Health Service Commissioner

SECOND REPORT FOR SESSION 1997-98

SELECTED INVESTIGATIONS COMPLETED OCTOBER 1996 TO MARCH 1997

Presented to Parliament pursuant to Section 14(4) of the Health Service Commissioners Act 1993

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Health Service Commissioner

Third Report for Session 1996-97

Selected investigations Completed October 1996-March 1997

This report contains a selection of 24 reports taken from the 143 completed between October 1996 and March 1997. Many of the reports were issued by my predecessor, Sir William Reid, whom I succeeded in January 1997. I have not, however, distinguished here between reports issued by Sir William and those issued by me: I have adopted the convention of using the first person singular to denote the holder of my office. I am pleased to continue the practice of publishing a selection of my reports in order to bring the results of my enquiries to a wider audience who may benefit from the experience of others. I do not find every complaint to be justified. This volume contains one case (W44/95-96) in which I did not uphold three out of the four complaints.

During 1996-97, my Office began to receive complaints which had been considered under the new NHS complaints procedure introduced in April 1996 in England, Scotland and Wales. My predecessor drew attention in his last volume of Selected Cases to common themes in the findings of his first investigations into decisions by conveners (non-executive directors of NHS bodies who had been selected for this role) on whether or not to accede to a request for an independent review of a complaint. In this volume I have included four more such cases in order to enable lessons to be learned from these early cases as the system settles down and conveners become more familiar with their role. In my Annual Report for 1996-97, which is being published at the same time as this volume, I have set out some of the emerging lessons from the first cases received by my office which have been considered under the new NHS procedures.

For the first time, the text of this report (and of my Annual Report) is to be made available through the Internet. I hope that this will enable more people to study the texts of my reports and draw lessons from them.

My report of an investigation does not include all the evidence obtained during an investigation. In deciding what to include I satisfy myself that no matter of significance has been overlooked, and reach my findings on the basis of what I consider to be relevant evidence gathered by an entirely independent investigation.

Appendix I gives a glossary of the most commonly used abbreviations; but it is not comprehensive. In many cases names are given in full when they first occur and abbreviated thereafter.

Appendix II gives the dates on which the investigations of each of the published cases began and finished. It includes the names of the health authorities, boards and trusts against whom the complaints were made. I have maintained the anonymity of those who put the complaints to me, and of individual members of staff.

MICHAEL BUCKLEY

Health Service Commissioner
(Ombudsman)

June 1997

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comments

Case No. E.965/94-95-Relative not told of patient's deterioration and death, delay in viewing body and handling of complaint

Matters considered

Failure of communication about dying patient, delay in viewing body, complaint-handling

Body complained against

University College Hospitals NHS Trust, London

Summary of case

A woman complained about the failure of staff at University College Hospital, London, to inform her of her elderly father's deterioration and death during the night of 21-22 July 1994. Although the woman lived in another part of the country she had travelled to London intending to visit her father the next day, and could have come into the hospital during the night if she had been contacted. When the woman asked to view her father's body the next morning, she was unable to do so for several hours. The University College London Hospitals NHS Trust did not reply to the woman's complaint to them.

Findings

I upheld the complaints. I found that the woman had asked to be contacted immediately if there was any significant deterioration in her father's condition; but staff did not do so until some hours after his death, when an inexperienced student nurse broke the news. I criticised the Trust for their lack of instructions to staff on informing relatives about the condition of patients who are near to death. When the woman arrived at the hospital she had to wait several hours before staff were able to arrange for her to see her father's body. The arrangements were left to the student nurse who was not familiar with the relevant instructions, which in any case were incomplete. When the woman complained to the hospital manager she received a letter of acknowledgement which contained a number of errors, for which I strongly criticised the Trust. A full reply was promised within 20 days; but despite repeated promptings-including several by my Office-none was ever sent. I noted that this was the fifth recent case in which I had to criticise the Trust for failings in dealing with complaints.

Remedy

The Trust apologised and agreed to improve guidance on care of the dying, keeping relatives informed, and arranging for them to view the deceased, and to make sure that complaint-handling procedures were properly understood by all staff and carried out.

comments

Case No. E.1190/94-95-Policy for funding incontinence supplies to residential care homes and complaint handling

Matters considered

Refusal to reimburse care-home residents for incontinence supplies-replies dilatory

Body complained against

East Norfolk Health Authority, Norfolk

Summary of case

In June 1993 the proprietor of a residential care home learned that under new national guidance health authorities had been required from April 1993 to fund the provision of incontinence supplies to people living in independent residential care homes on the same basis as to those living in their own homes. She asked the former Norwich Health Authority, succeeded on 1 April 1994 by East Norfolk Health Authority, about funding for her residents. They replied in October 1993 that funding was available to some but not all residents of care homes. As there was no equivalent restriction on funding for those living in their own homes, the complainant, her solicitor, and her MP wrote several further letters to the Health Authority but received no answer. In August 1994 she wrote to the Department of Health, who passed her letter to the Health Authority. They replied in November that they were working to achieve a consistent funding policy; and in April 1995 one was adopted. However, the Health Authority declined to reimburse those among the complainant's residents who had had to pay for their own supplies during the two years since April 1993.

Findings

Between April 1993 and April 1995 the Health Authority funded supplies to residents of care homes on a different basis from those to people living in their own homes. That was in contravention of the national guidance which required a consistent approach. The situation was rectified in April 1995 but the Health Authority had no justification for refusing reimbursement to those residents who had had to pay for their own supplies during the two previous years; and they had therefore suffered injustice. I also found that there were repeated delays and failures by the Health Authority in acknowledging and replying to letters sent by the complainant, her solicitor and her MP. A substantive response was finally sent only because of the enquiries she made through the Department of Health.

Remedy

The Health Authority apologised and agreed to reimburse the residents' costs. They have also changed their procedures for handling enquiries and complaints.

comments

Case No. E.1507/94-95-Nursing care and record keeping

Matters considered

Fall from bed, failure to record information about earlier operation.

Body complained against

Salford Royal Hospitals NHS Trust, Salford

Summary of case

A woman complained that while her father was in Hope Hospital, Salford, in March 1994 he fell out of bed having been left alone, even though nurses knew that he was restless and confused. The man had recently had an eye operation, which his son mentioned to nurses at Hope Hospital. The woman said that because no note was made of that, insufficient attention was paid to her father's eyes after his fall. A few days later he was found to have restricted vision in his right eye; and despite an operation he lost the sight of that eye.

Findings

I did not uphold the complaint about the fall because no evidence was found of lack of reasonable care by the nurses. I upheld the complaint that no record was made of the man's eye operation. What the man's son told nurses about the operation when his father went into Hope Hospital was not written down; and the nurses who cared for the man after his fall did not know about that. They said that if they had known about the operation they would have made sure a doctor examined the man's eyes immediately after his fall.

Remedy

The Trust apologised and agreed to make sure that all information relevant to patients' care and treatment was recorded and passed on when appropriate.

comments

Case No. E.110/95-96-Response to a critical report of an independent professional review (IPR)

Matters considered

The Trust's response to an IPR report.

Body complained against

Salisbury Health Care NHS Trust, Wiltshire

Summary of case

In 1992 the complainant's 18 year old daughter died after being admitted to Salisbury General Infirmary. An IPR, under the former NHS clinical complaints procedure, took place in 1994 and its report was highly critical of the treatment given to the young woman. It also considered the handling of her parents' complaint. In October 1994 the Trust set up a `complaint investigation panel' to consider the report and to report to the Trust Board. The complainants considered that the setting up of the panel and its subsequent report to the Board were an inadequate and inappropriate response to the findings of the IPR.

Findings

I found that the Trust put a lot of time and effort into addressing the problems highlighted by the IPR report; and I saw nothing which would cause me to question the seriousness with which they took the report. I considered it appropriate for the Trust to ask a group to study the report and produce a detailed action plan for Board approval; but the Trust did more than that and largely re-investigated the complaint. I did not consider that such a large element of re-investigation was appropriate, as it was bound to appear as if the Trust were acting as a court of appeal on their own case. I also considered it inappropriate for the panel to involve the chief executive and the legal manager both of whom were involved in the investigation of the original complaint There was some insensitivity on the part of the Trust to the appearance of what they were doing; and the inclusion in the panel's report of a preliminary comment criticising the IPR was unhelpful in that respect. When the Board decided to accept the panel's report those involved in the complaint withdrew from the meeting; but that was not recorded.

Remedy

The Trust apologised. They had already changed their recording of Board meetings to include any withdrawals from the meeting.

comments

Case No. E.447/95-96-Excessive delay in resolving a complaint

Matters considered

Excessive delay in replying to complaint-confusion over complaints procedure- delay in arranging IPR.

Bodies complained against

Pontefract Hospitals NHS Trust, Wakefield Health Authority and the former Northern and Yorkshire Regional Health Authority

Summary of case

A woman complained in June 1992 about treatment she had received at Pontefract General Infirmary, which was managed by Pontefract Health Authority (now Wakefield Health Authority) until 31 March 1993 and thereafter by Pontefract Hospitals NHS Trust (the Trust). There was a delay of six months until the consultant concerned provided his comments, during which time the woman was sent no holding letters. A substantive reply to her complaint was not sent until February 1993. In April 1993 she asked for her case to be referred to the Regional Medical Officer (RMO) of the former Northern and Yorkshire Regional Health Authority for an independent professional review (IPR) under the clinical complaints procedure which applied at that time. Staff dealing with the complaint at the Trust believed, incorrectly, that only a consultant could refer a case for IPR; and when he refused to do so no action was taken to refer the case until January 1994. Confusion arose between the Trust and the RMO's office about whether the Trust supported the IPR referral; and arrangements for the IPR were not put in hand until November 1994. The IPR was held in May 1995-some three years after the woman had first complained about her treatment.

Findings

I considered it a disgrace that the woman had to wait so long for her complaint to be resolved; and I strongly criticised the health authority and the Trust. I recognised that the period in question had seen many organisational changes for the bodies concerned; but that did not excuse the delay in resolving the woman's complaint. Despite his busy operating schedule, the consultant bore much of the blame for the initial delay in providing the woman with a response to her complaint; and staff handling complaints were remiss in failing to monitor progress and to keep the woman informed. When confusion arose about who could refer a complaint for an IPR the matter was allowed to drift, and no effort was made to seek the help of the Trust's chief executive. There was then further confusion over whether or not the Trust supported the IPR referral, which led to more delay. I upheld the woman's complaint.

Remedy

The bodies concerned apologised to the woman for the shortcomings I identified. The Trust's complaints procedure was revised; and the chief executive assured me that complaints were now dealt with promptly and closely monitored.

comments

Case No. E.920/95-96-Standards of nursing care, record keeping and communication

Matters considered

Failure to meet oral and personal hygiene needs-poor record keeping-poor communication with the patient's family-failure to inform family of circumstances of patient's death.

Body complained against

North Essex Health Authority

Summary of case

The complainant's father was admitted to Princess Alexandra Hospital, Harlow, in January 1995 following a stroke. He was unable to swallow, and a board by his bed read `nil by mouth'; but staff continued to offer him food and drink. He developed a sore mouth but his wife was told mouthwash tablets were not available. Nursing staff were evasive when members of the family asked about his care. On 28 February his wife visited him and found him covered in excrement. A nurse told her that he had been disturbed during the night by another patient and she had not wanted to waken him. The family later found that there was no record of the incident in his nursing or medical notes. In the evening of 28 February the police informed the family that the complainant's father had died. The family were not aware that he had fallen from a balcony to his death until they were contacted by the Coroner the following day. The hospital was administered by the Health Authority until March 1995. Since then it has been managed by Princess Alexandra Hospital NHS Trust.

Findings

I found that the standard of nursing care received by the complainant's father was inadequate. I commended the Trust for developing and implementing an action plan, following the complaint, to address the inadequacies identified. However, I was concerned to note that senior staff were in some doubt about the effectiveness of that plan. I found that the nursing and medical notes were not as complete as they should have been, and was concerned that this was also a problem elsewhere in the Trust. I found that communication with the family was poor while the complaint's father was a patient, and that there was an appalling breakdown of communication following his death. I considered it wholly unacceptable that the complainant's mother did not learn about the circumstances of her husband's death till the following day. I upheld the complaint.

