THE SCOTTISH OFFICE

Department of Health

NHS
MEL(1996)1

NHS Management Executive
St. Andrew's House
Edinburgh EH1 3DG

8 January 1996

Dear Colleague

HEALTH SERVICE COMMISSIONER REPORT: SELECTED INVESTIGATIONS COMPLETED APRIL - SEPTEMBER 1995

Summary

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

Background

2. The Commissioner's 6 monthly report gives detailed accounts of a selection of the 67 cases reported on by him during the period. The shorter summary versions (epitomes) also enclosed are suitable for wide distribution among staff.

3. A particular theme in the report is the occurrence of problems when patients are transferred. In several of the cases the events investigated had serious consequences for the patient; and in 3 cases the outcome of the investigations resulted in financial redress being given by the authority concerned.

Action

4. Board General Managers and NHS Trust Chief Executives are asked to:

4.1 distribute the epitomes as widely as possible;

Addressees

For action:
General Managers, Health Boards

Chief Executives, NHS Trusts

General Manager, Common Services Agency

General Manager, State Hospitals Board for Scotland

For information:
(epitomes only)

General Manager, Health Education Board for Scotland

Executive Director, SCPMDE

Chief Officers/Secretaries
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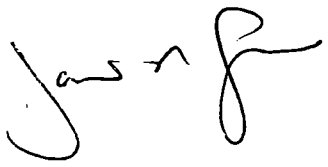
4.2 note that, on this occasion, a report on action taken to improve procedures in light of the Commissioner's report will not be required. An action report will however continue to be requested when the Commissioner's Annual Report is distributed, in preparation for the Chief Executive's annual appearance before the Select Committee on the Parliamentary Commissioner for Administration.

Yours sincerely



DAVID R STEEL
Head of Health Gain

MEL(1996)1

Epitomes of Selected Cases

Case No. E.220/93–94—Information about waiting times for examination and for surgery

Matters considered *Failure to provide reliable information about waiting times and admission dates—reimbursement for private treatment*

Summary of case On 19 March 1993 a woman was seen in the outpatient clinic of a consultant surgeon at Harold Wood Hospital. He told her that there was an urgent need for her to be examined under general anaesthetic. When she spoke to his secretary a week later, she was told that she might have to wait a year or more for the examination so she asked the consultant to carry it out privately. The results indicated that she needed surgery, but the consultant said that he could give no indication of when it could be carried out under the NHS because he had no NHS beds available. In view of that she had the operation done privately by the consultant on 20 May. The woman and her husband complained to the Havering Hospitals NHS Trust, which manage the hospital, that they were compelled to have treatment undertaken privately because the hospital had been unable to carry it out within a reasonable time. They sought financial redress.

Findings The woman and her husband had received information only from the consultant and his secretary, and they were not given any advice about what they could do if they felt that the waiting times were too long. The Trust had not been informed of the woman's concern about waiting times: it was possible that she could have been offered admission within a relatively short time as a NHS patient if the Trust had been told of her situation, as they should have been. The Trust could have done more to assess waiting lists of consultants whom they employed. I found that the Trust should accept responsibility because the inadequate information which the woman received came from staff employed by them. I upheld the complaint.

Remedy The Trust agreed to issue guidance to their staff on how they should deal with enquiries about waiting times and admission dates; and to reimburse the costs of the woman's examination and surgery.

Case No. E.558/93–94—Funding of dental treatment

Matters considered *Explanations given to patient—extra-contractual referral (ECR) funding arrangements*

Summary of case A woman needing highly specialised dental treatment was referred to the Charles Clifford Dental Hospital, Sheffield where in June 1992 she underwent a NHS assessment by a professor of restorative dentistry. She complained that it was not explained to her that the treatment she required would be undertaken privately, nor was she told about alternative available treatment funded by the NHS. She had to pay for the treatment she received. She sought redress.

Findings The position about costs was not properly explained to the woman and no consideration was given to the possibility known to the professor, of applying

to her home area health authority for funding as an ECR. Because she was offered no alternative to private treatment she was denied the possibility of NHS treatment. I upheld the complaint.

Remedy Sheffield HA, who manage the hospital, apologised and agreed to reimburse the woman the cost of her dental treatment.

Case No. E.825/93–94—Patient's fall and handling of complaint

Matters considered *Circumstances of fall by patient—failure to answer complaint*

Summary of case An elderly man with Parkinson's Disease was admitted to Colindale Hospital in June 1992 for respite care. Left unattended in the ward bathroom, he fell, fracturing his spine, and died two days later as a result. His daughter complained about the circumstances of the fall, asking how her father came to be left on his own in the bathroom and for details of the circumstances in which he was left. Seven months later she complained to me that the Trust had not answered her questions.

