in hospitals are inappropriate'.) He did not believe that any member of staff at Leeds Health Authority had been approached at the time of the patient's discharge.

20. The Authority's director of public health told my officer that she had not been involved in the handling of the complaint. She said that it was a health authority's duty to identify the health needs of the local population and to ensure that services were in place to meet those needs. That duty was limited by the resources available, and authorities had to identify priority areas. In Leeds, priority had been given to moving patients from long stay institutions into community settings. For acute medicine the regional policy was to move patients needing only nursing care into nursing homes. There had been a gradual reduction of long stay beds and the former Leeds Western Health Authority had had a declared policy of not providing medical beds for long term care. Some patients with severe brain damage were sent to placements outside the district, but that was for assessment rather than for the provision of continuing care. Leeds Health Authority monitored the performance of their providers, which were expected to conform to national policies and guidelines. In that way the Authority monitored the actions of the Trust. Hospital staff had a duty to provide relevant information to relatives before patients were discharged.

Findings

21. The complaint is that the patient's care in the nursing home should have been provided through, and paid for by, Leeds Health Authority. In order to place matters in context I have set out evidence about the discharge process which was followed in 1991. It is abundantly clear from the evidence of the consultant at the Infirmary, and the matron of the nursing home, that at the time of his discharge the patient was seriously incapacitated and required full time nursing care. At the heart of the complaint lies the question what provision should be made by health authorities for patients, like him, who need such care on a continuing basis. I have set out in paragraph 6 the position of the chief executive of the NHS Management Executive. The officers of Leeds Health Authority recognise the difficulties which the complainant faces in having to pay a substantial part of the nursing home fees, but they believe that the extent of the provision they have made is in line with national policy and that their services are broadly similar to those of other health authorities. I have been referred to regional policy (paragraph 19), but I take the view that it is irrelevant to the present case. It relates to elderly patients—usually interpreted as being those aged over 65 years—who are not by a long way as incapacitated as this patient. He was only 55 when discharged from the Infirmary.

22. The chief executive of the NHS Management Executive has stated that the NHS has a duty to provide care without charge where a doctor judges such care to be necessary on clinical grounds. He qualifies that by saying that there is an overriding duty to determine priorities within the financial resources available, and that consideration of clinical priority may mean that a particular patient needing inpatient nursing care may never have it provided. How should I regard Leeds Health Authority's position in the light of that guidance and the circumstances of this particular case? The patient had been in the care of the Infirmary for over eighteen months under a contract made by Leeds Health Authority. No one disputes that by August 1991 his condition had reached the stage where active treatment was no longer required but that he was still in need of substantial nursing care, which could not be provided at home and which would continue to be needed for the rest of his life. Where was he to go? Leeds Health Authority's policy, as explained by their chief executive, was (and still is) to make no provision for continuing care at NHS expense either in hospital or in private nursing homes. In particular I note that the contract for neurosurgical services makes no reference to continuing institutional care. This patient was a highly dependent patient in hospital under a contract made with the Infirmary by Leeds Health Authority; and yet, when he no longer needed care in an acute ward but manifestly still needed what the National Health Service is there to provide, they regarded themselves as having no scope for continuing to discharge their responsibilities to him because their policy was to make no provision for continuing care. The policy also had the effect of excluding an option whereby he might have the cost of his continuing care met by the NHS. In my opinion the failure to make available long-term care within the NHS for this patient was unreasonable and constitutes a failure in the service provided by the Health Authority. I uphold the complaint. I recommend that Leeds Health Authority make an *ex gratia* payment to the complainant to cover those costs which she has already had to incur and to provide for her husband's appropriate nursing care at the expense of the NHS in the future. I recommend also that the Authority review their provision of services for the likes of this man in view of the apparent gap in service available for this particular group of patients. (I record the similarities between this case and one—W.478/89–90—which was published in the Selected Case volume for October 1990–March 1991 and involved a failure to provide NHS after-care to a woman who had suffered severe head injuries.)

23. Although not formally subject to investigation by me, I am concerned about some faults in the arrangements made for the patient's discharge. The consultant decided in the exercise of his clinical judgment that the patient no longer required active treatment in ward 5. Since it was made clear that continuing occupation of an acute bed was not clinically appropriate, the complainant was left in the difficult position of choosing between refusing to accept his discharge or meeting the home's charges. None of the hospital staff

was aware of—nor did Infirmary policy apparently provide for—the requirement in the guidance (paragraph 7) to set out in writing, before discharge to a nursing home, who would pay the fees. I criticise that significant omission. The complainant was not given that information. I therefore regard her as having been placed under duress through that failure to inform her of all the relevant considerations she should have had placed before her. (I liken it to a case which I examined as Parliamentary Commissioner for Administration and published as a special report—Fourth Report for Session 1992–93, HC 519.) Although she acquiesced in the need for her to pay the nursing home fees, in my opinion that was inequitable in the circumstances. I recommend that Leeds Health Authority remind their providers of the need to follow the Department of Health's guidance on discharge procedures.

Conclusion

24. I have set out my findings in paragraphs 21—23. Leeds Health Authority have asked me to convey—as I do—their apologies to the complainant for the shortcomings which I have found and have agreed to implement my recommendations in paragraphs 22 and 23.

January 1994

W K REID

Health Service Commissioner for England

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HEALTH SERVICE COMMISSIONER
THIRD REPORT SESSION 1993-94 HC498
EPITOMES OF SELECTED CASES FOR
THE PERIOD OCTOBER 1993 TO MARCH 1994

1.FAILURE TO COMMUNICATE INFORMATION ABOUT A PATIENT'S TERMINAL ILLNESS - W.214/92-93

Matters considered

Inadequate communication between hospital staff and with a relative –transfer of records - poor handling by legal advisers of a complaint put through a solicitor - clinical complaints procedure.

Summary of case

A man whose father died in hospital some weeks after a routine operation at Manor Hospital, Walsall, complained that a consultant surgeon had not told him or the patient that he suspected cancer, that his father's medical records had not been transferred with him to another hospital, and that the response to his complaint had been deliberately delayed.

Findings

During his father's stay the man had not met or spoken to the consultant, relying instead on information provided by the nurses. The consultant told me that he had suspected cancer but had considered that invasive surgery to prove that, and chemotherapy, would be too painful and unpleasant for an elderly patient who was very ill. Normally he would have explained that to the family and could not understand why he had not done so. I could not question the clinical decision not to pursue diagnostic tests but I found that the consultant's suspicion had not been made known to his medical team, the nurses or the patient's son. I criticised as wrong in principle the consultant's expectation that the nurses could interpret medical notes, deduce a diagnosis and convey it to the patient or his family. When the patient was moved to a hospital nearby, entries in the notes made there showed that the patient's records had been sent with him. That aspect of the complaint had arisen from a misunderstanding although it was possible that a drug chart had been sent later. The man chose to pursue his complaint through his solicitor, and Manor Hospital referred the matter to their legal advisers at the West Midlands Regional Health Authority. I found no determination on the part of the consultant, the legal advisers or the hospital's management to resolve the complaint. There was undue delay, and a disturbing degree of complacency and lack of knowledge about NHS and local complaints procedures. When a reply was sent, it did not explain the availability of the clinical complaints procedure.