Remedy

The Trust apologised and agreed to carry out and act upon a planned independent review of nursing care; review their systems for auditing nursing and medical records to make sure that significant actions, interventions and decisions of staff were recorded and to consider improvements to, and greater awareness of, their policy on untoward incidents.

comments

Case No. E.1009/95-96-Delays in outpatient clinic and complaint handling

Matters considered

Unacceptable delays before seeing doctor at outpatient appointments-complaint handling

Body complained against

Salisbury Healthcare NHS Trust

Summary of case

In August 1995 a man complained to the chairman of Salisbury Healthcare NHS Trust that his wife had waited over an hour to see a doctor at a renal outpatient clinic at Salisbury District Hospital. The chairman replied in September 1995 that the clinic was oversubscribed, and urgent steps were being taken to improve the situation. On her next visit in November 1995 the wait was two hours. The man complained again and was dissatisfied with the Trust's response.

Findings

The Salisbury Trust provided accommodation and support staff for the clinic; and Portsmouth Hospitals NHS Trust provided the services of the consultant. In the past the service had been funded by the Regional Health Authority. Since the introduction of the NHS internal market, funding had been from Wiltshire Health Authority. I found that there was confusion between the two Trusts and the Authority about details of the funding arrangements, and about which Trust was responsible for managing waiting times. That led to delay in obtaining funding for an extra clinic session until June 1996. The Salisbury Trust failed to pursue adequately the need for a realistic clinic schedule while the extra clinic session was being arranged, and should have told the Portsmouth Trust about the complaint earlier.

Remedy

The Salisbury Trust apologised and agreed to approach the Portsmouth Trust and the Authority to clarify the responsibilities of each Trust for the clinic and the arrangements for monitoring its performance. They also agreed to clarify responsibilities for any similar jointly resourced clinics and to review their complaints procedure in respect of complaints involving other Trusts.

comments

Case No. E.1072/95-96-Communication with relatives after patient's death

Matters considered

Inadequate efforts by Trust to contact a man after his mother's death

Body complained against

St George's Healthcare NHS Trust, London

Summary of case

In September 1995 a woman was taken to the accident and emergency department of St George's Hospital, London. She was admitted to a ward where she died shortly afterwards. Her next of kin were not contacted; and it was only three weeks later, when a cheque which she had sent to her grandson was returned marked `drawer deceased', that her son learned of her death. When he met the director of nursing at the Trust in October 1995 he complained about the failure to contact him, and he received a written reply in November 1995, but remained dissatisfied.

Findings

There was no clearly understood policy about who was ultimately responsible for making sure that details of patients' next of kin were obtained. In this case the woman's details were not obtained when she was admitted. The hospital had two sets of notes for the woman-with different versions of her first name- the one used on this occasion did not include next of kin details. Efforts to trace the woman's relatives after her death were inadequate. Although staff contacted the woman's bank, the local council, and the local police that provided no help in tracing her relatives. The Trust should have contacted the police formally at a more senior level about an apparent change in their policy about making enquiries. They should also have considered other actions such as contacting the woman's neighbours, entering her flat using the keys (which she had taken to hospital with her), or seeking involvement of the social services department. It seemed possible that if the cheque had not been returned the hospital would have arranged the woman's funeral without further effort to contact her family.

Remedy

The Trust apologised and agreed to complete their written policy on the arrangements for obtaining and recording information about next of kin, and to consider making further efforts to avoid the creation of duplicate records. The Trust also undertook to agree new procedures with the local police and to produce written guidance to staff on action to take if the police were unable to assist in such situations.

comments

Case No. E.1129/95-96-Complaint handling by a Regional Health Authority.

Matters considered

Complaint to Regional Health Authority (RHA) about Community Health Council (CHC) and refusal of an independent professional review (IPR)

Body complained against

The former North Thames Regional Health Authority

Summary of case

In March 1995 a woman complained to the RHA about a delay by a CHC in providing help to pursue her concern about the RHA's refusal to arrange an IPR of the clinical care of her late sister. In September 1995 she complained to the RHA about both the CHC's and the RHA's failure to act on her concerns. She received no reply; and in November her MP wrote to the RHA on her behalf. The RHA replied in December 1995; but the woman remained dissatisfied. On 1 April 1996 the RHA ceased to exist and their responsibilities for complaints about CHCs were transferred to the North Thames Regional Office of the NHS Executive. Complaints about CHCs are not within my jurisdiction.

Findings

I found that the manager of the CHC unit at the RHA contacted the CHC's chief officer on a number of occasions, but apparently had acted only when prompted by the woman. The manager had agreed that she would contact the woman after a meeting with the CHC chief officer but failed to do so, leaving the woman with a false expectation that her case was being transferred to another CHC. I found a lack of awareness by RHA staff involved of relevant local and national guidelines on complaints. There was a delay in the RHA's recognising that they should also respond to the woman's concern about the IPR; and they did not draw the matter to the attention of the CHC chair despite their difficulty in getting action from the CHC chief officer. I upheld the complaint.

Remedy

The NHS Executive agreed to make sure that all regional offices were clear about whose responsibility it was to agree procedures for the handling of complaints about CHCs and to ensure that all outstanding matters concerning complaints about them were resolved as soon as possible.

comments

Case No. E.1134/95-96-Inadequate nursing care in a private nursing home

Matters considered

Inadequate nursing care-role of Health Authority

Body complained against

East and North Hertfordshire Health Authority

Summary of case

In October 1994 a man was transferred from an NHS hospital to a new private nursing home, where his care was funded by East and North Hertfordshire Health Authority. On 1 January 1995 his wife was told he had developed sores on both knees. When he was admitted to hospital on 3 January, it was noted that he also had a sore on his right hip, which appeared to have been dressed while he was in the home. There was no reference to the sore on his hip in the home's records. His wife complained to the Authority about the care he had received while in the home, but remained dissatisfied with their explanation.

Findings

I could not establish exactly why the man's sores developed, but concluded that they were a result of inadequate nursing care. Serious administrative failures lay behind that. The level of record keeping and care planning was inadequate. There were considerable staffing problems in the home at that time, with high turnover, sickness, and use of agency and inexperienced unqualified staff. On Christmas Day after two staff failed to attend there had been only two nurses (one unqualified) to care for 30 elderly mentally infirm patients. Patients had been admitted to the home too rapidly by the Authority. The specification for the care of NHS patients was inadequate, as were the arrangements for monitoring the patients' care.

Remedy

The home acknowledged the inadequacy of the nursing documentation - nursing notes were now audited three-monthly. The Authority recognised the inadequacy of their monitoring arrangements and had made improvements. The Authority maintained that they now had confidence in the care provided by the home, and agreed to review their contracting and monitoring arrangements.

comments

Case No. E.1242/95-96-Preparation of deceased and complaint handling

Matters considered

Preparation of deceased's body in the ward-loss of medical records-inadequate and dilatory investigation of complaint

Body complained against

King's Healthcare NHS Trust, London

Summary of case

In December 1994 a man was admitted to King's College Hospital, where he died two days later. His wife, son and a family friend arrived at the hospital shortly after the man's death; and the son and the family friend viewed the body in the ward. They were distressed by its condition, and considered that it had not been prepared in any way. In January 1995 the man's wife complained to the Trust about that and other matters. In June 1995 the Trust wrote, informing her that they could not locate the medical records. Meetings were held in July and September 1995; but the woman remained dissatisfied. She complained to me that she and her son were caused additional distress because of the failure to prepare her husband's body in the ward; that his medical records were lost because of inadequate monitoring procedures; and that the Trust's investigation into her complaints was inadequate and dilatory.

Findings

The ward staff could not recall the events surrounding the man's death; and on the available evidence I could make no finding on the complaint about the preparation of his body. The ward staff said that when a patient died the usual practice was to make the body presentable; but it was not the practice formally to lay out the body until after the relatives had seen the deceased. I upheld the complaint that the Trust misplaced the man's records; and I found that other documents in relation to this case had, at times, been mislaid. I also upheld the complaint about the way the Trust had handled the woman's grievances. I strongly criticised the Trust for not clarifying the woman's central concerns at the outset. Instead, issues became confused and a muddle was allowed to develop. The Trust accepted that initially they were dilatory in dealing with the complaint because the man's medical records were not available.

Remedy

The Trust apologised. They said they had already introduced revised arrangements for dealing with complaints. They had also made a number of changes to improve the safeguarding of records; and they agreed to monitor closely and audit the effectiveness of those new procedures.

comments

Case No. E.1275/95-96-Communication with relatives, mortuary procedures and complaint handling

Matters considered

Failure to communicate with relatives about seriousness of condition and on visiting arrangements-unsatisfactory mortuary procedures-inadequate handling of complaint

Body complained against

Barnsley District General Hospital NHS Trust, South Yorkshire

Summary of case

In early 1995 a woman was admitted to Barnsley District General Hospital for breast surgery. Following the surgery an infection in the woman's foot became worse, and she experienced breathing difficulties. An unconfirmed diagnosis of a pulmonary embolism was made; and she died on 5 February. The woman's daughter complained that the medical staff did not communicate the seriousness of her mother's condition, and that the nursing staff did not explain to her relatives that the policy on visiting hours was flexible. She also complained that her mother's body was stored unrefrigerated in the hospital mortuary after her death, rendering the body unsuitable to be viewed at the undertaker's. The daughter considered that the Trust failed to investigate adequately her complaint about a breach of confidentiality by a nursing auxiliary.

Findings

The opinion of the clinicians involved in the woman's care was that her death could not have been foreseen; and I did not criticise the medical staff for not telling her relatives that her condition was potentially serious. I was not persuaded that her relatives were deliberately denied information about flexible visiting arrangements; and I did not find that complaint made out. The Trust said that the woman's body was too large to be placed in the refrigerated cabinet in the mortuary. The Trust's staff and the undertaker's employees gave different accounts about the condition of the body; but I was persuaded that there was some deterioration. The position was not properly monitored and documented, and there was a failure to liaise with the woman's relatives. I upheld the complaint. I was critical of the lack of records in relation to the complaint about a breach of confidentiality; and I considered that the Trust could have done more to identify the staff member involved. I also upheld that complaint.

Remedy

The Trust apologised. They agreed to give guidance to medical staff about communication with relatives, and to remind mortuary staff of the need to monitor the state of bodies and to liaise with relatives if there were storage difficulties. They also agreed to reinvestigate the complaint about a breach of confidentiality and to remind staff dealing with complaints of the importance of recording significant discussions and of providing complainants with full replies.

comments

Case No. E.1312/95-96-Mislabelling of test result

Matters considered

Inadequate steps to make sure a specimen was correctly labelled-inadequate checks for test result-delay in doctors being informed about the mistake-delay in informing the patient

Body complained against

The Hammersmith Hospitals NHS Trust, London

Summary of case

In February 1995 a man had an operation to remove what was thought to be a benign tumour from his heart. In July 1995 he had a second operation to remove a blood clot from the same area. In reply to a complaint made in September 1995 his son was told by the Trust that the growth removed during the first operation had been mislabelled with the details of another patient who had an operation on the same day. The error was identified only when the growth unexpectedly recurred, and the test result, showing that the first growth had also been a blood clot, was traced in July.

Findings

I found that several opportunities were missed to identify the problem much earlier. It should have been noticed in the operating theatre - the label and form accompanying the specimen should have been checked. The apparent lack of a test result for the man should have been picked up when his care was reviewed; and the change in diagnosis should have prompted action when test results were reviewed. The system for checking test results failed; the man did not receive the appropriate treatment; and by the time the problem was identified he needed a second operation. Doctors treating the man were aware of the problem as soon as it was discovered in July; but it was not until the family complained in September that the Trust gave a full explanation of the mistake to the man and took action to avoid any repetition of the problem.

Remedy

The Trust apologised and agreed to remind staff of the importance of completing theatre documentation accurately, to audit it periodically, to amend their theatre policy, and to review and audit its arrangements for reviewing test results. They also agreed to remind staff of their responsibilities when such errors are discovered.

comments

Case No. E.1315/95-96-Patient care and communications with relatives

Matters considered

Inadequate nursing care-failure to follow `not for resuscitation' policy

Body complained against

Eastbourne Hospitals NHS Trust, East Sussex

Summary of case

The son of a woman who died in Eastbourne District General Hospital in January 1995 complained about aspects of her care. He believed that insufficient care was taken to ensure that his mother received adequate amounts of fluid, that nursing observations were often either omitted or not recorded, and that a doctor's specific instruction for two-hourly observations was not followed. He also complained that family members were not consulted before medical staff instructed that his mother should not be resuscitated in the event of cardiac arrest.