Findings After the patient's death the Trust immediately investigated the accident, held a disciplinary hearing and concluded that the nurse responsible for his care had not provided adequate help. They took disciplinary action against the nurse but made no reference to the failure of care in a letter of condolence to the family. When the patient's daughter later put questions about the accident to the Trust, they referred her letter to their solicitor for advice. He suggested a full reply but failed to produce one through an administrative oversight. The Trust failed to act because they had no arrangements to monitor progress in dealing with complaints referred to solicitors. The Trust replied over a year later, after I had started my investigation and my officer had reminded them but their letter gave no explanation or apology for the delay. It made no admission of the Trust's own view that the care provided had been unsatisfactory, and offered no apology for that. Two years after their father's death, his family had still not received answers to their questions or any apology for the shortcomings in care which led to the accident. I criticised the Trust for failing to monitor their solicitors' actions and the inadequacy of their response to the complainant. I upheld the complaint.

Remedy The Trust (i) took steps to ensure that staff monitored progress in dealing with complaints referred to their solicitors and (ii) reminded staff dealing with complaints that replied should explain the reasons for any failure in service and should contain an apology where appropriate.

Case No. E.851/93–94—Care of a young woman with meningitis

Matters considered *Delay in attending to patient in A and E—failure to monitor—delay in attendance of crash team—handling of complaint*

Summary of Case In April 1993 a young woman suffering from meningitis, was taken to the A and E department at William Harvey Hospital, Ashford, where she had to wait for medical attention before being sent to the radiology department for a scan. She was there for an hour without a doctor in attendance to monitor her condition. While being transferred to the intensive therapy unit she suffered a cardiac arrest but there was a delay in the arrival of the crash team. She died the next day. Her father complained about her care and about the hospital's unsatisfactory handling of his complaint. The hospital was managed

at the time by the South East Kent Health Authority, which were succeeded on 1 April 1994 by the East Kent Health Authority. Since then it has been the responsibility of the South Kent Hospitals NHS Trust.

Findings I found that on arrival the young woman was attended by nursing and medical staff without undue delay. The nature and extent of the supervision during her scan were for the clinical judgment of the staff concerned, and therefore outside my jurisdiction. I was satisfied that the decision not to send a doctor to the scan room was properly made. I criticised strongly the lack of an audit record of the response to the emergency call although I considered it likely that most members of the crash team were either already present or arrived promptly. I criticised the Authority's handling of the complaint: not all the relevant staff were interviewed during the investigation, inadequate explanations were given and there was delay in providing a definitive response.

Remedy East Kent Health Authority apologised. The Trust agreed to remind staff (i) of the importance of following agreed procedures for cardiac arrest and emergency calls, including completion of audit records, (ii) to clarify complaints before attempting an investigation (iii) to obtain evidence from all relevant staff and (iv) to follow complaints procedures.

Case No. E.935/93–94—Inadequate transfer arrangements

Matters considered *Appropriate transfer—transfer and transport arrangements*

Summary of case An elderly man was admitted to King George Hospital, Ilford in November 1992 for investigative surgery, which established that he had an inoperable malignacy and his family was told that he might be transferred to a geriatric ward at Barking Hospital. His wife was told one morning that he was to be transferred that day although, in her view, his condition had deteriorated overnight. There was delay before the arrival of an ambulance which then delivered several other patients before taking him to Barking Hospital. When he arrived no bed was available and he died shortly after one was found for him.

Findings There were written instructions for the transfer of patients between the two hospitals but none of the staff dealing with the man's transfer knew of their existence. I found no evidence that his fitness for transfer had been assessed by doctors on the day of his move. Nobody took steps to ensure that appropriate transport was provided and there was a failure in communication between the two hospitals: staff at King George Hospital believed that a bed was available at Barking Hospital but the evidence of staff there, supported by contemporary documents, was that no such arrangements had been made. I upheld all aspects of the complaint.

Remedy Redbridge Healthcare NHS Trust, who now manage both hospitals, agreed to review their discharge and transfer procedures and to make sure that all staff were fully aware of their responsibilities.

Case No. E.1004/93–94—Charges for spectacles

Matters considered *Optical charges regulations—response to representations*

Summary of case In June 1993 an advice centre wrote to Moorfields Eye Hospital, London questioning charges for the supply and subsequent repair of spectacles for a young man who was unemployed and suffered from epilepsy. The hospital maintained that the relevant regulations had been applied correctly.