Remedy

The Walsall Hospitals NHS Trust expressed their apologies and agreed to set out in writing what was expected of medical and nursing staff in communicating a suspected diagnosis, to take steps to resolve the man's clinical complaint, to clarify their

complaints procedure, and to ensure that their legal advisers were fully aware of the Department of Health guidance and the local complaints procedures.

2.DELAYED DIAGNOSIS, TREATMENT AND CARE OF AN ELDERLY PATIENT - W.242/92-93

Matters considered

Delay in carrying out a scan - inadequate nutrition and food intake not monitored - consultant leave arrangements and cover - handling of complaint.

Summary of Case

A man's stepfather, who was suffering from sickness and lack of appetite and was jaundiced, was admitted as an emergency patient to Basildon Hospital but a scan requested that day was not carried out for four days. Two further examinations were carried out during the twenty days he spent in the hospital before he was transferred to another hospital, where he died two days later. The complainant sought, but was refused, an independent professional review of his stepfather's treatment at Basildon Hospital. The man complained to me that the scan had been delayed because too many radiologists had been on leave at one time, that his stepfather's low food intake had not been monitored, and that he had not been offered Complan (food supplement) when it was needed. He also complained that the Health Authority had taken far too long to deal with his complaint and that there was no specific time scale within which a complainant could expect a reply.

Findings

My investigation was hampered because the hospital could not name several of the doctors (particularly locums and junior doctors) who had attended the patient. The patient was admitted on a Friday under the care of a consultant on leave, and another two of the five consultant surgeons at the hospital were also on leave. Three of the four permanent radiologists were on leave. A request for a scan, made by a locum doctor, was not dealt with until after the weekend. Weekends also intervened at other critical times. That and a lack of team work meant that it took too long to determine the right treatment. (The clinical team suspected that the patient had cancer but nearly three weeks later, at the other hospital, it was found that he was suffering from a gallstone.) Neither the clinical team nor the nurses took any action to ensure that the fat free diet which the patient needed was provided, and his food and fluid intake were not monitored. The nurses did not take up the problems of poor appetite or diet with the doctors or the dietitians. Most of the nurses had little or no appreciation of the high fat content of many food supplements, inappropriate for a jaundiced patient. The nursing records and computer-generated nursing care plans were poor and signatures or initials on the clinical records were illegible. It took too long to reply to the complainant's letter; there was inadequate monitoring of his complaint and one reply was palpably inaccurate.

Remedy

The Basildon and Thurrock Health Authority and the Basildon and Thurrock General

Hospitals NHS Trust apologised to the complainant. The Trust agreed to review arrangements for consultant cover and supervision and their procedures for monitoring and meeting the nutritional needs of patients, and to hasten the phasing out of the inadequate care plans generated by computer.

3.DISCHARGE TO A NURSING HOME WHERE FEES WERE PAYABLE - W.256/92-93 AND W.579/92-93

Matters considered
Discharge of an elderly woman from a long-stay hospital to a nursing home where fees were payable - local handling of the complaint.

Summary of case
When it was decided to close Cane Hill Hospital a woman agreed to her aunt, who suffered from Alzheimer's disease, being discharged to a nursing home. About a month before her aunt was discharged the woman attended a meeting, convened by the Bromley Health Authority, at which the financial implications were discussed. The woman then withdrew her consent saying that she had not realised until the meeting that her aunt would be responsible for paying the home's charges. After further correspondence with the hospital she agreed 'with the greatest reluctance' that the move should go ahead. The complaints which I investigated were that the aunt's discharge from hospital was in contravention of guidance issued by the Department of Health; that the hospital behaved insensitively; that the Ravensbourne NHS Trust, which were responsible for the provision of NHS community-based care, responded inadequately to the woman's requests for her aunt to be returned to a NHS hospital; and that both the Health Authority and the Trust handled the woman's complaints unsatisfactorily.

Findings
I found that the Health Authority's policy of making provision, in appropriate cases, in local homes rather than in long-stay hospitals accorded with national policy. The Department of Health's guidance is capable of different interpretations but I did not dissent from the view that health authorities do not have an inalienable duty to provide hospital care for a person who is judged not to need it. In this case the consultant psychiatrist responsible for the aunt's care while she was in the hospital considered that her needs could be met at the home. My investigation showed that the woman had been aware for some time before the meeting that her aunt's discharge might have financial implications and I considered that some of the responsibility rested with her for ascertaining the precise position. I criticised the failure of the Health Authority to follow central guidance - under which they were required to provide written clarification as to whether they would pay the home's fees - at the earliest opportunity. The woman had already received an apology on behalf of the Health Authority in respect of a letter which she considered insensitive, and I upheld her complaints about the way in which the Trust replied to the concerns which she raised with them after her aunt's discharge.

Remedy

The Health Authority and the Trust apologised for the shortcomings I identified. The former agreed to take action to ensure that patients discharged to nursing homes, or their relatives, were given timely written information about the financial implications and about sources of further information which might be of help to them. I found no cause to recommend financial redress.

4.LACK OF CARE AND TREATMENT FOR AN ELDERLY PATIENT - W.306/92-93

Matters considered

Treatment for sore mouth and throat - inadequate nutrition - poor records - poor communications - failure to prevent attack by another patient or inform family of attack.

Summary of case

A woman complained that her elderly husband, who was admitted to Rochford Hospital for respite care, developed a sore mouth and swollen throat which was not treated until his family complained several times about a lack of care. During his second week in hospital he told his relatives that nurses had dropped him as they moved him from a chair to his bed. On one occasion when his daughter visited the man had cuts to his face, and she was then told that he had been attacked in the early hours of the morning by another patient. Three days later, a nurse telephoned the man's wife to say that he did not want any visitors as he wished to sleep all day. Members of his family visited the next day but they were not told of the seriousness of his condition. Four and a half hours after they had left the family were told by telephone of the man's death.

Findings

Although the man's medication made him susceptible to mouth infections, the clinical records and nursing care plan did not mention that risk and the family's concerns were not recorded. For a long period the man was practically unable to eat and had difficulty in drinking, but those problems were not raised with the doctors or the dietitian. When a doctor was eventually asked to look at the man's mouth he was found to have quite a serious degree of thrush. After a few days of treatment the man was able to take food. I found inexcusable the lapses in care and delay in treatment. I made no finding on the complaint that the man had been dropped by staff. The nurse who contacted the man's wife to tell her that he did not want any visitors did not consider that the deterioration in his condition was sufficiently serious to mention to the family; but the doctor who also saw him that morning thought he might die at any time. Key discussions and aspects of care were not recorded and the records were so fragmented as to make it impossible to discern a general and continuous appraisal of the patient's condition and care. I criticised the poor communications between staff and with the patient's family. I made no finding on whether the attack on the man by another elderly patient could have been prevented, but the relatives were caused unnecessary distress by not being informed of the attack before they visited.