Findings

I upheld the complaint about the woman's fluid intake: I found that the absence of a proper care plan, the lack of certain fluid charts, and the unsatisfactory nursing records together constituted a failure of care in that matter because there was no clinical management structure in place to make sure that such care was given. I found that the care which the woman received, including her observations, was not fully and properly recorded. Because of inadequate documentation, I was unable to make a finding on frequency of the observations or whether a doctor's instruction in relation to that was ignored. The Trust's `not for resuscitation' policy stated that relatives were not normally involved in making the decision but should, where possible and appropriate, be informed of the decision and why it had been taken, and have their comments noted. I was not persuaded that the medical staff told the family of the decision not to resuscitate the woman, and found that other aspects of the Trust's `not for resuscitation' policy were not followed.

Remedy

The Trust apologised and agreed (i) to give clear guidance to staff about monitoring the fluid intake of patients who are sedated, drowsy or confused, and to remind staff of the need to make full records about fluid intake; (ii) to issue clear, written instructions to nurses about recording the care which is given; (iii) to remind ward managers and consultants to make sure their staff are aware of and implement protocols on patient observations; and (iv) to remind all medical staff of the requirements of their `not for resuscitation' policy and that, in particular, consultants should make sure that all junior staff are aware of that policy and follow it.

comments

Case No. E.1344/95-96-Cancellation of a child's test at short notice, no new appointment offered

Matters considered

failure in service when a child's test was cancelled at short notice and a new test date was not given; conflicting explanations given for the cancellation of the test

Body complained against

Chelsea and Westminster Healthcare NHS Trust, London

Summary of case

A child was referred by a consultant from Chelsea and Westminster Hospital for a food absorption test. The test was to be performed by the Vitamin B12 unit, which was located on the same site as the hospital but was not one of the services offered by the Trust. The child had had no food or drink for 17 hours when he attended an appointment for the test on 19 December 1995. At 5.00 pm the test was cancelled without warning. The child's mother complained about that; that in the following months she received different explanations for that cancellation from the Trust; and that a new appointment had not been offered by the Trust.

Findings

I found that the Trust had been trying to formalise their relationship with the Vitamin B12 unit since August 1995. They set the doctor a list of conditions to be met if the Trust was to continue to allow their consultants to refer patients. The Trust had offered the child an appointment before the issues of concern about the unit had been resolved. I considered it disgraceful that differences between the principal players caused the child's test to be cancelled at such a late stage. Once the appointment was offered, the test should have taken place. I also found that the Trust had failed to offer a new appointment for the test while it had been administratively possible to do so during the time when the doctor heading the unit had an honorary contract with the Trust. I did not uphold the complaint that the Trust had given conflicting explanations to the complainant about the reasons why the test had been stopped: the reasons why an appointment was not offered changed as events developed.

Remedy

The Trust apologised and agreed to make every effort, with the complainant, to resolve the impasse over the child's test, including considering alternative provision.

comments

Case No. E.419/96-97-Trust's communications with a patient's GP and complaint handling

Matters considered

Communication between the Trust and GP about an unsubstantiated allegation-handling of complaint

Body complained against

North Tyneside Healthcare NHS Trust, Tyne & Wear

Summary of case

A man complained that in August 1995 the Trust wrote to his GP conveying an unsubstantiated allegation about his behaviour: the allegation concerned an incident which occurred when the man attended the pathology department of the hospital to hand in some samples for testing. The Trust maintained that the receptionist in the pathology department had felt threatened by the man's manner; and the biochemistry departmental manager said that she wrote to the GP for several reasons, one of which was to prevent his patients coming to the pathology department with misconceptions about when their test results would be ready. As a consequence of the departmental manager's letter the GP removed the man from his list. The man further complained about the Trust's handling of his complaint about the matter.

Findings

The departmental manager's letter to the GP was very short and emphasised a view that the man's conduct had been threatening, which he strongly denied. I was unable to establish the manner in which the man had spoken to the receptionist; but I found that the letter to the GP lacked balance. I was not persuaded that there was sufficient evidence to justify the type of phraseology used in the letter; and I considered that before writing to the GP in the terms that they did the Trust should have raised their concerns with the man and given him the opportunity to respond. To that extent I upheld the complaint. I also found shortcomings in the way in which the Trust dealt with the man's complaint.

Remedy

The Trust apologised and agreed to remind staff of the need to deal with all complaints thoroughly and to comply with the terms of their new complaints procedure.

comments

Case No. E.587/96-97-Response to request for access to records

Matters considered

Poor and insensitive handling of request for copies of records and corrections; consultant's manner

Body complained against

Greenwich Healthcare NHS Trust, London

Summary of case

In September 1994 a woman's baby was delivered at home by staff of Greenwich Healthcare NHS Trust, and died the next day in Greenwich District Hospital. The woman applied for access to the Trust's records of the delivery. She was allowed to view the records; but when she asked for copies hospital staff told her that she would first have to meet the consultant paediatrician. When they met the woman found the consultant's manner intimidating. The records contained statements that the woman had refused to go into hospital for the delivery. The Trust accepted that that was not the case; but there was a long delay before they agreed to change the records to reflect the true position.

Findings

The consultant's views about granting access to the records were properly sought by hospital staff under the terms of the Access to Health Records Act 1990. He decided to release the records only after meeting the woman and her husband, and subsequently stated that was because he wanted to take the opportunity to counsel them. However, I found no evidence that any counselling was offered at that meeting. The consultant was concerned that the parents might be contemplating legal action and questioned them about that at the meeting. I criticised him for allowing such considerations to affect his actions, and for making the meeting a precondition of the woman receiving copies of the records. I found that it took the Trust almost four months to respond effectively to the request for the records to be changed.

Remedy

The Trust apologised and agreed to review their arrangements for dealing with applications for access to records and requests for corrections to be made to those records under the Act.

comments

Case No. E.591/96-97-Convener's decision not to convene an independent review

Matters considered

The procedure followed by a convener in deciding not to convene an independent review

Body complained against

North Staffordshire Hospital NHS Trust, Stoke-on-Trent

Summary of case

A man sought an independent review, under the national procedures introduced on 1 April 1996, of his grievances about the care and treatment of his mother, who was a patient at North Staffordshire Hospital, in November 1995. His request was considered by the Trust's convener. In July 1996 the convener told the man that his request for an independent review had been refused.

Findings

I found that the convener did not follow the NHS Executive guidance for the handling of complaints in the NHS. The convener obtained independent medical advice from the Trust's medical director, who had not seen the patient's medical records at that time and who, therefore, could not have made an effective assessment. The convener failed to address the specific issues raised by the man, and did not set out fully his reasons for his decision to refuse an independent panel.

Remedy

The Trust apologised and agreed to review the convener's decision in the light of the procedures laid down in the national guidance, and to consider whether there was scope for further efforts at local resolution.

comments

Case No. E.859/96-97-Convener's decision not to convene an independent review

Matters considered

The procedures followed by a convener in deciding not to convene an independent review

Body complained about

Croydon Health Authority (the HA)

Summary of case

A man sought an independent review, under the national procedures introduced on 1 April 1996, of his grievances arising from a visit to his general practitioner (GP) in May 1996. He also complained that it was unreasonable to refuse him access to his health records. In September 1996 the HA's convener told him that his request for an independent review was refused. The convener said that a review panel could not release medical records to him, and he should consider taking legal advice to obtain the access he sought.

Findings

I found that the convener did not comply with the national guidance for the handling of complaints by the NHS because he failed to take all reasonable steps to consider whether a review panel would resolve the conflicting account of events given by the man and the GP. In particular he took no steps to discover whether there were witnesses who might help to resolve the different accounts, or whether the medical records might do so. The clinical adviser to the convener had not seen the man's medical records before giving advice: I considered it a matter of self-evident good practice that an adviser should see such records. The convener did not address all the man's concerns. I also found that the convener had not established the reasons why the GP had refused the man access to his records and that the convener had wrongly concluded that a panel could not consider such a matter.

Remedy

The Health Authority apologised and agreed to review the convener's decision in the light of fresh clinical advice obtained from an independent adviser who had seen the man's medical records.

comments

Case No. E.944/96-97-Convener's decision not to convene an independent review

Matters considered

The procedure followed by a convener in deciding not to convene an independent review

Body complained against

Epsom Health Care NHS Trust, Surrey

Summary of case

A man sought an independent review, under the national procedures introduced on 1 April 1996, of his complaint about the failure to take a blood test when his daughter attended the accident and emergency department of Epsom General Hospital in August 1995 suffering from pain in her leg. The man's daughter was due to fly to Australia the following day. During the journey her symptoms worsened and she was later diagnosed as having leukaemia.

Findings

I found that the convener did not comply with the NHS Executive guidance for handling complaints in the NHS. The convener misdirected herself by applying an inappropriate test in deciding to refuse an independent review; defended those complained against; and did not tell the man she had obtained independent clinical advice on his complaint. That advice supported key elements of the man's complaint and I strongly criticised the convener for failing to take due account of it.

Remedy

The Trust apologised and told the complainant that they accepted the conclusions of the independent clinical adviser.

Case No. E.1298/96-97-Trust's response to a request for an independent review and the convener's decision

Matters considered

Handling of request for independent review procedure followed by convener

Body complained against

St Helens and Knowsley Hospitals NHS Trust, Merseyside

Summary of case

A man complained to the Trust that, in December 1995, doctors at Whiston Hospital failed initially to diagnose a condition affecting the muscles of his leg. His request for an independent review of his case was refused by the Trust's convener.

Findings

I found that the Trust had delayed passing the man's request for an independent review to the convener and that the convener, investigated matters herself instead of referring them back for further local resolution. I did not uphold a complaint that the convener had failed to take independent clinical advice, though she had not told the complainant about that advice.

Remedy

The Trust apologised and agreed to reconsider the man's request for an independent review. In future, requests for independent review will be sent straight to the convener, who will tell complainants whether independent clinical advice has been taken in reaching a decision.

comments

Case No. S.64/95-96-Communications with patient and relatives

Matters considered

Communication with patient and relatives-nutrition-nursing care-escort and transport arrangements

Body complained against

Hairmyres and Stonehouse Hospitals NHS Trust, East Kilbride

Summary of case

A man underwent surgery in 1992 for cancer of the gullet. His symptoms recurred in 1994, and on 12 August he attended a routine outpatient follow-up appointment at Hairmyres Hospital. On 23 August he was admitted to the hospital for a prostate operation. He died in hospital on 18 September. His wife complained that at no time was the man told of the strong probability that the cancer had recurred or spread; after his admission to hospital inadequate attention was paid to his nutritional state; he was taken for a bone scan to another hospital in an unsuitable ambulance without a proper escort, and his intravenous fluids were discontinued for the journey; and in one ward he was nursed in a draughty area where he was continually cold.

Findings

I found that the man and his family were left without adequate information. During the period in question the man's care passed between different clinicians, none of whom told him of the suspicion that the cancer had returned. I upheld the complaint about his nutritional state to the limited extent that it was inadequately managed during part of his time in hospital. Although a suitable ambulance was used to transport the man for his scan, I found that his fluids should not have been discontinued for the journey and that the lack of a trained nurse escort substantially delayed his return. I did not consider that nursing staff were aware that the man was cold until they were told by his wife; but I considered that they should have been more alert to his needs.

Remedy

The Trust have agreed to take steps to ensure that where a patient passes through the care of a number of clinicians, the responsibility for keeping the patient and his family informed is clearly established, and to remind nurses of the fluid requirements of patients being sent for bone scans.

comments

Case No. W.34/95-96-Care of an elderly person and communication with relatives

Matters considered

Supervision and assistance with eating and hygiene needs-administration of medication-communication with relatives-procedure for certifying death

Bodies complained against

Llanelli/Dinefwr NHS Trust, Llanelli and Derwen NHS Trust West Wales, Carmarthen

Summary of case

In October 1994 a woman was admitted to Prince Philip Hospital, which is managed by Llanelli/Dinefwr NHS Trust. She was later transferred to Mynydd Mawr Hospital, which is managed by the same Trust, and then to Bryntirion Hospital which is managed by Derwen NHS Trust West Wales, before being re-admitted to Prince Philip Hospital on 20 January 1995. The woman's son complained that in the first two hospitals his mother's hygiene needs were not met, and that because of inadequate supervision she did not eat her meals or take her medication. He also complained that a nurse told him, incorrectly, that his mother had died; that instructions left in all three hospitals to the effect, that his mother should not be revived if she suffered a total collapse were ignored; and that when she did die the correct procedure for certifying her death was not followed.