Findings The charge for supplying the spectacles was correct but the hospital took insufficient steps to find out whether a contribution towards the repair of the

spectacles might be justified. I criticised the tone of some letters from the hospital to the advice centre, as well as delays arising from the loss of records and shortcomings in investigating and answering the complaint.

Remedy Moorfields Eye Hospital NHS Trust agreed to review their record-holding procedures and to ensure that all complaints were investigated thoroughly and answered comprehensively. They later told me that the cost of repairing the spectacles had been refunded.

Case No. E.1108/93–94—Delays in outpatient services

Matters considered *Delay in providing scan results—arrangements for outpatient appointment*

Summary of case A man attending a pain clinic at Birmingham Accident Hospital was sent for a MRI scan at the Royal Orthopaedic Hospital, Birmingham on 9 July 1993. The Accident Hospital closed on 8 August and the pain clinic was moved to the General Hospital, Birmingham. He enquired about the scan results several times but received no reply until November when, after writing to the General Hospital manager, he was asked to attend the pain clinic on 9 December. He complained that there had been an unreasonable delay in providing the scan results to him and his GP, and that on 9 December he had had to wait too long to be seen.

Findings Although he had little experience or clinical interest in pain clinic work, a consultant had tried to keep the pain clinic service going despite a lack of settled premises and adequate staffing. I criticised the hospital for allowing that situation to continue for over seven months. The scan results had been sent to the consultant at the Accident Hospital on 12 July but appeared to have gone astray, although no-one could explain why. It was also possible that they had been received but no action taken. A simple 'brought forward' system could have prevented the inconvenience that the man suffered. I criticised the consultant for failing to notify the man's GP of the results until a year after the referral. The consultant's secretary had failed to record the 9 December appointment in the pain clinic diary and because of that the man was not expected and his records had not been obtained. A search was then made for them but they were not found for some time and the man had to be seen without them. I found that the Authority, while undergoing a period of major change, had failed to maintain an adequate grip on an important area of patient care. I upheld both complaints.

Remedy South Birmingham Health authority, who managed all three hospitals at the time, apologised for the shortcomings I identified. The University Hospital Birmingham NHS Trust who have managed the General Hospital since 1 April 1995 agreed to make sure that all departments had adequate patient referral systems in place.

Case No. E.36/94–95—Received lack of independence of investigation into an untoward incident

Matters considered *Delayed medical care after injury to patient—untoward incident procedure not followed—lack of independence of investigation.*

Summary of case During the night of 25/26 June 1993 a patient in a ward at Leavesden Hospital, Watford was found to have unexplained bruising when a nurse checked him at 5.30am. The duty doctor was telephoned three times but did not come until after 9.00am. The patient's sister complained of a failure to provide medical care and to follow procedures for untoward incidents. She also complained that the handling of her complaint by Horizon NHS Trust, Hertfordshire was inadequate and lacked independence.

Findings The delay in providing medical attention could have been significantly reduced if there had been more effective communication between the nurse and the duty doctor. A doctor's decision about when a patient needs to be seen is taken in the exercise of clinical judgment which I cannot question, but I was surprised that the duty doctor did not come more promptly when told that the patient had head injuries. I criticised staff for ignoring the hospital's untoward incident procedure: they should have investigated the incident immediately and informed the patient's relatives earlier. Once the matter eventually came to the attention of senior managers a thorough investigation was carried out. There were two inquiries, the second being chaired by the Trust's director of nursing. Though she was not directly responsible for managing the nursing staff, I did not see how she could have been perceived as independent. The Trust are considering introducing an independent element in future inquiries.

Remedy The Trust apologised for their shortcomings. They agreed (i) to remind nursing staff of the importance of giving doctors precise details of any injuries sustained and their view of the urgency of the situation and (ii) to draw to the attention of medical staff the Trust's guidance for on-call doctors.

Case No. E.38/94–95—Clinical complaints procedure

Matters considered *Handling of complaint—misleading information about clinical complaints procedure*

Summary of case In may 1993 a woman complained to St George's Hospital, Lincoln about aspects of her late partner's care and treatment. Dissatisfied with the general manager's reply which she received on 8 July, she wrote to the North Lincolnshire District Health Authority (HA), which at the time managed the hospital. The HA's reply failed to satisfy her, and in October she asked that her complaint be referred to the Trent Regional Health Authority (RHA) under the clinical complaints procedure. In April 1994 the acting regional medical officer wrote rejecting her request for an independent professional review (IPR). She complained to me that the HA had dealt with her complaint in a dilatory and unsatisfactory manner, that there were inaccuracies in the general manager's reply and that the RHA misled her about the clinical complaints procedure and delayed the review of her case.