Remedy
The Southend Health Care NHS Trust agreed to remind all staff of the need to assess patients at risk of developing mouth infections and to plan and prescribe appropriate preventative care, including adequate nutrition and fluids. They agreed to review their guidance to nursing and medical staff about record keeping and safeguarding records, and about allocating responsibility for ensuring that next-of-kin are informed of any significant deterioration in a patient's condition; and to consider what guidance should be given to staff about contacting relatives when a patient is injured while in the hospital's care.

5.LACK OF INFORMATION ABOUT CHARGES FOR A PRIVATE PATIENT - W.314/92-93.

Matters considered
Information given to patient before admission - response to complaint about private patient charges.

Summary of Case
A man attended an outpatient clinic at Oldchurch Hospital, Romford, as a private patient and was admitted urgently as a private inpatient for immediate exploratory surgery. After occupying a single room for two days he was nursed in a general ward for five weeks before being moved to a private hospital shortly before his death. His widow was charged £7020 for his stay at Oldchurch Hospital. Although her husband's insurers paid the bill, she questioned the amount but received no reply. She enlisted the help of her local community health council and her Member of Parliament but still received no satisfactory reply.

Findings
The man was referred from one specialist to another for investigation of a somewhat different condition from the one for which he had been attending the outpatient clinic. Neither he nor his wife was told that the standards of care, food, and accommodation were the same for all patients in the hospital and that there were no special facilities for private patients nor were single rooms reserved specially for them. There were only six such rooms in the hospital. They were not told that the man could choose to be admitted as a NHS patient. When his widow wrote to the hospital complaining that £7020 for two days in a single room was excessive, her letter was passed from one official to another. Her concerns about standards of food and the nursing care given to her husband were never answered. A letter sent by her Member of Parliament was lost. The staff wrongly thought that hospital complaints procedures did not apply to private patients in NHS hospitals. Department of Health guidance issued in 1986 about managing private practice and rendering accounts was not followed. The woman's complaint was ignored and in my opinion she was treated discourteously and insensitively. I upheld her complaint.

Remedy
The Barking and Havering Health Authority apologised. The Havering Hospitals NHS

Trust agreed to ensure that potentially fee-paying patients have explained to them what is covered by daily charges, to follow Department of Health guidance, to deal with private patients complaints in accordance with written complaints procedures, and to make arrangements to monitor effectively all complaints.

6.CARE OF PATIENT WITH SEVERE LEARNING DIFFICULTIES - W.351/92-93

Matters considered
Housing, health care and safety needs of a person with severe learning difficulties - community care re-settlement provisions.

Summary of case
A young man with severe learning and physical disabilities had been living in a purpose-built bungalow at a mental handicap unit with three other similarly disabled people for four years. Wolverhampton Health Authority planned to transfer back into the local area some patients who had been receiving care at a hospital outside the Health Authority's area and to re-settle them at the unit; those patients had challenging behaviour. The Authority was building new accommodation at a different site to house patients with needs like the young man. At a public meeting at which plans for the new accommodation were discussed his mother had voiced opposition to him being moved, because he had become settled at the unit. She had thought that the purpose-built bungalows at the unit were intended to provide a home for life for her son and others with similar disabilities. The Authority accepted her objection and the decision was made to house him in a different bungalow at the existing unit with several other residents, at least one of whom had attacked him before, who were considered less of a risk to the man than those with challenging behaviour. The man suffered physical attacks by other residents which he was unable to repel and had to be kept apart from them for his safety. The Health Authority had found no other effective solution to meet his needs. The mother complained that the Authority had failed to ensure her son's safety, had deprived him of a stable environment, and had not provided a satisfactory solution for him.

Findings
The Health Authority and the young man's consultant decided to change the use of the unit from a long term care establishment into an assessment centre for those with challenging behaviour, but that was not explained to his mother. Because staff remembered her opposition at the public meeting, she was not offered a place for her son at the new accommodation. Segregating him from most of the other residents during the day to ensure his safety meant that he was moved frequently between buildings and that, and the lack of compatible company, deprived him of the stable but stimulating environment which he was deemed to need. Eventually, a case conference involving the local social services department and all the health professionals involved in the man's care was held but no solution to the problem was identified. I criticised the Health Authority's lack of determination in tackling the problem. Their decision to re-settle patients from outside the area, at a time when the development of alternative local services was inadequate, worked to the detriment of the woman's son and a

number of other patients for whom they had made no provision and had no plans.

Remedy
The Health Authority apologised for the deficiencies which I found. They agreed to review their planning and provision for the small number of highly dependent patients like the woman's son and, with the social services department, to produce a comprehensive long term care plan - to be agreed with the woman - to meet her son's needs.

7.RIGHT TO BE ACCOMPANIED AT AN INDEPENDENT PROFESSIONAL REVIEW - W.502/92-93

Matter considered
Refusal to allow a community health council officer to accompany a woman and her husband at an independent professional review.

Summary of case
A woman and her husband, together with the chief officer of a community health council, were to attend an independent professional review arranged by Wessex Regional Health Authority, the woman having previously told the Authority that she wished the chief officer to be present as complainant's friend. The independent consultants who were to undertake the review were told that the CHC officer was to be present, but the woman was expecting also to be accompanied by her husband. On the day, the consultants said that they would see the woman in the company of either her husband or the chief officer, but not both. She regarded that as unreasonable and contrary to Department of Health guidance.

Findings
I considered that the consultants had acted unfairly in not being prepared to accept the woman and her husband as joint complainants in a review which was to be about the circumstances of the birth of their child. They had in my view placed too narrow an interpretation on the Department of Health guidance about the conduct of meetings with complainants. There should be no doubt about the right of a complainant to have a community health council officer present not as a representative of that body but in the capacity of patient's friend. I upheld the complaint.

Remedy
The Health Authority apologised for the shortcomings which I found. The consultants asked me to convey to the woman and her husband their regret for any distress caused by their interpretation of the guidance. I invited the Department of Health to consider whether regional directors of public health and the Joint Consultants Committee should be reminded of the right of complainants to decide who should be present as a friend at any meeting held under the clinical complaints procedure.

8.UNEXPECTED COSTS AFTER TRANSFER TO A PRIVATE HOME - W.524/92-93

Matters considered
Transfer to private residential home without prior notification or discussion about responsibility for payment of fees.

Summary of case
An elderly woman who lived alone fell and was taken to the accident and emergency department of the West Cornwall Hospital where her leg was put in plaster. She was unable to walk and could not be discharged home but was transferred the same day to a private residential home. On receiving a bill for £928 for her stay in the home she asked the Royal Cornwall Hospitals NHS Trust to pay but they declined. She complained that her transfer without agreement beforehand about responsibility for paying fees was contrary to Department of Health guidance, and sought redress.