Findings

Because there was no documentary evidence from Prince Philip Hospital about the woman's dietary needs, and because nurses could not remember her, I was unable to reach a conclusion about the standard of dietary care there. Nurses in Mynydd Mawr Hospital recognised the woman's dietary problems; but their efforts to encourage her to eat were unsuccessful. I was not persuaded that there were failures in supervision and assistance at mealtimes, and did not uphold that aspect of the complaint. I did not find made out the complaint that the woman's hygiene needs were not met, though it was possible that during her first week or so in hospital she was not included in two-hourly incontinence checks because she was assessed initially as `self-caring'. Insofar as nurses did not make sure that medication they had given out was taken, I upheld that aspect of the complaint. I found no maladministration in the action taken when the woman's condition deteriorated; but because of a nurse's error the woman's son was told that his mother was dead when that was not the case. When the woman did die the cause of death was certified by a doctor who had not seen her within the previous 14 days. Because of that the coroner could not accept the certificate, and the woman's son had to return to the hospital to obtain another from a different doctor before the death could be registered. I criticised Llanelli/Dinefwr NHS Trust for failing to make sure that their staff were fully aware of their duties in that respect.

Remedy

Llanelli/Dinefwr NHS Trust apologised and agreed to remind staff that patients must be properly supervised when taking medicines, and that patients' specific needs should be accurately identified and care plans prepared promptly. They also agreed to issue written instructions about nurses' responsibilities with regard to informing relatives about a patient's death; and to make sure that doctors' induction training and supporting written guidance in respect of their contacts with registrars and coroners fully met requirements.

comments

Case No. W.44/95-96-Nursing care and adequacy of nurse staff

Matters considered

Adequacy of nutritional care-removal of vomit and urine containers-administration of medication-availability of nurses

Body complained against

East Glamorgan NHS Trust, near Pontypridd

Summary of case

In April 1994 a man with cancer was admitted to East Glamorgan General Hospital. His wife complained that because the man was too ill to complete a diet sheet he received inadequate nourishment while he was in the hospital. When the man's wife visited she found full vomit and urine containers by his bedside. She also found medication which had been left on the man's bedside locker. She considered the level of nurse staffing in the ward to be inadequate, and said that there were never any staff around when she needed help.

Findings

I considered it less than satisfactory that it took eight days to draw up a care plan dealing with the man's nutritional needs, despite it being known that his condition could lead to poor appetite and fluid intake; but I found no evidence of any lack of attention to the man's nutritional needs, so did not uphold that aspect of the complaint. I did not uphold the complaint that full vomit and urine containers were left by the man's bedside. There was evidence that his wife often removed containers herself but that did not arise from any laxity on the part of the nurses. I partially upheld the complaint that medication was left on the man's bedside locker; for I found deficiences in the records detailing its administration and a divergence of view as to whether the man was capable of taking the medication himself. I considered it likely that, if medication was left with the man, then proper monitoring was not carried out to make sure the drugs were taken. I found no evidence that the general level of staffing in the ward was inadequate.

Remedy

The Trust apologised for the shortcomings I identified and agreed to review their policy on drug administration to make sure that nursing practice was consistent.

comments

ANNEX I

Glossary of Abbrieviations

A and E department	Accident and emergency department
CHC	Community health Council
ECR	Extra contractual referral
GMC	General medical council
GP	General Practitioner
HA	Health authority
HO	House Officer
NHS	National Health Service
RHA	Regional health authority
SHO	Senior House Officer

comments

ANNEX II

Time taken for Investigation and Health service body involved

Case Reference	*Investigation started*	*Report issued*	*Time taken (weeks)*	Health body
E.965/94-95	2.5.95	23.12.96	86	University College Hospitals NHS Trust
E.1190/94-95	14.11.95	23.12.96	58	East Norfolk Health Authority
E.1507/94-95	20.6.95	20.11.96	74	Salford Royal Hospitals NHS Trust
E.110/95-96	26.3.96	18.3.97	51	Salisbury Health Care NHS Trust
E.447/95-96	27.7.95	24.12.96	74	Pontefract Hospitals NHS Trust Wakefield Health Authority the former Northern and Yorkshire Regional Health Authority
E.920/95-96	4.1.96	13.1.97	54	North Essex Health Authority
E.1009/95-96	6.12.95	20.12.96	54	Salisbury Health Care NHS Trust
E.1072/95-96	8.12.95	31.10.96	47	St. George's Healthcare NHS Trust
E.1129/95-96	24.1.96	6.3.97	58	The former North Thames Regional Health Authority
E.1134/95-96	29.12.95	20.1.97	55	East and North Hertfordshire Health Authority
E.1242/95-96	29.5.96	25.3.97	44	King's Healthcare NHS Trust
E.1275/95-96	16.4.96	28.2.97	45	Barnsley District General Hospital NHS Trust
E.1312/95-96	7.2.96	28.2.97	55	The Hammersmith Hospitals NHS Trust
E.1315/95-96	7.2.96	21.2.97	54	Eastbourne Hospitals NHS Trust
E.1344/95-96	13.2.96	21.3.97	57	Chelsea and Westminster Healthcare NHS Trust
E.419/96-97	17.7.96	21.3.97	35	North Tyneside Healthcare NHS Trust
E.587/96-97	17.4.96	25.3.97	49	Greenwich Healthcare NHS Trust
E.591/96-97	30.7.96	17.12.96	20	North Staffordshire Hospital NHS Trust
E.859/96-97	17.9.96	25.3.97	27	Croydon Health Authority
E.944/96-97	24.10.96	21.3.97	21	Epsom Health Care NHS Trust
E.1298/96-97	4.12.96	24.3.97	16	St. Helens and Knowsley Hospitals NHS Trust
S.64/95-96	19.12.95	24.12.96	53	Hairmyres and Stonehouse Hospitals NHS Trust
W.34/95-96	2.10.95	11.12.96	62	Llanelli/Dinefwr NHS Trust Llanelli and Derwen NHS Trust West Wales

comments

Case No. E.965/94-95-Relative not told of patient's deterioration and death, delay in viewing body and handling of complaint

Background and complaint

1. The background provided to the complaint by the complainant was that on 18 July 1994 her late father, who was suffering from abdominal pains, was admitted to University College Hospital, London (the hospital), for observations and tests. The hospital is managed by The University College London Hospitals NHS Trust (the Trust). On 21 July the complainant travelled from her home in the north of England to London to be with her father, arriving late in the evening and spending the night at his flat near the hospital. Her husband telephoned the hospital from their home at 7 pm, and was told that his father-in-law had had a comfortable day. At 9.10 am on 22 July the complainant telephoned the hospital and was told that her father had died during the night. The complainant went immediately to the hospital where a doctor told her that at 7.30 pm the previous evening he had been called to her father who was experiencing breathing problems. The complainant understood that staff had realised by 10 pm that her father was dying but made no attempt to contact her. The complainant wished to view her father's body but was not able to do so until 1 pm on 22 July because of delays in arranging the attendance of a mortuary attendant.

2. The complainant complained to the hospital on 22 July that she had not been informed of her father's death until she telephoned that morning. On 25 July the hospital manager sent a letter of acknowledgment, addressed incorrectly, providing contradictory information and stating that she would be sent a full reply to her complaint within 20 working days. No reply was ever received.

3. The matters investigated were that:

a. the complainant was not informed of her father's deterioration and death;

b. there was an unreasonable delay before she was able to see her father's body; and

c. the handling of her complaint was dilatory and inept.

Investigation

4. The Commissioner obtained the Trust's comments and relevant documents were examined. The Commissioner's staff took evidence from the complainant, her husband, a friend who accompanied her to the hospital and the Trust staff involved. I have not put into this report every detail investigated but I am satisfied that no matter of significance has been overlooked.

National guidance and Trust procedures

5. In January 1992 the Department of Health issued Health Service Guidelines HSG(92)8 about `Patients who die in hospital'. They included:

> `It is for providers to decide how to best meet [requirements to deal with dying patients properly] but written instructions and appropriate training for staff are probably the best way of achieving this.
>
> `Staff who have to deal with dying patients and the relatives .... should be familiar with the instructions so that they can do so sensitively. Copies of the instructions should be readily available, so that informed advice can .... be given .... to relatives ....
>
> `Instructions should include advice on .... ensuring as far as possible that relatives or close friends know of the clinical progress and possibility of death.'

6. At the time of the events complained about the Trust had no instructions for staff on informing relatives about the clinical progress of dying patients.

Complaint *(a) Complainant not informed of her father's deterioration and death*

7. The complainant told the Commissioner's staff that during the morning of 19 July 1994 a nurse at the hospital telephoned her at her home in the north of England to say that her father had been admitted to the Accident and Emergency (A and E) ward during the night. When she asked why she had not been telephoned earlier the nurse replied that it was hospital policy not to contact relatives between 8 pm and 8.15 am unless they specifically requested it. The complainant told the nurse that she wished to be contacted on the telephone number they had for her at any time during the day or night if her father's condition deteriorated. At 7 pm on 21 July, while the complainant was travelling to London with her friend, her husband telephoned the hospital and was told that his father-in-law was comfortable. The complainant telephoned her husband at 11 pm from her father's flat near the hospital and, on hearing his news, decided that there was no need to telephone the hospital herself. When she telephoned the hospital at around 9.15 am the next morning, she was shocked to hear that her father had died in the night. When she asked the nurse why the hospital had not told her of her father's deterioration, the nurse said only that when she came on duty at 8 am the night staff had told her to contact the patient's relatives and tell them of his death. She was a student nurse and had never had to carry out such a task before: as a result, she had put it off. The complainant's husband said that he had been at their home between 7 pm on 21 July and 9.30 am on 22 July. He believed that when he telephoned the hospital at 7 pm on 21 July he told nursing staff that his wife was travelling to London that night (see paragraph 10).

Documents

8. The patient information sheet which was completed by a casualty nurse when the patient was admitted to the A and E ward at 5.15 am on 19 July named his daughter as his next of kin and gave her home telephone number. The casualty nurse recorded that the complainant had not been notified and wrote `Inform in morning'. She made no entries after the headings `CONTACT AT NIGHT' and `UNDER WHAT CIRCUMSTANCES'. The staff nurse (the first staff nurse) who telephoned the complainant later in the morning to tell her of her father's admission noted on the patient information sheet that the complainant had been informed and gave the date. After the heading `CONTACT AT NIGHT' she wrote `Yes' and after `UNDER WHAT CIRCUMSTANCES' she wrote `Any'.

9. There are no records in the nursing notes of any telephone conversations between the nursing staff and the complainant or her husband nor is there any record of the fact that the complainant was known to be travelling to London on 21 July (see paragraphs 7 and 10). In an entry timed at 5 am on 22 July a staff nurse who had been on duty in the ward since 8 pm the previous evening (the second staff nurse) wrote that the patient had been given medication `at start of shift for ? pulmonary embolism'. She recorded that by 10 pm his urine output had dropped to nil and the doctors were asked to consider whether resuscitation should be attempted if he had a cardiac arrest. Efforts were made to contact the consultant at home `to discuss appropriate intervention' but without success. The second staff nurse wrote: `Night sister called at 3 am due to continuing deterioration in the patient's condition. Assessed [patient's] condition on ward and [doctor] informed .... Patient cardiac arrested at 03.55 hrs-crash team called. Basic life support given-declared dead at 4 am.' In an entry timed at 8.15 am she wrote: `Relatives phoned [-] no answer. Please ask them to contact a member of [the consultant's] team.' There are no entries in the notes after that.

10. Some time shortly before 2 September the senior nurse in the A and E department (the senior nurse) wrote a note for the consultant in charge of the A and E department (the consultant) about some enquiries she had made for a reply to the complainant's complaint (paragraph 2). She wrote: `On the Thursday evening [the complainant's] husband rang at 7 pm and was told his father in law's condition was okay. He stated to the nurse that his wife was on her way down to London. This was not passed on to the night staff. His condition deteriorated rapidly during the night and [he] died [at] approx[imately] 4 am. The [senior sister on duty in the hospital (the senior night sister)] spoke to the staff and went through the documentation and noted that no family had visited. As [their] address was out of London she made the decision not to call them but asked the staff nurse to do so first thing in the morning. .... she was unable to get through. Then [the complainant's husband] rang the ward and was informed and his wife rang at the same time. This was .... before they went off at 8 am. The staff assure me that if they had known the daughter was in London they would have done their best to ensure they had contacted her so that she could have been with her father before he died.'