Findings I did not find that the HA initially dealt with the woman's complaint in a dilatory or unsatisfactory manner. There was no evidence of inaccuracies in the general manager's letter of 8 July, but information provided by the HA's director of quality in September and October 1993 misled her about the clinical complaints procedure so that she formed the impression that the IPR would be its sole component. The RHA subsequently attempted on many occasions to explain the procedure but not until January 1994 did they provide her with written confirmation of it. I upheld the complaint to the extent that the HA misled the woman about the procedure. Delays occurred at the HA and the RHA while the case was being considered under the procedure. The woman's misunderstanding of the position could have been avoided if the procedure had been properly explained to her at the outset. It was unacceptable that it was over six months before she was told that her request for an IPR had been turned down.

Remedy Lincolnshire Health Authority, which succeeded the HA, and the RHA apologised. Lincoln Hospitals NHS Trust, which now manage the hospital, and the RHA agreed to provide to complainants with a clinical complaint a written account of the full procedure. The RHA agreed to issue as soon as possible guidance on handling clinical complaints.

Case No. E.46/94–95—Premature incorrect diagnosis

Matters considered *Premature diagnosis—communications—handling of complaints*

Summary of case A woman referred to a consultant surgeon about a lump in her breast was seen as an outpatient in July 1993 at St Mary's Hospital, Paddington. The surgeon diagnosed a tumour and outlined the treatment required, which included an operation in August for which the woman signed a consent form. The next day she underwent tests after which the consultant told her that the results showed a cyst. The woman complained to me that the initial diagnosis had been premature and had been given in an insensitive and uncaring fashion and that her GP was not informed of the revised diagnosis. She also complained that her first letter of complaint to the consultant had not been answered and the subsequent handling of her complaint by St Mary's NHS Trust, which manage the hospital, was dilatory and inadequate.

Findings There were conflicts in the evidence about what was said when the consultant surgeon diagnosed a tumour but I could understand why the woman thought she had been given a firm diagnosis. The distress caused was unnecessary when information to support or refute the diagnosis would be available the next day. There were no arrangements for counselling breast clinic patients immediately after diagnosis, or for making sure that they were fit to travel home. I saw that as a cause for concern, although arrangements had subsequently been introduced. I was unable to discover why the GP had not been informed of the revised diagnosis. There were no systems to make sure that letters dictated at clinics were sent and records of consultations kept on file. It took too long for the Trust send an initial reply to the woman's letter of complaint. When she raised further concerns she did not receive a definitive reply. I criticised the Trust's handling of complaints as I have done in the past.

Remedy The Trust agreed (i) to take care in communicating with patients about breast lumps, particularly when the diagnosis is tentative; (ii) to make sure that such discussions are recorded in the medical records; (iii) to review their procedures so that safeguards are in place to make sure that letters dictated after clinics are sent and that records of consultations are kept on file; (iv) to send a definitive reply to the complainant with an apology; and (v) to review the operation of their complaints procedure.

Case No. E.79/94–95—Refusal of extra-contractual referral (ECR)

Matters considered *Information about the ECR procedure—review based on inaccurate information*

Summary of case In July 1993 a man had his daughter admitted to a private clinic after being told by her general practitioner—who had been in contact with the purchasing manager of Mid-Surrey Health Authority—that the cost of her care would be met by the Authority as an ECR. On 5 August 1993 he was told that the Authority's ECR Panel had decided not to fund his girl's treatment. When he complained, the decision was reviewed and upheld by the Authority's ECR Appeal Panel on 15 February 1994, but the record of its decision contained inaccuracies.

Findings Records of telephone conversations showed that the purchasing manager had told the general practitioner not that funding had been approved but that the ECR would need to be considered by the Authority before funding could be made available. The guidance issued by the Authority to general practitioners left scope for misunderstanding about the prospects fo referrals being approved. To that extent I upheld the complaint. There was confusion about the role of the private clinic in the ECR procedure. Contrary to national guidance issued in September 1992, the clinic's medical director considered it was not

her role to approach the Authority for funding and assumed that the girl would be a private patient. Discrepancies in the report of the Appeal Panel's deliberations cast doubt on the Panel's understanding of the facts.

Remedy The Authority agreed (i) to revise the guidance issued to general practitioners; (ii) to arrange for the Appeal Panel to reconsider the matter and (iii) if the Panel upheld the decision not to fund the girl's treatment, to explain clearly which of the grounds for refusal provided in the national guidance applied.