Findings
A casualty doctor decided that the woman did not need to be kept in hospital, although several days later a fracture was diagnosed. When nurses found that the woman could not walk even when assisted, the casualty doctor telephoned a general practitioner and arrangements were made to admit the woman to a private residential home. I found no evidence that attempts had been made to find her a hospital bed, though it would have been possible to do so. The staff had not told the woman about fees for the home, nor had they followed the Department of Health guidance issued in 1989 or the local guidance about discharge procedures. The casualty doctor thought that any discussion about fees should have been the responsibility of the general practitioner. I upheld the complaint.

Remedy
The Trust apologised and paid the bill. They agreed to ensure that staff knew what was required of them under national and local guidance about discharge arrangements, and to discuss with social services the arrangements for ensuring that timely advice was available before any transfer to a private home.

9.HANDLING OF ALLEGATION OF SEXUAL RELATIONSHIP BETWEEN NURSE AND PATIENT - W.582/92-93

Matters considered
Response to allegation - referral to police - failure to give counselling.

Summary of case
A woman complained to consultants responsible for her care, and later to the unit general manager, that a male nurse had had a sexual relationship with her while she was a patient at Springfield Hospital. Two months later the general manager told her that an extensive investigation had been concluded and that appropriate action,

including informing the police, had been taken. The woman complained to me that the Wandsworth Health Authority had not investigated her complaint promptly, had delayed reporting it to the police and had failed to provide her with counselling. She also complained that she had been returned to the same ward after the termination of her resulting pregnancy, and that she had been given no assurance that adequate procedures had been put in place to prevent similar incidents in the future.

Findings

Although they had promised to take action, I found that the consultants took no positive steps until the woman put her complaint in writing. While recognising the need to discourage spurious or mischievous complaints I thought it unreasonable to require a woman to write formally about such a matter and I considered that action should have been taken when the complaint was made. I regarded as wholly inadequate the Authority's casual response to a potentially most serious allegation. Despite Health Department guidance, the hospital had delayed reporting the matter to the police until the completion of their investigations, some four months after the complaint was put, on the basis that they had first to decide whether the nurse had infringed his professional code of conduct. I did not find that argument remotely convincing. There was nothing to preclude a health authority from involving the police where an act of unlawful sexual intercourse might have been committed, without prejudice to their internal disciplinary enquiries; delay only made the task of the police more difficult. I found that the woman received counselling about the incident and her subsequent termination from her consultant, her general practitioner and a social worker. I was not persuaded that she had suffered hardship or injustice by not being told about, or referred to, other agencies and I did not uphold that aspect of the complaint. My investigation revealed that the woman had expressed a wish to return to the same ward and that, after her return, she had talked positively about being there, so I did not uphold that complaint either. The woman felt that her complaint had been to no avail because, although it had been upheld, no charges had been brought against the nurse who, in the months following the disciplinary hearing, had continued to work as a nurse elsewhere. Although the nurse was dismissed for gross misconduct, his registration to practice was a matter for the UKCC. The UKCC were not made aware of the case by the Authority until some six months after the disciplinary hearing. For that delay I severely criticised the Authority.

Remedy

The Authority apologised for the extremely worrying shortcomings I identified. The Authority's chairman agreed to ensure that guidance was issued, without delay, to all staff about the actions to be taken in respect of complaints relating to possible criminal offences.

10.INADEQUATE GUIDANCE TO AMBULANCE CREWS - W.624/92-93

Matters considered

Procedures for reporting road traffic accidents to the police - action taken to ensure compliance with local guidelines.

Summary
A man was knocked from his motorcycle when the door of a car was opened into his path. An ambulance came and he was taken to hospital. He was surprised that the police were not involved and later learned from them that, contrary to normal practice, the accident had not been reported to them by the ambulance crew at the time. The man complained to the London Ambulance Service (LAS), which is administered by the South West Thames Regional Health Authority. They acknowledged that their own procedures had not been adhered to in respect of reporting road traffic accidents to the police. They said that, although there was no legal requirement for such reports to be made, staff had been reminded that they should do so.

Findings
The LAS told me that their written control instructions (issued in 1978) had been overtaken by custom and practice; that a memorandum setting out a revised procedure had been issued in 1990 (they could not find a copy); that their staff had been reminded of the new procedure; and that a LAS/Metropolitan Police Communications Group had been established. In fact, the memorandum had been issued in March 1986, a copy being found eventually. I considered it sloppy practice not to have amended the control instructions at the same time. I also received no proof that the staff had received any recent written reminder of what to do when reporting road traffic accidents to the police.

Recommendation
The LAS apologised for their failings I recommended that they prepare and issue revised control instructions about road traffic accidents and ensure that the instructions made clear who was responsible for action under each stage of the procedure.

11.DELAY IN OBTAINING HIP REPLACEMENT SURGERY - W.688/92-93

Matters considered
Whether patient was informed that only one hip would be operated on at a time - delay caused by that procedure.

Summary of case
A woman who, at an appointment with a consultant orthopaedic surgeon at the Whittington Hospital, was told that both her hips needed to be replaced thought she had been put on the waiting list for both operations. Surgery to the right hip was performed and she was told that her left hip would be operated on when the right had healed. She later learned that she had been put on the waiting list afresh for her second operation. She felt that putting her name on the list for a second time, rather than carrying her name forward from the original entry, had caused her an unreasonable and avoidable delay in obtaining her second operation.

Findings
The decision that both of the woman's hips should not be operated upon at the same time was in my opinion made in the exercise of clinical judgment - as was the

decision to assess the outcome of the first operation before proceeding to the second. The oral and written evidence persuaded me that what would happen in respect of her operations had been explained to her. I did not uphold the complaint.

12.REFUSAL TO FUND IN-VITRO FERTILISATION (IVF) TREATMENT - W.711/92-93

Matters considered
Decision not to fund further IVF treatment at variance with health authority's approved policy.

Summary of case
A woman who was receiving IVF treatment paid for from non-NHS sources was told that the hospital she was attending in London no longer had funds to treat non fee-paying patients. She asked Bexley Health Authority, in whose area she lived, whether they would pay for her further treatment, but she was told that she was ineligible because she had already undergone more than two cycles of treatment. The complaint which I investigated was that the decision by the Health Authority was at variance with their approved policy, which stated that patients in their area who were already receiving IVF treatment would be limited to two cycles, each paid for by the Authority. My investigation was confined to establishing the Authority's intentions when approving the policy, and to considering whether there had been maladministration in arriving at or implementing their decision in this case.

Findings
The wording of the recommendation which led to the Authority's decision was capable of being interpreted in more than one way. I found that the Authority intended that patients who had already had two or more cycles of IVF treatment, however they had been funded, should not be eligible for more. I criticised the Authority for mislaying some of the woman's correspondence. That resulted in her not receiving a letter, sent to all local patients receiving or awaiting IVF treatment, which explained their decision and would have left her in no doubt about the position.

Remedy
The Health Authority apologised to the complainant for the shortcomings in communication which I identified.

13.INADEQUATE EXPLANATIONS BEFORE SURGERY - W.716/92-93

Matters considered
Consent to treatment - communication with a patient - private patient status and local procedures - handling of complaints.