Staff evidence

11. The first staff nurse confirmed to the Commissioner's staff that she had made the entry on the patient information sheet recording the complainant's wish to be contacted at any time during the day or night but said that she did not remember the patient. She said she would have made the entry immediately after she made the telephone call. She had been on duty until 8.30 pm on 19 July but not again until after 22 July. She was not told about the complainant's complaint or asked about her entry in the notes at any time before she was told that the Commissioner's staff wished to interview her for this investigation.

12. The second staff nurse said that when she came on duty at 8 pm on 22 July the patient's condition was beginning to

deteriorate. It was suspected that he had had a pulmonary embolism. Around midnight it was recognised that he was dying and the second staff nurse then discussed with the senior night sister whether or not they should contact his daughter. The second staff nurse said that neither she nor the senior night sister had seen the entry in the notes that the complainant wished to be telephoned at any time if there was any reason to speak to her. She accepted the possibility that the entry had been there at the time and that they had both overlooked it. Because there was nothing in the notes to indicate that the complainant was in London when the patient died, the nurses delayed telephoning her home number until 6.30 am. The nurses then made a number of calls but there was no answer although the telephone rang. The second staff nurse accepted, that with hindsight, they should perhaps have telephoned at midnight.

13. The senior night sister said that it was the general practice at the hospital not to contact relatives between 8 pm and 8 am. During the night of 21-22 July she had visited the ward two or three times; she was aware that the patient was deteriorating and that staff were discussing his resuscitation status. She believed that she was called to the ward to assess his condition about an hour before he died. After his death she had looked at the patient information sheet for details of his next of kin and contacting arrangements, but there was no entry after `CONTACT AT NIGHT' or `UNDER WHAT CIRCUMSTANCES' and she could find no information elsewhere in the notes about any visits or telephone calls from relatives. Because of that and because the complainant's home was far away, she had decided that staff should not break the news to her until the morning. She had therefore asked the night staff to start telephoning the complaint's home number at about 6.30 am, but there had been no reply. If the number had been engaged or unobtainable she would have asked the local police to send an officer to the address. They discovered that the complainant was in London only when her husband telephoned and told them that she had travelled then the previous evening. The senior night sister said that she and the other staff on duty had been upset to learn that not only had the family been in touch with the ward but while the patient was dying his daughter had been staying in his flat near the hospital. They then checked the notes again for information about previous contacts with the relatives but found none. The senior night sister then spoke to the day staff about the importance of recording such information in the notes. Asked to comment on the first staff nurse's evidence that she had entered the contact details on the patient information sheet on 19 July (paragraphs 8 and 11), the senior night sister said she was certain they were not there when she saw the sheet on 22 July. She could not explain the discrepancy.

14. The senior night sister said that when the complainant telephoned the ward during the morning of 22 July and was told of her father's death, the senior night sister spoke to the complainant's friend who was with her at the time. The senior night sister asked if she could speak to the complainant but the friend said that she was too upset. The senior night sister told the friend that it had been her decision not to telephone during the night; she now realised that the decision had been wrong and she offered her apologies.

15. The student nurse (paragraph 7) said that she came on duty at 8 am on 22 July. As she was at the end of her training she was carrying out a number of tasks in the ward on her own although she continued to be supervised by the senior staff nurse in charge of the shift who was acting as her mentor. He had insisted that she telephone the complainant to inform her of her father's death. The student nurse thought it was inappropriate for her to do so; she had never had to carry out such a task before; she had not been trained, and she did not know the patient. Eventually she agreed although she continued to think the decision wrong but, while she was reading the notes and discussing with the senior staff nurse what she might say, the complainant had telephoned. The senior staff nurse took the call and passed the handset to her. She then broke the news to the complainant.

16. The senior staff nurse said that when he came on duty at 8 am the senior night sister was still in the ward and she mentioned that there had been difficulties in contacting the complainant. He gained the impression (he could not say from whom) that the complainant had asked to be contacted at any time if her father's condition deteriorated and that her husband had been spoken to earlier that morning. The senior staff nurse could not remember asking the student nurse to telephone the complainant or handing her the handset when the complainant telephoned. He said that in his role as the student nurse's mentor, which included identifying tasks to give her for experience, he might well have suggested that she make the telephone call to the relatives. He would have provided advice and support. He would not have forced her to take the complainant's call.

17. The consultant told the complainant on 31 August 1994 (see Appendix) that the hospital `could and should have rung' her at her home telephone number during the evening of 21 July. He commented to the Commissioner's staff that irrespective of what was noted on the patient information sheet, the family should have been contacted as soon as it became apparent that the patient's condition was deteriorating fast. That was particularly important because no relatives had visited him. The decision was one which nursing staff were able to make; it did not need a doctor's authority. He thought that if a student nurse had been left to break the news of a patient's death to the patient's relatives that merited criticism.

18. At the end of the investigation the deputy to the Trust's chief nurse said that the Trust had drafted a policy on care of the dying which included guidance on keeping relatives informed. Many of the nursing staff were aware of its contents because it

had been discussed twice in the Trust's nursing practices committee.

Findings *(a)*

19. It is clear from the entry in the patient information sheet and the first staff nurse's evidence that the complainant's wish to be contacted immediately if there was any significant deterioration in her father's condition had been recorded on 19 July. The entry should have been acted on at once when he began to deteriorate during the evening of 21 July. (With regard to the senior night sister's assertion that it was not there when she looked in the notes after the patient's death, I conclude that she was mistaken.) The staff who took the complainant's husband's call at 7 pm on 21 July had not recorded that his wife was on her way to visit her father and, as a consequence, the staff on the night shift were not aware that she was coming and did not telephone her at her father's flat so that she could be with him before he died. I agree with the senior night sister that her decision not to telephone during the night was wrong, and I note that she immediately offered an apology. I criticise the Trust for their lack of instructions for staff on informing relatives about the condition of patients who are or may be near to death.

20. The nursing staff say that after the patient's death they began to telephone the complainant's home from 6.30 am but their calls were not answered. The complainant's husband was there and I cannot say why they did not make contact. It appears from the entry in the notes (paragraph 9) that the day staff took over the task at 8.15 am. There are some discrepancies in the different accounts of the timing of what happened after then, but the sequence of events is clear. The senior staff nurse instructed an untrained and inexperienced student nurse who had not known the patient to make the call. She, understandably, took time to prepare for it. While she was doing so, first the complainant's husband and then the complainant telephoned and the senior staff nurse gave the complainant's call to the student nurse to answer. That was wrong - particularly in view of the hospital's failure to inform her of her father's death before then. The senior staff nurse should himself have spoken to her and broken the news with the special consideration due in the circumstances. I note that the Trust have now drawn up a policy on care of the dying and keeping relatives informed. I am concerned that four years after the issue of the Department of Health's guidance on the subject, the Trust's policy is still only in draft, and recommend that the Trust finalise and implement it without further delay. I uphold the complaint.

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comments

Case No. E.1190/94-95-Policy for funding incontinence supplies to residential care homes and complaint handling

Background and complaint

1. The complainant is the owner of a residential care home for the elderly within the boundaries of East Norfolk Health Authority. The background which she provided to her complaint was that in June 1993 she learned that from 1 April 1993 health authorities had been required to fund the provision of incontinence supplies to persons living in independent residential care homes on the same basis as to those living in their own homes. She asked the former Norwich Health Authority, succeeded on 1 April 1994 by East Norfolk Health Authority (the Health Authority), what funding would be available for residents of her residential care home. They replied in October 1993 that funding was likely to be available only for residents who were demented or doubly incontinent. Further letters about the matter which the complainant, her solicitor and her Member of Parliament (the Member) sent to the Health Authority were not answered. On 17 August 1994 the complainant wrote to the Department of Health complaining that the policy adopted by the Health Authority meant that new residents in her home, whose incontinence supplies had been provided without charge by the Health Authority when they were living in their own homes, were no longer entitled to free supplies. Her letter was passed to the Health Authority who replied in November acknowledging that there was a difference between funding arrangements for persons in residential care homes and those for persons living in their own homes, and stating that they were working to achieve consistency. From 1 April 1995 the Health Authority adopted a policy of funding incontinence supplies for persons living in residential care homes on the same basis as for those living in their own homes. However, they refused to reimburse the complainant and her residents for the supplies they had purchased between April 1993 and April 1995.

2. The matters subject to investigation were that:

   a. the Health Authority were dilatory in replying to the complainant's enquiries about the funding of incontinence supplies; and

   b. their refusal to reimburse the cost of the incontinence supplies which the complainant and her residents purchased between April 1993 and April 1995, despite Department of Health guidance that such supplies should be funded on the same basis as those for people in their own homes, was unreasonable. The complainant sought redress.

Investigation

3. The statement of complaint for my investigation was issued on 12 December 1995. I obtained the comments of the Health Authority and examined relevant documents and correspondence. One of my staff took evidence from the complainant and staff of the Health Authority and Norwich Community Health Partnership NHS Trust (the Trust) which is now responsible for providing incontinence services to residents in the Health Authority's area. Evidence was also obtained from the Department of Health. I have not put into this report every detail investigated but I am satisfied that no matter of significance has been overlooked.

National guidance on the provision of incontinence supplies

4. On 18 December 1992 the NHS Management Executive issued Health Service Guidelines HSG(92)50 on the funding of community health services for persons in residential care homes. The guidance reminded health authorities that they were responsible for providing incontinence supplies to residents of local authority and independent residential care homes `on the same basis as to people in their own homes'. It stated that where such services were provided they must be free of charge to people in independent sector residential care homes as well as local authority homes. It also stated: `The extent to which [such] services can be provided is a matter for health authorities' judgment taking account of the resources available and competing priorities.' On 21 October 1993 the Parliamentary Under Secretary of State for Health wrote to the Member in reply to an enquiry on behalf of the complainant: `[The requirement that health authorities should provide incontinence supplies to persons in residential care homes `on the same basis' as to people in their own homes] means that once health authorities decide the overall level of provision, continence materials/aids should be made available to people in residential care homes using the same criteria as for people living in their own homes.' He sent a copy of the letter to the chairman of the Health

Authority.

Complaint *(a) Delays in replies*

5. An Appendix to this report summarises the events and correspondence relating to the complainant's complaint. The complainant said that she was concerned about the Health Authority's delays during three periods - first, from her enquiry about her residents' entitlement to free supplies on 3 July 1993 to the announcement of a partial service in October and November 1993; secondly, from her letter of 29 November 1993 questioning the interim arrangement to 17 August 1994 when one of her residents who was affected was reassessed; and thirdly from her formal complaint about the arrangement on 17 August 1994 to the reply from the Health Authority's chief executive on 17 November 1994. (Note: Before the change of health authorities in April 1994 the chief executive had been the district general manager of the former health authority. I refer to him as the chief executive throughout this report.)

Procedures for handling complaints and enquiries

6. The Health Authority's complaints procedure stated that the head of corporate business was responsible for dealing with all written enquiries and complaints. The procedure set a target of four weeks for full replies to complaints. It required that holding letters should be sent to the complainant every four weeks or when a significant delay became known, and that progress should be monitored regularly by a bring-forward system. A record of enquiries and complaints received by the Health Authority was kept in a manual register in which it was also recorded to whom the complaint had been passed for a draft reply and the deadline for submission of the draft. The system was computerised from April 1994.

Staff evidence

7. The head of corporate business said that she was on holiday when the complainant's letter of 3 July 1993 (see Appendix) was received. The chief executive's secretary knew that other enquiries had been received on the same subject and passed the letter to the deputy director of planning who was dealing with them. The letter was not recorded in the head of corporate business's manual register for enquiries and complaints but was placed instead in a general file for all the enquiries received from residential care home owners about incontinence supplies. She acknowledged it when she returned from holiday but made no entry in the bring-forward system to check with the deputy director of planning whether she had produced a draft reply because she believed that the Health Authority would soon be sending details of their planned service to the residential care home owners. In the event, to settle what the service should be took much longer than expected. She did not remember seeing the complainant's letter of 14 September (see Appendix) but in any case by that time the Health Authority should have written to her explaining why they had not yet sent a detailed reply to her enquiry. The reason was again probably that she was expecting a decision soon about the service and the residential care home owners could then be told about it.