Case No. E.93/94–95—Care of an elderly patient and unsatisfactory handling of a complaint

Matters considered *Medical staff not aware of local policies—delay in obtaining x-rays and arranging a bone scan-complaint handling.*

Summary of case On 13 May 1993, a man's elderly mother, who had fallen at home, went to the accident and emergency (A and E) department of Southampton General Hospital where an x-ray was taken of her left knee. Despite the man's protests that his mother was complaining of pain in her hip and could neither sit nor walk, she was discharged. On 14 May, she was admitted to an elderly care ward, and on 17 May was transferred to a second hospital where further x-rays revealed fractures to both femurs. She died shortly afterwards. On 18 May 1993 the man complained to Southampton University Hospitals NHS Trust, which manage the hospital, that his mother's discharge from A and E was contrary to the Trust's policy that any elderly patient with mobility problems should be referred to the hospital's elderly care unit. He also complained that an x-ray taken in the A and E department was not obtained while his mother was in the elderly care ward, and that a bone scan was not arranged, although it was recorded in her medical notes that one was needed. He found the Trust's reply dilatory and unsatisfactory.

Findings The casualty officer was aware of the Trust's policy but, because of a misunderstanding about the level of assistance available to the woman at home, considered that she would be able to manage if discharged. I did not uphold this complaint. The x-ray taken in A and E was not obtained because the admitting doctor in the elderly care ward did not consider it essential, having been incorrectly told by the woman's general practitioner that the possibility of a fractured hip had been excluded by the A and E department. I upheld this aspect of the complaint. The bone scan, which was not intended as a means of diagnosing a fracture, could not be performed at a weekend and I could not question the clinical judgment of the doctor who considered it was not needed urgently. I found serious shortcomings. The Trust's complaints procedure attempted to introduce additional steps into the clinical complaints procedure. The initial reply did not give details of the action taken as a result of the complaint. There was a delay in informing the man of the clinical complaints procedure and I criticised strongly the advice eventually given. A review of the complaint promised by the chief executive did not take place. Almost seven months lapsed before the complaint was referred to the Trust's medical director who took a further five and a half months to reply. I criticised the delay and discourtesy in failing to acknowledge three letters written by the man during this period.

Remedy The Trust agreed to (a) provide written guidance for medical staff in the A and E department about referrals made to the elderly care unit; (b) review their arrangements for making sure that general practitioners receive information promptly about patients who attend the A and E department; (c) revise their procedure for handling complaints; (d) make sure that clear and full advice about the current complaints procedure is available to patients and others; and (e) review their arrangements for monitoring complaints.

Case No. E.233/94–95—Misfiled x-ray results

Matters considered *Arrangements for reporting and filing test results—handling of complaint*

Summary of case In preparation for a prostate operation, a man had a pre-operative chest x-ray at Airedale General Hospital in November 1992. In November 1993 an x-ray taken at another hospital showed that he was suffering from cancer of the lung. A chest specialist then confirmed that the 1992 x-ray had shown a shadow on the lung. On 1 February 1994 the man complained to Airedale NHS Trust about the serious error made in November 1992. The Trust replied on 13 May.

Findings The evidence strongly suggested that the x-ray report was simply filed away by a ward clerk before it was seen by a doctor. I criticised the level of training and supervision of the ward clerk and the inadequate arrangements for monitoring and acting upon x-ray reports. I found that the Trust took an unreasonably long time to reply to the man's complaint and did not explain fully why his x-ray report was filed away without any action being taken.

Remedy The Trust apologised. They have taken steps to prevent a recurrence of such an event, and agreed to keep the revised procedures under review. They also agreed to remind all staff of the need to respond quickly to complaints in line with the guidance in their complaints procedure and charter.

Case No. E.260/94–95—Elderly patient falling out of bed

Matters considered *Lack of care—inadequate records—relatives not told—handling of complaint*

Summary of case An 89 year old woman in King George Hospital, Essex in March 1994 fell out of bed during the night and injured her head. The nurses heard a noise—possibly a call from another patient—and found ..... on the floor. The following afternoon her daughter found that her mother's bed was empty. No-one seemed to know where she was until a visitor said that she had gone for an x-ray after a fall. The woman's son complained about lack of care and that the handling of his complaint, by Redbridge Health Care NHS Trust which manage the hospital was unsatisfactory.

Findings My investigation was hampered by lack of essential records of the nursing care planned and provided to the patient. The incident report form about the fall was incorrectly completed and significant information was added only after the staff knew that the family had complained. I found conflicting evidence about whether cot sides were in use and could make no finding on that aspect of the complaint. As some key witnesses had died, I could make no finding on whether the patient had waited an excessive length of time to receive attention after her fall. There was confusion among nurses about when, and by whom, relatives should be told about an accident. I upheld this aspect of the complaint. The Trust's initial investigation into the complaint was cursory as some key witnesses were not interviewed. I upheld this aspect of the complaint.