Summary
A woman's cardiac pacemaker became dislodged while she was undergoing cardiac surgery as a private patient. She understood that the procedure to remedy the problem was to be performed under the NHS at Killingbeck Hospital, Leeds, administered by the Leeds Health Authority. Immediately before that operation was carried out she asked about its exact nature. The surgeon said that on grounds of cost he would only resite - not replace - the pacemaker but on the consent form he wrote 'Replace pacemaker'. The woman and her husband believed that he had changed his mind to accord with her wishes and earlier understanding of what was intended. It turned out that he had not and, later, she also received a bill for his services. She complained first to the surgeon, and later to the general manager, about what had happened.

Findings
I investigated five complaints. They were that the surgeon had not given a clear explanation of the proposed surgery; duress had been placed on the woman to sign the consent form, which was itself ambiguous and misleading; the decision, on grounds of cost, not to fit a new pacemaker or batteries was unreasonable; she should not have been sent a bill by the surgeon for his services; and the responses from the surgeon and the Authority to her complaint were dilatory and inadequate. I was satisfied that the surgeon had explained what he intended to do and that his decision to resite the pacemaker had been based solely on his clinical assessment of the risks and advantages. The words on the consent form were undoubtedly misleading and, although duress might not have been the intention, the woman had little option but to sign because she had already received her pre-medication and believed that her pacemaker was malfunctioning. The hospital's records showed that the woman was a NHS patient, so she should not have been sent a bill. Although the complaints were answered adequately I found that there had been a delay of 14 weeks, which was well outside the Authority's target for replies.

Remedy
The woman did not have to pay the bill. I recommended that the Authority should remind their staff that whenever possible explanations should be given, and consent forms signed, well before surgery takes place and that the forms should be worded in unambiguous terms. The Authority also agreed to my recommendation that their staff should be reminded of the importance of following the correct procedures for identifying and charging private patients.

14.HANDLING OF A COMPLAINT ALLEGING MISCONDUCT BY A JUNIOR DOCTOR - W.828/92-93

Matters considered
Handling of complaint and disciplinary procedures.

Summary of case
A woman complained to Lancaster Health Authority about the conduct and attitude of

a registrar during an examination at a hospital outpatient clinic. After she had met an officer from the Authority the complaint was passed to the Lancaster Acute Hospitals NHS Trust, which manage the hospital. She met the consultant responsible for her care but later declined an invitation to attend a further meeting with a panel of two consultant obstetricians and the personnel director. She complained that the matter had been handled insensitively and not in accordance with established procedures.

Findings
When she met the Authority's officer the woman gave her account of the incident and signed a statement prepared for her. The matter was then transferred to the Trust, and the chief executive arranged for the woman to see the consultant responsible. Again she told her story and at his request provided a further signed statement. The chief executive, considering the complaint a serious matter, set up an examination panel, originally intended to comprise four obstetricians and the personnel director, and the woman was invited to give her account for the third time. She declined. The panel found the complaint about the registrar's behaviour not to be substantiated, and the chief executive saw no need to take the matter further. The woman's complaint was about what she saw as unacceptable behaviour by the registrar during a clinical examination. That should have been handled under the provisions of Department of Health circular HC(90)9 which provides guidance to health authorities on how to tackle serious disciplinary charges. Under the circular the chief executive should have reported the matter forthwith to the Trust chairman – whose inclusion in the circular's procedures I looked upon as designed to give a degree of independence – for him to decide how to proceed. It should have been established, before setting up a panel, whether a prima facie case existed. I upheld the complaint that the woman's complaint about the behaviour of the registrar had not been dealt with in accordance with national policy. I also found that the woman's complaint had been dealt with insensitively because the Trust had been more concerned about how to deal with the registrar than how to resolve the complaint.

Remedy
The Trust apologised. They agreed to review their procedures for dealing with complaints where disciplinary issues were involved, ensuring that they adhered to Department of Health guidance.

15.HANDLING OF COMPLAINT BY FAMILY HEALTH SERVICES AUTHORITY – W.873/92-93

Matters considered
Procedures followed – interpretation of guidance – delay in responding to correspondence.

Summary of case
A woman had written to Salford Family Health Services Authority about a GP continuing to prescribe sleeping tablets for her mother, despite the fact that her mother abused prescribed drugs. She complained to me that the Authority had not given due

consideration to whether or not they could accept her complaint without her mother's written consent. After her mother's death the woman wrote again to the Authority complaining about the GP. By the time she was told that the Authority had not accepted her letter as a complaint and that she needed to write again, her complaint was out of time.

Findings
The Authority had not made proper enquiries about whether the woman's mother was incapable of complaining for herself, and had not acted in accordance with the NHS (Service Committees and Tribunal) Regulations. Misleading guidance in a leaflet from the Department of Health had left the Authority uncertain about what was required of them and had led them to conclude, mistakenly, that they could accept third party complaints only with the patient's written consent or where the patient had died or was under age. I considered that there was little doubt that the letter sent to the Authority after the mother's death indicated that the woman had a complaint and wanted it treated as such; but the Authority interpreted the letter only as a request for help. The delay caused her subsequent letter of complaint to be ruled out of time.

Remedy
The Authority have approached the Family Health Services Appeal Unit to see whether the injustice of the woman's complaint being ruled out of time can be remedied, and have undertaken to inform the woman of the outcome. They told me that they will ask the Department for further guidance to Family Health Services Authorities on the issues I raised.

16.HANDLING OF COMPLAINT BY FAMILY HEALTH SERVICES AUTHORITY - W.878/92-93

Matters considered
Initial information to complainant - inappropriate use of informal procedure - conduct of a conciliatory meeting

Summary of case
A man complained to the Hertfordshire Family Health Services Authority abut the treatment provided to his wife by the doctors of a general medical practice. The Authority decided that the complaint should be handled under the informal procedure and assigned the case to a lay conciliator, who arranged a meeting between the man and his wife and the practice doctors. The man remained dissatisfied, and his complaint was subsequently dealt with under the formal procedure. He complained to me that the informal procedure had been inappropriate and that he should have been offered a formal investigation at the beginning. He complained too that his, and his wife's, concerns had not been fully addressed at the meeting and that he had not been properly informed about what would happen as a result of the meeting.

Findings
I found that, given the nature of the man's complaint, the decision to use the informal

procedure was not in accordance with Department of Health guidance. Attempting to deal informally with matters which are not simply minor grievances is something my predecessors and I have criticised. I upheld that complaint. The man had not been informed initially either about the procedural options open to him or that his local community health council could help him with his complaint, and I upheld that complaint also. I noted with approval that, by the time of my investigation, the Authority had changed their standard letters to rectify those errors. I learned that the lay conciliator had brought the meeting to a close when, after more than two hours, it appeared unlikely that reconciliation could be achieved. Since reconciliation was the purpose of the meeting I found no fault in that, though it was clear at the time that the man had wished to continue putting his case. Because the meeting was held at a practice premises normal procedures were not followed and the man was not told about what would happen next. I upheld the complaint about the conduct of the meeting in that respect only.