8. The head of corporate business said that the letters received between November 1993 and May 1994 from the complainant, her solicitor and the Member were treated as follow-up correspondence about the previous enquiry and were not recorded in her manual register for that reason. When the system was computerised in April 1994 follow-up letters were entered but only those about enquiries and complaints received after the system was computerised. The letters about the complainant's enquiry should have been acknowledged, sent to the deputy director of planning or the contracts manager and entered in the bring-forward system with a target date for their draft reply. The head of corporate business could not explain why that had not been done. The deputy director of planning and the contracts manager did not remember being asked to prepare draft replies to any of the letters.

9. The head of corporate business said that when the complainant's letter of 17 August 1994 was received from the Department of Health she should have entered in the bring-forward system a target date for the contracts manager's draft reply but did not. She did not remember what happened at the time or why it took until 17 November for a reply to be sent. She was unaware of the complainant's correspondence with the director of quality (see Appendix, 17 August and 19 October 1994) although, as the designated complaints officer, she would have expected to have been told about that.

10. The deputy director of planning said that the complainant's letter of 3 July 1993 was one of many similar enquiries received around that time by the Health Authority about their plans for providing incontinence supplies to persons in residential care homes. She had been asked to prepare a general letter for all the care home owners explaining the Health Authority's position, and decided to wait before doing so until the Health Authority's district continence advisory committee (the advisory committee) produced clinical criteria for the service. However, when it became clear in late August that they would not produce the criteria as quickly as had been expected, the Health Authority decided that, rather than let the situation drag on indefinitely, they would introduce an interim service which would show the care home owners that the Authority were taking steps to meet their responsibilities. She drafted the chief executive's letter of 26 October 1993 to residential care home owners but had not seen the complainant's letter of 14 September because responsibility for dealing with such letters lay with

the head of corporate business.

11. The contracts manager said that the complainant's solicitor had told him during their telephone conversation on 4 July 1994 (see Appendix) that her client was not happy with the way in which the chief executive had dealt with her previous enquiries and she wanted to know if there was any other person to whom she could write to make a complaint. He suggested the Health Authority's director of quality as he sometimes investigated complaints within the Health Authority. He did not know that the complainant subsequently had complained to the director of quality and although he prepared the letter of 17 November 1994 for the chief executive's signature, he was unable to say why a reply was not sent to her earlier.

12. The director of quality said that he did not remember seeing the complainant's letter of 17 August 1994 and he was unable to identify who had acknowledged it on his behalf. Having received the Trust's letter of 4 November 1994, he asked the Trust's locality manager to send a standard letter to all the residential care home owners explaining the position concerning supplies. He believed that he told her to make sure that the complainant received one. The locality manager, employed by the Trust, said she had no recollection of being asked by the director of quality to send such a letter, and none was sent.

13. The chief executive told my staff that it had not been necessary for him to see all letters addressed to him and if his secretary or the head of corporate business knew how to deal with a particular letter they would proceed without consulting him. He checked the content of letters prepared for his signature before they were sent but had no recollection of his letters to the complainant. Since the events about which the complainant had complained, the Health Authority had put in place effective arrangements for dealing with enquiries and complaints. When the new NHS complaints procedure was introduced in April 1996, all complaints staff had received instructions on recording details of complaints and follow-up letters.

Findings *(a)*

14. Between July and October 1993 the complainant was kept waiting for a reply to her enquiry while the Health Authority decided what service they would provide. The head of corporate business had expected the Health Authority to make the decision sooner than they did, but that cannot excuse the failure to send holding letters, or to reply to the complainant's follow-up letter of 14 September. The delays between November 1993 and November 1994 were due to repeated failures to deal with a succession of letters and inadequate monitoring of progress. Between November 1993 and July 1994, the Health Authority failed to reply to five letters from the complainant, the Member and the complainant's solicitor; they eventually replied only after the solicitor telephoned the contracts manager. When the complainant complained in August 1994 to the director of quality she had to wait another three months for a reply and the final letter was only sent as a result of enquiries she made to the Department of Health.

15. In my recent report of an investigation into another complaint about the Health Authority's handling of the changes to arrangements for incontinence supplies to residential care homes during 1993 and 1994 (E.193/93-94 issued on 26 March 1996) I also found repeated failures to acknowledge and reply to enquiries and complaints. In the last two years the Health Authority have changed their procedures for handling enquiries and complaints. In my other report I recommended that they should keep their arrangements under review and monitor performance carefully. I uphold the complaint.

Complaint *(b) Refusal to reimburse costs of supplies*

16. The complainant said that the national guidance on the provision of incontinence supplies (paragraph 4) declared clearly that the provision to persons in residential homes should be consistent with that for persons in their own homes. The Health Authority had introduced a partial service from late 1993 which allowed for funding of incontinence supplies to persons in residential homes only if they were doubly incontinent or demented. That breached the national principle of consistency because residents who did not satisfy that criteria had to pay for their own supplies while persons with the same needs living in their own homes continued to receive free supplies. Five of her residents suffered as a result-three who were already living in her home before April 1993; a resident who arrived in August 1994 and paid her own fees; and a resident who arrived in October 1993 and whose fees were paid by Social Services. The first three residents had to pay around £5.50 per month for the two years during which the interim arrangement was in force-a total of almost £130 each. The person who arrived in August 1994 and paid her own fees had to pay about £16 a month for eight months-a total again of almost £130, and the costs for the person whose fees were paid by Social Services were about £12 per month which amounted to over £215. In her case, although Social Services had said in April 1994 that the complainant could not charge her for supplies because the Health Authority should pay, the Health Authority refused to pay and she had to bear the cost herself from then until April 1995.

17. The complainant said that her main concern in pressing for reimbursement was for the two residents who had come from their own homes. She could not understand why they should have to start paying for their supplies simply because they had moved into her residential care home. The Health Authority's argument was that the national guidance allowed them to take account of available resources and priorities in deciding what to provide (paragraph 4). However, the Health Authority had

been providing their supplies when they were living in their own homes, and to continue to do so when they moved to her residential care home would not have increased the call on available resources.

Evidence from the Department of Health

18. An official of the Department of Health told my staff in August 1996 that the Department's guidelines (paragraph 4) emphasised the need to achieve consistency between the service to persons in residential care homes and that for persons in their own homes. The discretion allowed to health authorities in determining the level of provision according to available resources and priorities was subject to that principle.

Staff evidence

19. The contracts manager said that at the time (December 1992) when the national guidance (paragraph 4) was issued, to take effect on 1 April 1993, the practice of the former Norwich Health Authority had been to meet the costs of all incontinence supplies by the NHS to persons living in their own homes, but not to meet any of the costs of such supplies to persons living in residential homes. The Health Authority's financial plans for 1993-94 were in an advanced stage, and they could not provide for the estimated additional cost (£630,000) of meeting the costs of the supplies for all persons living in residential homes.

20. Late in 1993, the Health Authority decided on a partial service to persons in residential homes. It involved the Health Authority meeting the cost of supplies to residents who were doubly incontinent or demented, but not to other residents. The Health Authority considered that their line was not contrary to the national guidance (although it was, to a degree, inconsistent). They preferred it to the option of reducing the service to persons living at home, which would have been very disruptive. Assessments for payments under the partial service were made from January 1994 and payments were made from March 1994. The contracts manager accepted that it was an anomaly that, under the partial service, some persons entering a residential home ceased to receive funding for their supplies, but it was not possible to make exceptions for such cases while retaining the principles of the partial service.

21. The Health Authority decided to include in their Health Investment Plan for 1995-96 provision to meet the additional cost of funding incontinence supplies to all persons, including those in residential homes. The funding was provided, and the full service was introduced in April 1995.

22. When the partial service was introduced, the Health Authority agreed to reimburse the costs incurred since April 1993 (when the national guidance took effect) for supplies to doubly incontinent or demented residents, whose costs were covered by the partial service. They considered that in doing so they were meeting the costs resulting from their delay in developing the partial service which they thought, met the requirements of the national guidance. Later, however, when they obtained funding for a full service (from April 1995), they considered that to be a new service, and did not see a comparable case for compensating those who were not provided with it previously.

23. The contracts manager said that, although the complainant was the only home owner to have made such a claim for her residents, accepting her claim would set a precedent for others. On the basis of the estimate by the Trust's locality manager in May 1994, that might have cost the Health Authority up to £250,000 for the time between April 1993 and the start of the full service. However, from their experience in providing reimbursement when the partial service was introduced, for practical reasons the actual amount claimed might be much smaller.

24. The chief executive gave three reasons for the Health Authority's introduction of the partial service. First, they believed that they should not start up services which they could not afford to maintain. Secondly, they considered that they should give priority to the most serious cases. Thirdly, they considered that they should not withdraw services which were already provided to persons living in their own homes. He considered that the partial service had been consistent with the national guidelines and the Health Authority had moved towards a consistent service in steps according to the resources available. He confirmed the contracts manager's account of the Health Authority's reasons for not offering reimbursement to residents not eligible for the partial service.

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comments

Case No. E.1507/94-95-Nursing care and record keeping

Background and complaint

1. The background to the complaint was that the complainant's father was admitted to Hope Hospital, Salford (the first hospital), on 16 March 1994 with a suspected heart attack. At the time of his father's admission the complainant's brother explained to nurses that his father had had an operation a fortnight earlier to remove a cataract and implant lenses. He also handed over eye drops which his father was using. During the night of 17 March his father was confused and restless but nurses reassured and watched him until they were called away to attend to another patient. The patient then fell and struck his head heavily on the floor. The complainant and her sister were told about the fall the next day by a nurse who said that their father had been examined by a doctor and that no x-rays had been taken because there were no signs of a fracture. Later that day the complainant's father was transferred to another ward (ward NE3) in the hospital. On 21 March, during a medical examination, he was found to have restricted vision in his right eye, and a preliminary diagnosis of a detached retina was made. He was transferred to a second hospital and underwent operations to attempt to repair the damage, but he lost the sight of the eye. Hope Hospital is managed by Salford Royal Hospitals NHS Trust (the Trust).

2. The complainant wrote to the Trust on 11 April 1994 to complain about the fall; she asked what had been done to assess her father's vision after the accident and why four days had elapsed between the fall and the discovery of the detached retina. She received an acknowledgment of her complaint on 25 April and a substantive reply on 6 June. There appeared to have been delays in posting both letters. On 21 June the complainant replied to the Trust disputing much of what they had said. Her letter was acknowledged but, despite sending reminders, she received no substantive reply.

3. The complaints investigated were that:

a. despite his restlessness and confusion on the night of 17 March the complainant's father was left alone and fell;

b. no record was made of his recent eye operation with the result that insufficient attention was paid to his eyes after his fall; and

c. the response to the complainant's complaint was dilatory and inadequate.

Investigation

4. The Commissioner obtained comments from the Trust and relevant papers, including the patient's clinical records, were examined. The Commissioner's staff took evidence from the complainant and her brother and from the Trust staff involved. I have not put into this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Point (c) of the complainant's complaint was considered by the Commissioner as part of a special investigation into complaint-handling by the Trust. The results of that investigation were published on 6 June 1996 as the Commissioner's second report for the 1995-96 session (House of Commons Paper 429). His findings on point (c) are summarised in paragraph 22 of this report.

Complaint *(a) Fall during night of 17 March*

5. The complainant said that when she visited her father in hospital on 18 March a charge nurse told her that the previous night her father had been confused and had fallen while trying to get out of bed. She did not remember him saying anything about there having been cot-sides on the bed (see paragraph 7). She did not think that her father would have been able to climb over cot-sides or undo them. The Trust's reply to her complaint implied that her father had got out of bed and was standing up when he fell. (The letter included `It is documented on the accident form that [the patient] had got up to use the urine bottle, was unsteady on his feet and thus fell.') The fact that her father was left alone even though he had been restless suggested to her a lack of care.

Documents

6. The charge nurse on duty in the heart care unit during the afternoon shift (2 pm-10 pm) on 17 March wrote in the patient's nursing notes: `Slight confusion evident later in the evening.' The next entry, made by a sister (the first sister) on duty during the night shift (9.30 pm-7.30 am), included: `Appeared settled during early part of the night .... 1 am Got out of bed to use

bottle and fell banging head ....' An accident report form was completed by a staff nurse (the first staff nurse) and the first sister. The first staff nurse wrote that the incident happened at 1.10 am. The patient `was found lying on floor. Said he was going to toilet and fell.' The first sister wrote under the heading `Action taken': `Patient cot sided and advised to seek assistance if wanting to vacate bed.'