Remedy The Trust apologised. They agreed (i) to remind staff of the importance of completing documentation fully and promptly and to carry out periodic checks on the completeness of nursing records and incident report forms; (ii) to introduce written guidelines on procedures for contacting relatives about accidents to patients; (iii) to amend incident report forms to show whether relatives had been contacted; and (iv) to make sure that all staff are aware of and implement their new complaints procedure.

Case No. E.264/94–95—Discharge to private nursing home care

Matters considered *Inadequate discharge procedure—failure to provide NHS care*

Summary of case A 55 year old man admitted to Alexandra Hospital, Redditch on 8 September 1992, after suffering a cerebro-vascular accident was later transferred to the stroke unit at the Princess of Wales Hospital, Bromsgrove, which at the time was managed by North Worcestershire Health Authority. Since 1 April 1993 it had been the responsibility of North East Worcestershire Community Health Care NHS Trust. On 25 March 1993 the man was discharged to a private nursing home. The Health Authority declined to meet the cost of his continuing care.

Findings The consultant at the stroke unit decided in March 1993 that the man no longer needed treatment as a hospital inpatient. That decision, made in the exercise of clinical judgment, was not open to question by me. The man was highly dependent and could not be nursed at home. As the Health Authority had decided, as a matter of policy, not to contract for private nursing home places, and as they had only 24 long stay beds which they admitted were insufficient to meet the need, their policy excluded NHS funding for the continuing care of younger, highly dependent patients not in need of hospital inpatient treatment. I found that to be a failure to provide a service which it was a function of the Health Authority to provide. I also found shortcomings in the procedures followed when the man was discharged from hospital.

Remedy The Health Authority agreed (i) to reconsider their decision on funding the care of the man and of other similar patients; (ii) to consider making an ex gratia payment to the man's wife for costs she had already incurred; and (iii) to monitor the Trust's adherence to their agreed discharge guidelines. Afterwards they informed me that they had paid the man's wife the sum of £.....

Case No. E.287/94–95—Delay in arranging tests and treatment after a diagnosis of breast cancer

Matters considered *Arrangements for tests and treatment when breast cancer has been diagnosed—handling of complaint.*

Summary of case On 14 May 1993 a woman was told by her GP that a routine mammogram showed breast cancer and that she should contact the hospital for an appointment. She telephoned several times and was told that the mammogram had not been received. Eventually she was offered an outpatient appointment for 26 May, when she was told that tests would be arranged and that she was likely to be admitted to hospital before 24 June. After several telephone calls to the Chelsea and Westminster Hospital she was told on 8 July that the tests had been arranged for 20 July at the Charing Cross Hospital. She complained of having been caused unnecessary stress and that the handling of her complaint was unsatisfactory.

Findings There had been two delays—the first in arranging the appointment for 26 May. Factors contributing to that delay were that the mammogram had been sent to the Chelsea and Westminster Hospital but the temporary secretary arranging the appointment was based at Charing Cross Hospital and did not give adequate priority to the task. The second delay from 26 May to 2 July (when a registrar referred the woman to a consultant surgeon at the Charing Cross Hospital) was caused by continued problems in obtaining the mammogram. The handling of the complaint by the North West Thames Regional Health Authority, which administered the hospitals until April 1994,

was flawed by unacceptable delays. The final reply, which had not been seen by the former director of operations of Chelsea and Westminster Hospital, was signed in her name and contained a number of inaccuracies.

Remedy The Chelsea and Westminster Healthcare NHS Trust and Hammersmith Hospitals NHS Trust (which now has responsibility for Charing Cross Hospital) agreed to (i) remind all staff of the importance of maintaining systems for tracking medical records and of replying promptly to requests for records; (ii) tell junior doctors to alert senior medical staff when prompt replies are not received; and (iii) review their handling of complaints and remind medical staff of the importance of dealing promptly with complaints.

Case No. E.517/94–95—Disregard of information about a patient's needs

Matters considered *Lack of appropriate diet—inadequate supervision—patient left on a mattress on the floor—hygiene—complaint handling*

Summary of case A woman's mother, who had suffered a stroke, was transferred to St Charles Hospital, Paddington on Friday 22 April 1994. The woman complained that her mother did not receive appropriate care in respect of diet and supervision at night, despite information she had given to the nurses; and that when her mother became agitated during the night she was inappropriately left on a mattress on the floor. The floor of the cubicle was dirty. The reply to her complaint was dilatory, inadequate and insensitive, in particular by offering condolences on the death of her mother while she was still alive.