Remedy
The Authority apologised for their shortcomings.

17.DELAY IN PROVIDING THERAPY FOR PATIENT WITH CHRONIC DISABILITIES - W.893/92-93

Matters considered
Care and treatment - communications with the patient's family

Summary
A young man who had chronic physical and mental disabilities was sent to a specialist unit in London for assessment. On his discharge home recommendations were made for further therapy which his family had understood would be available locally at Grimsby District General Hospital. A consultant in disability medicine visited the man at home but the expected physiotherapy and occupational therapy were not then provided. When the family pressed for action the chief executive of the Health Authority wrote that it was for the patient's general practitioner to arrange the continuing therapy, and that the Authority would be insisting on a case conference with social services and other parties to prepare a care plan. In further correspondence the consultant said that he was unable to assess the patient's needs because he had no facilities at the hospital's outpatient clinic, and the director of public health wrote that the necessary therapies were available at the hospital and that access to them was through the consultant. The young man's mother complained that a further assessment by the consultant should not have been a pre-requisite to her son obtaining further therapy at the hospital, that the delay had been detrimental to his interests and that the case conference had not been held.

Findings
I found that the complainant and the general practitioner each understood the purpose of the young man's stay in London to have been the assessment of his treatment needs. However, the consultant decided in the exercise of his clinical judgment -

which I may not question - that he needed to make a fresh assessment before any therapy could be considered. He did not have a clinic in Grimsby, but had one in Hull. At first he told me that to have seen the young man in Hull would have been unfair to the staff there, but he said later that the reason was that it would have confused the patient. I regarded it as unsatisfactory that he did not explain that at the time. While I was unable to make a finding on this part of the complaint, I was concerned that, contrary to what the complainant had been led to believe, the provision of therapy services for her son turned out to be dependent on available resources. It was not for me to judge whether the delay in providing treatment caused the patient clinical detriment, but the consultant's refusal to use his clinic in Hull (and, for this patient, the physiotherapy department in Grimsby) deprived the patient of care. A clinical psychologist could also have become involved sooner than was the case. I considered it unacceptable for patients to be used as bargaining counters to obtain additional resources and facilities. I upheld the complaint in part. I found that neither the consultant nor the general practitioner had been asked their opinion before the chief executive wrote about holding a case conference. They opposed one at that stage, but no one told the family that the conference would not be held. I upheld the complaint about that.

Remedy
Grimsby and Scunthorpe Health Authority apologised for the shortcomings in this case. While I did not make any specific recommendations I asked the chief executive to let me know what steps were being taken to bring forward the clinical care the young man required.

18.HANDLING OF A COMPLAINT ABOUT A DOCTOR ON LIMITED REGISTRATION - W.908/92-93 AND W.1019/92-93.

Matters considered
Arrangements for employing, and supervising the work of, an overseas doctor holding a limited registration certificate - status of a fiancé as a complainant - handling of complaint - clinical complaints procedure - refusal of an independent professional review.

Summary of Case
A woman who had her appendix removed at the John Radcliffe Hospital, Oxford, considered that on two occasions a surgical registrar's treatment deliberately caused unnecessary pain. Her fiancé complained on her behalf and the complainants eventually met the hospital's general manager, the surgical registrar, and the consultant concerned. The complainants were dissatisfied with the meeting and the response to further letters they wrote to the general manager. They complained to Oxfordshire Health Authority but matters remained unresolved. When they asked Oxford Regional Health Authority for an independent professional review under the clinical complaints procedure they were told that that was not possible because the surgical registrar was no longer employed in the NHS and had returned to his native land.

Findings
I found disconcerting weaknesses in the arrangements for employing visiting doctors such as the surgical registrar, who was without a contract for over five of the six months he had spent at the hospital, on a training programme organised by a University surgical unit. Although the fiancé was shown on the woman's records as her next-of-kin and she had explained in writing why she wanted him to act for her, the response to the complaint was delayed, and relations soured, by a legalistic dispute over whether the fiancé was acceptable as the complainant. There were shortcomings in the arrangements for the meeting, although I found that the attitude of the patient's fiancé had contributed to the failure of the meeting. The consultant refused to deal with any further correspondence about the complaint and no steps were taken to take it forward under the clinical complaints procedure. The regional medical officer's decision to refuse an independent professional review he explained to the complainants as being based on considerations of contract and discipline. I regarded those as irrelevant to the clinical complaints procedure. I upheld the complaints against both Health Authorities.

Remedy
Both Health Authorities apologised for the shortcomings which I found. The Oxfordshire Health Authority agreed to remind all consultants of their responsibilities in respect of the clinical complaints procedure, to tighten the local complaints procedure, and to review arrangements for issuing contracts to visiting doctors and for supervising their work.

19.PROVISION OF EMERGENCY DENTAL CARE - W.1026/92-93 AND E.710/93-94

Matters considered
Emergency dental services for visitor to a seaside town - handling of complaint.

Summary of case
A woman attended the accident and emergency department of Scarborough Hospital during the small hours of a Sunday morning after an accident while she was a visitor to the town. She was treated for facial injuries and told to return after 9.00 am because she needed dental treatment for a broken tooth. On doing so she was given an urgent appointment with a clinical assistant in oral surgery in a town 20 miles away. The complaints which I investigated were that hospital staff had made insufficient effort to arrange for the woman to receive emergency dental treatment locally, and that her complaint about what had happened had not been handled satisfactorily.

Findings
The doctor who saw the woman when she first attended the A and E department did not consider her to need immediate referral to the clinical assistant. When she returned at 9.30 am another doctor followed the hospital's usual practice in cases where a nerve was exposed and arranged treatment by the oral surgeon on call - on the day in question that was a general dental practitioner in the neighbouring town

who specialised in such work. The doctor regarded the woman as fit to travel and the journey to be necessary if the tooth was to be saved; the necessary equipment was not available at Scarborough Hospital. I did not uphold that aspect although I observed that, had the woman been told why she needed to see the dentist in the neighbouring town, the complaint might never have arisen. The hospital accepted that the woman should have been offered more help with her travel arrangements. It had taken two and a half months to reply to the woman's first letter of complaint and over seven and a half months to answer a second letter. The initial response was superficial and the other, though much better, was inadequately researched.

Remedy
The Scarborough and North East Yorkshire Healthcare NHS Trust apologised to the woman for the shortcomings which I identified.

20. ALLEGED FAILURE TO PROVIDE CHIROPODY TREATMENT - W.1032/92-93

Matters considered
Arrangements for chiropody treatment.

Summary of case
A man went to a mobile chiropody clinic in Skegness because he had an ingrowing toe nail but was told that he could not be seen without an appointment. He then went to the casualty department at the local hospital from where he was directed to another chiropody clinic, but there he was told that he should ask his general practitioner for an appointment to be arranged. An appointment was made with the mobile clinic but he attended a week early because, he said, his foot had become septic. He was offered limited treatment pending his scheduled appointment but considered that unacceptable. The services in question are administered by the South Lincolnshire Community and Mental Health Services NHS Trust.