7. In a statement made to the Trust's administration manager for medical specialties (the administration manager) for their reply to the complainant's complaint in April 1994, the first staff nurse wrote: `When we came on [duty] [the patient] had cot-sides up and was told not to get out of bed on his own.' In another statement the first sister wrote that immediately before the accident the patient appeared `to be rational and orientated'. She wrote that `there was no reason to be in attendance' on him. After the fall he got back into bed `and was cot sided with his agreement for his own safety. An x-ray was not undertaken but a neurological observations chart was maintained hourly throughout the night.'

Staff evidence

8. The first sister told the Commissioner's staff that she had been the named nurse for the complainant's father. (Note: The Trust's Patient's Charter explains the role of a named nurse as being to `take special interest in your care and discuss it with you'.) Another sister (the second sister) and a staff nurse were on duty with her during the night shift on 17/18 March. (The administration manager confirmed that three nurses was the established staff number for the night shift in the heart care unit.) The first sister could not remember being told when her shift started that the patient had been confused but her entry in the notes indicated that she had been aware that he had been restless earlier in the evening but had then settled down. She was certain that the patient had cot-sides on his bed when she came on duty and that they had been raised as a precautionary measure. She did not see the patient's fall because, at the time, she was speaking to another patient's relatives in the reception area of the unit. She thought it unlikely that the patient could have climbed over the cot-sides, but he might have moved to the bottom of the bed before getting out, as some patients often did. After the fall the cot-sides were taken down to put the patient back in bed and were then re-erected. That was what she had meant when she wrote `patient cot sided' in the accident report (paragraph 6).

9. The first staff nurse said he remembered that when he came on duty for the night shift on 17/18 March the patient had been slightly confused. The first staff nurse and the second sister were with another patient in the main unit when the complainant's father fell. He confirmed that the first sister had been at the entrance to the unit talking to a third patient's relatives. None of the nursing staff witnessed the accident. He heard a thud, looked over and saw that the complainant's father was lying on the floor on his back at right-angles to the bed. He was conscious but had suffered an injury to the back of his head.

10. The lead nurse in the heart care unit (the lead nurse), who was not in post at the time when the complainant's father was in the hospital, said that deciding what action to take to deal with a restless patient was a matter for the professional judgment of individual nurses. Cot-sides might be appropriate if a patient was rolling about in bed. The policy now was that if it was decided to use cot-sides the decision and the reason for it should be recorded in the nursing records and explained to the patient's relatives. That had not been the practice when the complainant's father was a patient.

Findings *(a)*

11. It was recorded that the complainant's father was confused during the early part of the evening of 17 March. The action necessary to deal with that confusion was a matter for the professional judgment of the nurses on duty at the time. The first sister noted that when she came on duty the patient appeared to have settled and her evidence, and that of the first staff nurse, is that precautions were taken for his safety by erecting cot-sides to his bed. That he fell is highly regrettable but I have found no evidence of a lack of reasonable care by the nurses. I do not uphold the complaint.

Complaint *(b) No record of eye operation*

12. In her letter to the Trust dated 21 June 1994 the complainant wrote:

> `The nursing staff were, or should have been, fully aware of my father's recent eye operations. As you know, he was admitted to the heart care unit .... on the evening of March 16. My brother .... drove to [the first hospital] that same evening .... en route he called in at my father's bungalow in order to collect the eyedrops that he knew were essential. [He] arrived on the heart care unit at approximately 9 pm. He .... handed the two bottles of drops to a female nurse at the central nursing station and gave a full explanation about their administration and the reasons why - because of the very recent operation to remove a cataract and to implant lenses .... My brother .... explained the difference between the two bottles and the reasons why not once but two or three times because he felt that the nurse in question was not really listening. He did not see her make any note of the information which was being given.'

13. The Trust's complaints manager replied to the complainant in a letter dated 6 December:

> `[The] visit by your brother was not documented in the nursing care plan, and although his eye medication is mentioned, the reason for his receiving such medication .... has not been documented. It has become clear from interviews with different members of staff that this information, although not documented, was passed on verbally [orally]. .... However correct procedure is for such information to be documented, as there is always a possibility that important details can otherwise be forgotten.
>
> `I would, therefore like to offer you a sincere apology, that our documentation and communication were not of the required standard.
>
> `It is clear from our investigations that the communication regarding your father's eye surgery could have been of a higher standard. If this had been the case, then it is possible, but by no means certain, that his blurred vision might have been discovered earlier. However, the advice we have received suggests that this would have been unlikely to make any difference to the outcome of the retinal detachment.
>
> `.... There are clear lessons for us to learn, particularly in the area of communications, and I would like to assure you that we will make strenuous efforts to improve the standards of our service.'

14. In a letter to the Commissioner's staff, the patient's son wrote that he visited the heart care unit between 6.30 pm and 7.30 pm on 16 March and explained to a nurse about his father's recent cataract operation and his eye drops. He visited a second time at around 9 pm and told a female nurse that his father had recently had an operation for cataracts and needed eye drops. The next day when he visited his father he asked a nurse in attendance whether the eye drops were being administered and was told that they were. His father then joined the conversation and it was clear from his remarks that he had spoken to the nurses about the eye operation and the eye drops were being given.

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comments

Case No. E.110/95-96-Response to a critical report of an independent professional review (IPR)

Background and complaint

1. The account of the complaint provided by the complainants was that their 18 year old daughter died in Salisbury General Infirmary (the hospital) on 9 June 1992. At that time the hospital was managed by Salisbury District Health Authority. The complainants complained to the Health Authority about the treatment their daughter received at the hospital immediately before her death. Those complaints were considered by independent clinical assessors in September and October 1993 at an independent professional review (IPR)-the third stage of the NHS clinical complaints procedure at that time. The IPR also considered some aspects of the administrative handling of the complaints put by the complainants. The report by the IPR assessors, which was issued in August 1994, was critical both of the clinical management of the complainants' daughter and of the administrative handling of the complaints. On 1 April 1994 the management of the hospital became the responsibility of Salisbury Health Care NHS Trust (the Trust). In response to the IPR report the Trust set up a `complaint investigation panel' (the Panel), consisting of Trust employees and Board members, to consider the findings of the IPR. The Panel reported to the Trust Board in December 1994. The complainants considered that the setting up of the Panel and its subsequent report to the Trust Board were an inadequate and inappropriate response to the findings of the IPR.

2. The complaint subject to investigation was that the Trust's response to the findings of the IPR was inadequate and unsatisfactory.

Investigation

3. My predecessor obtained the comments of the Trust and other relevant papers were examined. My staff took evidence from the complainants and from Trust staff. Evidence was also taken from the chair and two employees of the former South and West Regional Health Authority (the RHA), although that body was not the subject of the complaint. The RHA was abolished on 1 April 1996. My predecessor explained to the complainants that their complaint might in part concern action which in his opinion was taken in the exercise of clinical judgment, which at the time was outside his statutory jurisdiction.

Evidence of the complainants

4. The complainants said that they received a copy of the IPR report and they thought it had been just and fair. They were told that a working party (the Panel) was being set up to advise the Board on its response to the report. They were given a copy of its terms of reference when they arrived to speak to the Panel. The chairman of the Trust also met them that day before the Panel meeting. They thought that the Panel had been set up to implement the IPR report; but they did not know how that was normally done. They did everything they could to co-operate.

5. When they received the Panel's report they considered that it had reinvestigated the complaint and that the Trust had replaced the IPR report with their own. In their view the Panel report minimised and diffused the blame for what happened to their daughter and undermined the recommendations made in the IPR report by disagreeing with some of its conclusions. The complainants expressed concern about the preliminary comments in the Panel report (which recorded highly critical comments about the process of the IPR and some of its contents). They complained that no evidence was given to justify those comments. They later became concerned that three people (the chief executive, the medical director and the legal manager, who they understood had been the director of nursing) criticised in the IPR report and who were involved in either their daughter's treatment or the investigation of their complaint, had been part of the Panel or were members of the Board when it approved the Panel's report. That was against natural justice - it was wrong for staff to be involved in an investigation of their own conduct. When they told the Trust they were unhappy with the Panel report the Trust did not appear to take much notice of their views and did not seem to understand how the report might appear to someone outside the Trust. The complainants wanted some form of disciplinary action or other public recognition that the treatment given to their daughter was not acceptable to the Trust. They did not think the Panel report had done that. (Note: Complaints about personnel matters, such as decisions about disciplinary action against staff, are outside my jurisdiction.)

National guidance

6. A circular, HC(88)37, issued in 1988 by the Department of Health and Social Security about hospital complaints procedures, described the three stages of the clinical complaints procedure in operation at the time relevant to my report. Regional Health Authorities became involved at the second stage, when their regional medical officer (RMO) considered whether an IPR should be held. Describing the IPR stage the circular said that there should be two independent clinical assessors who, as well as considering the clinical judgment of the medical staff, should `consider whether there were any other circumstances which had contributed to the problems in the case and on which they could usefully make recommendations, which they would include in their report to the RMO.'

7. The circular said that on conclusion of the IPR:

> `The district administrator [later replaced by `Trust chief executive' for Trusts] will .... write formally to the complainant on behalf of the authority [or Trust], with a copy to the consultant. The district administrator will, where appropriate, explain any action .... taken as a result of the complaint but, where clinical matters are concerned, he will follow the RMO's advice regarding the comment which would be appropriate.'

It gave no other relevant guidance on what action hospitals should take as a result of IPR reports.

Local guidance

8. A Serious Incident Policy, which was introduced by the Health Authority in December 1993 (ie after the young woman's death) and continued to be used by the Trust, said:

> `The purpose of any serious incident inquiry is to establish and present the facts relating to the incident and, in the light of the findings, to make recommendations for appropriate action with the aim of preventing recurrence and improving care, by critical analysis of the incident .... .
>
> `....
>
> `The nature of the serious incident will determine the nature of the investigation .... It is likely, however, that the investigation process will be conducted in one of the following ways:-
>
> `....
>
> `Officer Inquiry, involving an Inquiry Team which may comprise of the Chief Executive (or an officer he assigns), appropriate professional manager and nominated Consultant representative. This may be appropriate in a more complex clinical case or where the incident indicates that `hybrid' (i.e. clinical & managerial) follow-up action may be required;
>
> `Non Executive Inquiry, undertaken by a Panel of non-executive members, constituted following consultation between the Chief Executive and the Chairman. The inquiry Panel will be supported by a senior officer appointed by the Chief Executive and the written report of their findings and recommendations will be submitted to the Executive Board.
>
> `....
>
> `If in the course of investigation, it appears that the incident may have occurred or been aggravated as a result of professional misconduct or incompetence by staff, the individual(s) concerned should be informed at the earliest possible opportunity that disciplinary action may be instigated and advised of their rights ....'

Documentation

9. On 20 July 1994 the RHA's consultant in public health medicine (who had organised the IPR process) wrote to the RHA's then director of public health (another term for RMO) as follows:

> `Attached is an expert [IPR report]. It is thorough, admirable and very disturbing ....
>
> `This report requires unusual handling ....
>
> `I do not think that the usual procedure after an [IPR], - that of me writing to the .... Trust intimating how it should be communicated to the complainants, and what they should be informed of proposed recommendations, - will be sufficient in this case. .... I think you may want to discuss this with RHA colleagues, possibly formally, and then to

take it more formally to the .... Trust. (There is no precedent in the Clinical Complaints in this Region for that step, but there is equally no case with so many shortcomings and criticisms.)'

10. The RHA discussed the IPR report at a closed session of the RHA on 30 September 1994. The minutes of that meeting record that a copy of the report had been sent to the complainants and to the Trust. However, a letter from the RHA chair to the chairman of the Trust, enclosing a copy of the report is dated 12 October. It said:

> `.... I would ask the Trust Board to .... consider each of the recommendations .... and inform the RHA by 30 December 1994 what action they intend to take in respect of all aspects of the recommendations including action against medical and nursing staff ....
>
> `....
>
> `I cannot stress too strongly the serious nature of this complaint both in respect of its handling within the Trust prior to its referral to the Region and in respect of the serious inadequacies of clinical standards ....'