Findings The nursing staff failed to act on information which explained the patient's dietary needs; they wrongly thought that it would not be possible to obtain a special diet until after the weekend; they disregarded the complainant's concerns and the previous nursing notes about her mother's tendency to become very distressed at night and her need for individual supervision. I question their professional competence. The St Mary's NHS Trust, Paddington, which manages the services involved, said that placing a patient's mattress on the floor was not normal procedure but the staff did so to maintain a safe environment. The nurses had used their professional judgment to respond to a difficult situation, and their decision was therefore outside my jurisdiction. The floor of the cubicle was dirty despite opportunities to clean it during the day. The delay of two weeks before the woman's letter of complaint was acknowledged did not appear to be the fault of the Trust and I did not consider there to be any significant delay after that. There were a number of errors in the final reply to the complainant including the offer of condolences on her mother's death three days before she died.

Remedy The Trust agreed to remind staff (i) of the importance of correct nutrition; (ii) of the arrangements for obtaining a special diet at weekends; (iii) of their duty to take account of all relevant information when assessing patients' needs. The Trust agreed to introduce guidelines on dealing with patients who are very distressed or agitated. They apologised for their shortcomings.

Case No. E.593/94–95—Conduct of assessors during an Independent Professional Review

Matters considered *Conduct of IPR—attitude of assessors—handling of complaint*

Summary of case Two women complained about their mother's care and treatment at Sunderland District General and Ryhope General Hospitals. An IPR took place in March 1994. After seeing the IPR report one of the daughters complained to Northern and Yorkshire Regional Health Authority about the conduct of the independent

assessors, whose behaviour during the IPR she considered inappropriate and disrespectful. The women complained to me that the RHA did not respond to their complaint about the assessors' conduct.

Findings I found nothing to suggest that the assessors had behaved in an inappropriate or disrespectful manner. The daughters' conviction that their mother's treatment had been negligent affected their view of the conduct of the IPR: when it did not go their way, they alleged that it had been badly conducted. I found that the RHA did not respond to the complaint about the conduct of the IPR. There was a difference of opinion between the RHA and the Joint Consultants Committee—who provided the assessors—about who should investigate such complaints.

Remedy The RHA apologised about their handling of the complaint. They agreed to ask the NHS Executive to seek to reach agreement with the JCC as soon as possible about handling complaints about the conduct of assessors.

Case No. E.714/94–95—Handling of a complaint by the London Ambulance Service (LAS)

Matters considered *Dilatory handling of a complaint—effect of disciplinary proceedings.*

Summary of case A woman complained to the London Ambulance Service in October 1993 about the service they had provided to her late father. Although telephone calls and meetings took place, a definitive response was delayed pending the outcome of disciplinary proceedings. There was confusion about whose responsibility it was to keep the woman informed.

Findings At first the woman was satisfied with the progress on her complaint, but after a decision to take disciplinary proceedings, the papers were sent to the personnel department. There, because of staffing problems, there was inordinate delay in arranging the disciplinary hearing. Through poor communications it was deferred several times. The woman was not told what was happening. Nearly 14 months after her initial complaint the chief executive informed her of the outcome of the hearing but his letter, containing a carelessly worded apology, was an inadequate response to a serious complaint.

Remedy LAS and the South Thames Regional Health Authority (to whom LAS are responsible) apologised. LAS agreed to clarify who should deal with enquiries or correspondence received after a complaint has been referred for attention under the disciplinary procedure. The Regional Health Authority agreed to improve their scrutiny of individual complaints against LAS.

Case No. E.1026/94–95—Communications about care and medication

Matters considered *Communications with next of kin—inaccurate drug records.*

Summary of case A woman was admitted to Broadgreen Hospital, Liverpool in November 1993. Her daughter complained that staff did not inform her of her mother's poor prognosis for over a week and that doctors did not discuss with her the prescription of morphine or a decision not to resuscitate her mother in the event of cardiac arrest.

Findings The decision to prescribe morphine, being a matter of clinical judgment, was outside my present jurisdiction. I was satisfied that it was not necessary for the complainant to be consulted. There was an error in the date of a prescription for morphine and I was unable to reconcile differing accounts about the time it was administered. Staff did not know that the Trust had

a written policy on resuscitation which required the views of relatives to be considered. It was clear from the medical records supported by the evidence of staff that the woman's condition had deteriorated suddenly and I was satisfied that her daughter was informed without undue delay.

Remedy The Royal Liverpool and Broadgreen University Hospitals NHS Trust apologised for the shortcomings which I identified. The Trust agreed to remain all staff of the need to complete drug records accurately and to ensure that staff were aware of and followed the resuscitation policy.