Findings
I learned that new patients visiting a chiropody service clinic without an appointment were required to complete a referral form, including a medical history, so that chiropodists could carry out a proper assessment and provide safe treatment. I found that the man had refused to complete a form and therefore would not be given an appointment but that when he telephoned later with the necessary details an appointment was made for him by the chiropody service for three weeks ahead, well within the deadline of six weeks for assessing new patients. I was satisfied that the man had been offered first aid treatment at both clinics and I found that to be a satisfactory response to his immediate medical requirements. The man had chosen not to accept what he saw as a limited form of treatment which did not meet his expectations. I did not uphold the complaint.

Remedy
None.

21.INADEQUATE SEARCH FOR MISSING GENERAL PRACTITIONER RECORDS - E.46/93-94

Matters considered
Responsibilities of a Family Health Services Authority in respect of patients' medical records held by general practitioners.

Summary of case
A man was told by his general practitioner that some of his medical records appeared to be missing. He made a formal complaint to the North Yorkshire Family Health Services Authority who replied that, although they were responsible for passing his records from one general practitioner to another each time he registered with a new GP, the records were the property of the general practitioners and it was unlikely that the Authority were responsible for the loss. The complaint which I investigated was that the Authority had made insufficient effort to find the missing records after the man wrote to them.

Findings
There had been some doubt locally about whether the general practitioner or the Authority was the owner of patients' records. The view of the Department of Health is that such records are owned by the Family Health Services Authority concerned, so this Authority's view of their responsibilities was incorrect. They had a responsibility to take reasonable steps to ensure that records were kept securely and that they were readily available when needed. They had omitted to issue guidance to GPs about the preservation and destruction of records. I upheld the complaint.

Remedy
During my investigation the Authority contacted all the practices with which the man had been registered in order to find out whether they still held any records of his treatment. No records were found. The Authority apologised to the man for the shortcomings which I found and agreed to issue guidance to GPs about the preservation and destruction of records.

22.DELAYED RESPONSE TO REQUEST FOR INFORMATION ABOUT A BABY'S DEATH - E.305/93-94

Matters considered
Inadequate and delayed replies to a mother's request for information about the causes of her baby's death - notification of death to a coroner - poor handling of a complaint put through a solicitor - clinical complaints procedure - safeguarding of records.

Summary of case
A woman's baby underwent three operations at the Queen Elizabeth Hospital for Children, Hackney, but died a few weeks later. The woman asked for a post mortem

to find out the causes of the baby's death and a doctor at her general practitioner's practice also wrote to the hospital for information. He received a very detailed response from the consultant, who also wrote to the woman but by then she had asked solicitors to write on her behalf to the hospital to obtain the information. Having received no adequate reply to letters addressed to the hospital manager the solicitors wrote on several occasions to the general manager of the Hospitals for Sick Children Special Health Authority. They eventually received a full copy of the baby's records (and a bill), which they returned as they had not asked for them. After the matter had been referred to me the hospital manager's successor replied substantively to the solicitors in terms very similar to the letter which the consultant had sent to the woman's general practitioner.

Findings

The consultant, who had told the woman that he did not know why her baby had died, notified the death to the coroner. The coroner decided that he did not need to be involved. A post mortem was instead carried out by the hospital and the consultant's letter to the general practitioner essentially followed the technical terms of the post mortem report. The letter from the consultant to the woman, which coincided with her approach to her solicitors, was in simple lay terms but the apparent contradictions in it left her feeling dissatisfied. The hospital manager assumed that she was dealing with a medical negligence case rather than a request for information. I considered that, even so, had the hospital procedures for dealing with complaints or potential litigation been followed properly, the woman's concerns might have been addressed earlier and the misunderstanding about ligation avoided or corrected. I was also concerned that for a period of several months the clinical records were missing. The eventual reworking, by the new hospital manager, of the consultant's letter to the general practitioner fell far short of the hospital's requirement to avoid technical terms when writing to complainants and omitted mention of the clinical complaints procedure.

Remedy

The Health Authority apologised for what they described as a 'lamentable breach' of complaints procedures. They also agreed to implement measures for monitoring the handling of complaints; to remind staff dealing with complaints of the need to draw attention to the provisions of the clinical complaints procedure, where appropriate; and to review their procedures, in respect of medical records needed for a complaint or litigation, so as to ensure that such records were kept secure.

23.LACK OF CARE BY AMBULANCE SERVICE CONTRACTORS - E.309/93-94

Matters considered

Movement of patient to private ambulance - response to complaint

Summary of case

A woman complained that, despite his heart and breathing problems, her late husband had been required to walk from the ward to the ambulance when he left hospital. The ambulance was from a private ambulance company providing services under contract

for the Lancashire Ambulance Service, which is the responsibility of the Preston Health Authority. She complained that the findings in the Ambulance Service's response to her complaint were inaccurate and based on the version of events provided by the proprietor of the private ambulance company.

Findings

The request form for the man's journey home indicated that he required a chair and two attendants, but I found that the ambulance company proprietor had gone into the ward alone without a wheelchair or carrying chair. Accompanied by the proprietor, the man then walked to the ward exit, but his subsequent account of why he did so differed essentially from that of the proprietor. None of the ward nurses recalled the event, but from their evidence about the man's capabilities and his awareness of his limitations I did not believe that he would have walked unless he had been encouraged to do so. I upheld the complaint of a failure in care. I found also that the Ambulance Service's own investigation had shown the patient's version of events to be more credible that the proprietor's. Yet, in their response to the wife, they did not make clear that there was a conflict of evidence. The way they set out the proprietor's account in what they described as their 'findings' led her to believe that they preferred his account to that given by her husband. I rejected the proprietor's evidence and I upheld the complaint about the Ambulance Service's response. They told me that they had since ended the contract with the company involved.

Remedy

The Ambulance Service apologised for their shortcomings.

24.DELAYS IN TREATMENT DUE TO MALADMINISTRATION - SW.61/92-93 AND SW.95/92-93

Matters considered

Discharge procedures - communication between staff - handling of correspondence - management of waiting list.

Summary of case

A man discharged from Stirling Royal Infirmary, to which he had been admitted after suffering a heart attack, was told that he would be recalled for an echo-cardiogram. Not until his wife and GP had written separately about his follow-up care did that examination take place - some five months later. He then attended the clinic of a visiting consultant cardiologist from Western General Hospital, administered by Lothian Health Board, and was told by a registrar that he would have an angiogram at that hospital in four to six weeks time. Despite enquiries from his wife he had to wait two months longer than that. At a subsequent outpatient clinic he was offered surgery and the next day the man's wife wrote accepting the offer. By the time the man died some two months later, he had still not been put on the cardiac surgery list. His wife complained about the delays in his treatment.