Case No. G.1/93–94—Handling of complaint

Matters considered *Handling of complaints about medical records and adequacy of community nursing service*

Summary of case Since 1985 Worcester and District Health Authority had been in protracted correspondence with a woman who alleged that she had been deprived of an adequate community nursing service and complained of errors and omissions in her medical records. In October 1993 the Authority asked me to investigate whether their handling of the woman's complaints since June 1992 had been adequate. I agreed to do so having established that the woman regarded the Authority's handling of her complaint as unsatisfactory. In March 1992 her GP asked for district nursing service, which had been provided some years earlier by the Authority, to be reinstated. In June the Authority told the woman that they could offer visits by a continence advisor but made no mention of district nurses. In March 1993 the Authority told the woman that a district nursing service could not be offered, but did not explain why. Later in March she complained to the Authority that there were omissions and inaccuracies in her hospital and GP records and that although staff in the chief executive's department of the Authority were aware of that, they had done nothing. On 10 May two non-executive directors of the Authority considered papers on the woman's case (which comprised more than 1,000 pages of correspondence, nursing notes and other papers) and later the same day produced a two-page report on her complaint, making four recommendations for future action. The chairman of the Authority made changes to the report before it was sent to the woman. These included the deletion of one of the recommendations and the insertion of a statement that no evidence of maladministration by the chief executive's department had been found.

Findings Whether the woman needed nursing support was a matter of professional judgment which is not open to question by me. I found it unsatisfactory that she received no explanation about that. The complaints which the woman put to the Authority in March 1993 were not properly investigated and I strongly criticised the way in which the Authority, and in particular its chairman, dealt with the non-executive directors' report. I concluded that by 1993 the Authority had closed their minds to the possibility that there might be any substance in the woman's representations and that their intention in initiating the non-executive directors' review, and then in seeking my involvement, was essentially to justify the stance they had taken.

Remedy The Authority apologised for the shortcomings I identified. They agreed to carry out a new investigation of the woman's complaints, involving the Family Health Services Authority and other agencies as necessary.

Case No. S.41/94–95—Discharge from A and E department

Matters considered *Discharge arrangements—use of ambulances*

Summary of case After being assaulted, a man was taken by ambulance to the Accident and Emergency department of Monklands Hospital, Airedare in the early hours

of 27 April 1994. He complained that when he was discharged at 3.00 am, despite having no money for a taxi fare, he was offered no assistance or alternative transport; and that he was left to walk to his parents' home, where he arrived some five hours later in a state of collapse.

Findings Contrary to the man's assertions, the nurses tried to give him what help they could, including offering to telephone his parents or a friend, to arrange a taxi or, as a last resort, to let him wait in the department until the first bus came in the morning. The man insisted that he wanted an ambulance to take him home, which was not justified on medical grounds. He refused to consider any alternatives and eventually left the hospital of his own free will. I criticised his selfish and demanding behaviour which had wasted NHS staff time which could otherwise have been devoted to more deserving patients.

Case No. W.71/93–94—Discharge to private nursing home

Matters considered *Discharge arrangements to private nursing home.*

Summary of case A man's elderly wife was admitted to Withybush Hospital, Haverfordwest, which is managed by Pembrokeshire NHS Trust, after falling at home. When her condition had stabilised a consultant told the man that she would not improve further and would have to be discharged. The man did not think he was capable of caring for his wife at home so, on 23 April 1992, he arranged for her to be admitted to a private nursing home. The man complained that he had been obliged to pay for continuing nursing care which should have been funded by the NHS. He believed he had not been given enough information for him to make an informed choice about the options available.

Findings The consultant had told the man that his wife could have been looked after at home with appropriate support but the man had chosen instead to pursue the nursing home option. He knew what cost would be involved but several months later he complained after obtaining information about discharge procedures from the Welsh Office via his MP. Pembrokeshire Health Authority, who were responsible for purchasing NHS services for local residents had arrangements to fund community nursing support in patients' homes and did not generally fund private nursing home placements. That was a decision they were entitled to make. Hospital discharge procedures had not been adequately developed and staff had communicated with the man about them in a some what haphazard way. Doctors and nurses had considered the financial implications of nursing homes and the level of community support to be matters for him to discuss with a social worker yet no formal referral to the social work department was made. Hospital staff believed that the man was content with the nursing home option, and he had agreed to that in a letter to the consultant. I found that the man had sufficient knowledge about the available options for his wife's future care but I criticised the hospital for not having a fully informative discharge policy.

Remedy The Trust apologised for the shortcomings I found and agreed to conduct discussions with the local authority about discharge procedures and the provision of continuing care. I invited the Trust to consider whether they wished to offer the man financial redress but they concluded that they had no responsibility to do so.