Findings

I found that the echo-cardiogram was overlooked because the role and responsibilities of junior doctors in organising follow-up care were not fully understood. Procedures were inadequate for communicating instructions and recording and monitoring that follow-up care had been arranged. But for the persistence of his wife the treatment might not have been provided. Inadequate communication between the registrar and a secretary meant that the man's name was included on the routine angiogram list (a wait of three to four months) when the soon list had been intended. When the wife enquired about the delay the registrar forgot to reply to her. The consultant cardiologist later failed to put the man on the cardiac surgery waiting list after the wife had written because the secretary was unable to find the man's medical records which the consultant needed to see before adding him to the list. Many weeks went by. Because the cardiologist had no procedure for monitoring responses to his requests for medical records, the absence of the man's records went unnoticed until the man's GP made an enquiry. I found that letters sent to the consultant cardiologist's visiting clinic were not seen by him until his next clinic there, which could be up to four weeks later.

Remedy
Forth Valley Health Board agreed to ensure that the Stirling Royal Infirmary NHS Trust reminded staff of the need for good communications on giving and receiving instructions about patient care; reviewed their induction of house officers; and completed their revision of a patient discharge form. Lothian Health Board agreed to review their procedures for communicating waiting list information to secretaries and to formalise written procedures for secretarial staff, the recording of the receipt and dispatch of mail and medical records and monitoring procedures which the cardiologist had introduced. Both Boards apologised and agreed to take steps to ensure that correspondence sent to the cardiologist's visiting clinic was made available to him promptly.

25.DELAY IN SEEING A DOCTOR - SW.75/92-93

Matters considered
Communication between nursing staff and relatives - issue of post-mortem reports - handling of complaint.

Summary of case
A woman complained that, although a nurse had asked her to wait on the day of her husband's emergency admission to Aberdeen Royal Infirmary because a doctor wanted to see her, she had not been approached by any doctor despite waiting for several hours. She had also been misled and caused additional distress by two contradictory autopsy reports. She considered that the responses from the Grampian Health Board and later the Aberdeen Royal Hospitals NHS Trust to her complaint had not accurately reflected what had occurred.

Findings
I found that, after the woman was asked to wait to see a doctor, she had waited in

vain for an exceptionally long time before being advised to go home. The ward had been busy at the time so some delay would have been understandable, but as no effort had been made to ensure that the woman was seen by a doctor or to keep her informed of what was happening I concluded that the staff had simply forgotten that she was waiting. To make matters worse the nurse who eventually spoke to her apparently made no effort then to contact a doctor, thus making her wait a total waste of time. I found that the woman had not appreciated that a post-mortem report giving the results of the pathologist's macroscopic (naked eye) examination, which she had been shown by her GP, was only a preliminary report and would be followed by a histology report. When that report was issued some seven weeks later it confirmed the presence of malignant disease, which had been diagnosed by the physician treating her husband but had not been identified on macroscopic examination. In the meantime the woman had been left with the mistaken impression that her husband's condition might have been diagnosed wrongly. I commented that, where macroscopic findings differ from a hospital clinician's diagnosis, some discussion between the pathologist and the clinician before communicating with a third party, such as a GP, would be prudent. I was critical of unnecessary delay before the histology report was issued. I found that the Board's responses to the complaint had not entirely accurately reflected what had occurred.

Remedy
The Board apologised and agreed to ensure that the Trust, which now manage the hospital, should (a) remind ward staff of what is expected of them when a relative is waiting to see a doctor and (b) review their policy of sending post-mortem reports to GPs where macroscopic findings are at variance with a hospital clinician's diagnosis.

26.DELAY IN PROVIDING NON-URGENT AMBULANCE TRANSPORT FOR A VERY ELDERLY PATIENT - WW.51/92-93

Matters considered
Provision of an ambulance to take a patient home - care in accident and emergency department - explanation for delay - standards in respect of non-urgent ambulance services.

Summary of Case
A 90 year old woman, who fractured her pelvis in a fall at the nursing home where she lived, was taken to Ysbyty Gwynedd where she was x-rayed and seen promptly by a doctor. The doctor decided she should be discharged into the care of the nursing home. At 11.35am transport was requested but she waited on a trolley in the A and E department until an ambulance eventually arrived and collected her at 6.10pm.

Findings
Gwynedd Health Authority agreed that the woman had waited far too long and said that, had it been known that a substantial delay was likely, she could have been admitted to a ward. The nurses had made several requests for an ambulance. Because the woman had to travel lying down, it needed to be an emergency

ambulance or one with stretcher facilities and an attendant. I found that the nurses had given attention to the woman's needs but that the problem over transport should have been referred to senior hospital staff earlier. At the ambulance control room the staff had not recorded the request for what they regarded, despite the woman's special requirements, as a non-urgent same-day journey. Such requests were simply 'remembered' and dealt with 'as and when' a suitable ambulance became available. I was told that it would not have been possible to use any of a number of emergency ambulances which were available because they had to stay at their stations to provide emergency cover, and that because the day in question was very busy it had not been possible to say when an ambulance would be available. My staff's analysis of the ambulance service workload showed that it had been a busy day but not unduly so and that there had been some ambulances, including some waiting outside the hospital, which could have been used to take the woman home earlier. I criticised the inaccurate replies to the complainant and to me, the non-recording of requests, lack of time standards, lack of monitoring of non-urgent transport, and the premature disposal of a relevant control room recording tape.

Remedy
Gwynedd Health Authority apologised and agreed to issue guidance to medical staff that, when discharging vulnerable patients, they should make clear at the outset by what time discharge should happen. They accepted my recommendation that the ambulance service should record all requests for transport; introduce standards for non-urgent transport and undertake a sample survey to measure their performance in respect of non-urgent transport; and issue guidance about keeping control room tapes.

27.PROPERTY HANDLING PROCEDURES - WW.54/92-93 AND WW.59/92-93

Matters considered
Recording of property removed from a seriously injured patient - transfer of patient's property - evidential value of property - notification of death to a coroner.

Summary of case
An outdoor pursuits instructor who was instructing a group of abseilers fell and was taken by ambulance to Tywyn Hospital (a small cottage hospital), which is administered by Gwynedd Health Authority. From there he was transferred to Bronglais General Hospital where, some hours later, he died of his injuries. Over three years later (and after two inquests into the death) the man's father discovered that hospital staff had given property which might have included items of evidential value - namely, clothing and an abseiling harness with a karabiner wrongly to a third party. Both Tywyn Hospital and Bronglais Hospital (which is the responsibility of East Dyfed Health Authority) denied removing any of the man's clothing or property. The father complained to me that correct procedures had not been followed.

Findings
I found, despite some conflicting evidence, that written procedures had been ignored.

I also found some defects in those procedures. I upheld the complaint against both hospitals.

Remedy
Both Health Authorities apologised and agreed to remind staff of the need to follow written procedures. I recommended that such procedures should included advice about property which might have an evidential value. I also recommended that clearly marked property bags be used by Gwynedd ambulance staff, that clearer staff guidance be provided about what items should be recorded as valuable, and that a renewed search be made for a missing property book. I also recommended that medical staff should be reminded to record the date, time and circumstances of the notification of a death to a coroner.