11. The complainants had been sent a full copy of the IPR report by the RHA and on 17 October 1994 wrote to the chairman of the Trust :

> `.... We .... expect an appropriately robust and forceful reaction from the Trust, which will make it clear to all the individuals involved the gravity with which it views the .... deficiencies which characterised [our daughter's] care and describes the measures it intends to take ....
>
> `[Your] response should be based not only on the reviewers' specific recommendations, but also on the wider issues touched on in our complaint ....'

12. The chairman's reply on 20 October included:

> `I have decided to establish a small working party of five people chaired by the Non-Executive Chairman of our Audit Committee .... to advise the Board on its response.'

13. The terms of reference for the Complaint Investigation Panel were agreed at a Board meeting held on 11 November 1994 and included:

> `Purpose .... The Panel has been established to consider the report of the [IPR] .... concerning the care of .... [the complainants' daughter] in [the hospital] on 9 June 1992.
>
> `Procedures .... In its decisions, the Panel will take note of the letter from [the RHA chair] dated 12 October 1994 and the various letters of complaint or comment sent by [the complainants].
>
> `The Panel will consider the circumstances surrounding the death of [the complainants' daughter] and the procedures followed during the handling of the subsequent complaint leading up to the setting up of the [IPR].
>
> `....
>
> `The Panel will make recommendations:
>
> a. to improve the clinical handling of cases of this nature and to reduce the risk of recurrence
>
> b. to improve any weaknesses in the Trust's procedures for the handling of serious complaints and taking specific note of the Serious Incident Inquiry Policy now in force
>
> c. to deal with any disciplinary procedures or counselling felt necessary as a result of unsatisfactory clinical or personal performance or conduct.'

14. The Panel was to consist of two non-executive directors, two clinical directors and the chief executive. The director of human resources and the legal manager (acting as secretary to the Panel) were to be in attendance. The minutes of the Board meeting described the Panel as a sub-committee of the Board. At the beginning of the terms of reference a note said:

> `[The chief executive] shall not be present when the Panel is considering his correspondence and actions taken upon receipt of the complaint from [the complainants] and shall take no part in the compilation of that part of the Panel's Report which deals with the same.'

15. Panel meetings were minuted for 9, 15 and 21 November and 4 December. Those minutes and the Panel's report showed that the Trust staff interviewed included the chief executive, the consultant in charge of the accident and emergency department (where the complainants' daughter received some of her treatment) who was also the Trust's medical director (the medical director), and the legal manager. (Note: The legal manager had held various positions in the Trust including director of nursing from April to September 1994, and had been involved in some of the initial investigation of the complaint.) The complainants attended and spoke at the first meeting.

16. The Panel minute of 21 November 1994 included:

> `There [was] a series of questions, with discussion, to the chief executive .... There followed questioning of the [legal manager] about the role of the Legal Manager as it operates in normal circumstances .... [and] in the [complainants'] case .... [The director of human resources] addressed the Panel advising on disciplinary arrangements ....'

17. The minutes of a Board meeting held on 9 December 1994 noted that after a report on the Panel's progress:

> `[A non-executive director] asked the Board to note that he knew the complainant well and would therefore prefer not to be actively involved in the Board Meeting [on 19 December which was held specially to discuss the Panel's report] although he would attend to make sure it remained quorate.'

The non-executive director concerned did not attend the meeting on 19 December.

18. The minutes of the special Board meeting show that it was attended by the chairman of the Trust, the chairman of the Panel, a non-executive director who was not a member of the Panel (the second non-executive director), the director of finance, the director of strategy and business development, the chief executive and the medical director. The first clinical director and the corporate business manager were `in attendance'. The minutes showed that the Board accepted the Panel's recommendations and decided (among other things) that:

> `.... The Executive team should be invited to review the report, consider the implications arising and implement the recommendations of the report.
>
> `[The Panel should be] asked to meet again to audit the recommendations of the report and report back to the Board.'

The minutes do not mention anyone having withdrawn from the meeting at any time.

19. The Panel's report began with a half page `preliminary comment' (reproduced in full at Appendix A) recording comments made in evidence which were `highly critical' of the IPR. It proceeded to reply to recommendations made by the IPR, points made by the complainants, and by the RHA. It included general comments and a list of findings and recommendations. In Appendix B to this report, I set out details of the IPR's recommendations, the responses to each point in the Panel's report, and relevant additional information from evidence to my investigation.

20. A letter dated 20 December 1994 from the chairman of the Trust Board to the chair of the RHA enclosing a copy of the Panel report said:

> `The Panel .... reported to the Board .... on 19 December when its recommendations were unanimously accepted.
>
> `Having carefully considered the [IPR's] findings and recommendations we do not now recommend disciplinary action, with the junior doctors because they are no longer in our employ, with others either because it was never warranted or because too much time has passed. On this matter we broadly agree with the Independent Reviewers ....'

21. A letter dated 24 January 1995 from the chair of the RHA to the chairman of the Trust said:

> `.... I am pleased that the Trust has taken the matter so seriously ....
>
> `I am disappointed however that despite the very clear evidence of serious deficiencies in the care provided to [the complainants' daughter] there is to be no disciplinary action in relation to the staff involved. This is, of course, ultimately a matter for the Trust as the employer but I hope that due regard will be paid to how the absence of any reprimand appears when viewed from the outside.'

22. The Panel met on 11 April and 11 July 1995 and 13 June 1996 to review progress on implementing the recommendations. They obtained and considered detailed reports on progress in implementing the recommendations and audits of their effectiveness.

23. In a letter to the complainants' Member of Parliament in August 1995 the chief executive of the NHS Executive for England said that he viewed the case with great concern and that their daughter's treatment had been unacceptable. He continued:

> `It is clear that the Trust has dealt with the issues very thoroughly since receiving the report of the [IPR]. It has carried out a detailed and comprehensive examination of the issues raised by the review, drawn up a plan of action to implement the recommendations, and fully accounted for their actions and decisions to the RHA and to [the complainants]. It has also explained why it did not consider that it was appropriate to take disciplinary action against the individuals concerned.'

After further correspondence and a meeting with the complainants, the chief executive of the NHS Executive for England wrote to them on 3 May 1996 that he was pleased to hear of my investigation; if my report brought new relevant information to light that would be addressed immediately.

24. In a letter to my predecessor dated 8 May 1996 the Trust's chief executive said:

> `Turning now to the question of the appropriateness of our response to the IPR report, my first observation is that the Trust directors in accordance with the Trust's Serious Incident Inquiry Policy and Procedure. The Panel's terms of reference were carefully drafted and comprehensive. In its deliberations it gave careful consideration to the IPR report and to additional information submitted for its consideration by the complainants and by the Regional Health Authority.
>
> `The objectives of the Panel focused around determining how the Trust ought to respond to the recommendations of the IPR, with a particular desire to ensure that all the necessary lessons were learnt. The recommendations of the panel were action oriented in consequence, and wide ranging. Its advice on the question of disciplinary action was formed after careful and measured consideration had been given to the issue and to the requirements both of the Trust's disciplinary procedures and employment law more generally.'

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comments

Case No. E.447/95-96-Excessive delay in resolving a complaint

Background and complaint

1. The background provided by the complainant is that on 7 June 1992 she complained to the unit general manager of Pontefract General Infirmary (the hospital) about treatment she had received at the hospital. On 12 February 1993 a substantive reply was sent by Pontefract Health Authority (the first health authority), which managed the hospital at the time, but the complainant remained dissatisfied. On 21 April 1993 she asked for an independent professional review (IPR) of her treatment, but it was not until 27 January 1994 that she received confirmation that her case had been sent to the Yorkshire Regional Health Authority. She was then told in July by the clinical complaints adviser (the adviser) of Northern and Yorkshire Regional Health Authority (the RHA) that neither the Pontefract Hospitals NHS Trust (the Trust), which managed the hospital from 1 April 1993, nor the consultant concerned wished to proceed with the IPR. In October 1994 she heard that they were prepared to proceed, and the IPR was held on 24 May 1995.

2. The matters investigated were that:

a. there was undue delay in replying to the complainant's complaint and in forwarding her request for an IPR to the Yorkshire Regional Health Authority; and

b. there was further unreasonable delay and confusion before the IPR was held.

Investigation

3. The comments of the Trust, Wakefield Health Authority (the second health authority), and the RHA were obtained and relevant documents examined. One of the Commissioner's investigating staff took evidence from the complainant, the chief officer of Pontefract Community Health Council (the CHC officer) and staff of the health bodies concerned. I have not put into this report every detail investigated but I am satisfied that no matter of significance has been overlooked.

Organisational background

4. Pontefract General Infirmary was a directly managed unit of the first health authority until 1 April 1993, since when it has been run by the Trust, which was created on that date. The unit general manager of the hospital was appointed as chief executive of the Trust (the chief executive). On the same date the first health authority merged with another health authority to form the second health authority. The district general manager of the first health authority (the district general manager) became chief executive of the second health authority.

5. On 1 April 1994 Yorkshire Regional Health Authority merged with Northern Regional Health Authority to form the RHA. In May 1995 the regional medical officer (the RMO) for the Yorkshire region of the RHA left and his post was combined with that of his counterpart in the Northern region (the second RMO). On 1 April 1996 the RHA was abolished and replaced by the Northern and Yorkshire regional office of the NHS Executive.

Guidance on the clinical complaints procedure

6. Circular HC(88)37, issued in June 1988 by the Department of Health and Social Security (DHSS) gave guidance to health authorities on hospital complaints procedures. (New procedures which came into force on 1 April 1996 do not apply to this case.) Annex B of the circular set out the procedure to be followed for complaints relating to the exercise of clinical judgment by hospital medical and dental staff. The procedure was in three stages. The first related to attempts to resolve the complaint locally. If that failed the procedure moved to stage two. The circular provided that:

> `.... The next step, in this second stage, is for the Regional Medical officer (the RMO) to be at once informed; this should be done by the consultant, informing the district general manager that he had done so ....'

The RMO would decide whether to grant an IPR. If an IPR was granted the RMO arranged for all aspects of the case to be considered by two independent consultants in current practice in the appropriate specialty or specialties.

Complaints procedure

7. The second health authority were unable to provide the Commissioner with a copy of the complaints procedure in use at the first health authority in June 1992 when the complainant made her complaint. I have, however, seen a copy of the procedure that was in use from October 1992 to April 1993, which states:

> `.... where a formal complaint is made .... it should be dealt with promptly ....'

The Trust's complaints procedure, issued on 4 June 1993, stipulated that complaints should be handled speedily.

Key events and correspondence

8. Set out below the key events and correspondence:

7 June 1992-The complainant wrote to the hospital to complain about her clinical treatment.

8 June-The district general manager wrote to the complainant acknowledging receipt of another letter of complaint from her which had been passed to him by the Department of Health. On the same day the complainant's complaint was passed to the director of operations at the hospital (the surgical general manager) for action. (Note: the director of operations later became the general manager for anaesthetics and surgery at the hospital.)

22 June-The surgical general manager sent the consultant surgeon responsible for the complainant's treatment (the consultant) a copy of her letter of 7 June and asked for a written report as soon as possible.

21 August-The health authority's business manager (the business manager), who later became the business manager at the Trust, asked the surgical general manager for a reply. The surgical general manager sent reminder letters to the consultant on 7 September and 6 October.

12 September-The complainant's Member of Parliament (the MP) enquired about progress and on 15 September was told by the chairman of the first health authority that the investigation was at an advanced stage.

20 December-The consultant sent his report on the complaint to the surgical general manager. It was dated 29 October 1992.

28 January 1993-The surgical general manager sent a reply to the complaint to the CHC officer, who replied on 10 February saying that there were drafting errors in the letter, which he had corrected. The CHC officer asked that an amended version be returned to him as soon as possible. That was sent to him on 12 February.

14 April-A meeting was held involving the complainant, her husband, the MP, the CHC officer, the consultant and the surgical general manager to discuss the complaint.

21 April-The complainant wrote to the surgical general manager requesting that her case be referred for consideration for an IPR.

23 April-The surgical general manager wrote to the business manager asking for advice on the process involved in pursuing an IPR. The business manager replied on 10 May that:

> `.... The initial request must be directed to [the RMO] by [the consultant] ....'

3 June-The surgical general manager asked the consultant to refer the complaint to the RMO.

16 September-The CHC officer wrote to the business manager, referring to earlier reminder letters dated 27 May, 9 July, and 11 August. He said that:

> `.... This complaint goes back over twelve months and Pontefract General Infirmary has certainly not showered itself in glory over the speed with which it has been handled.
>
> `Since a meeting on 14 April 1993 .... we have been trying to establish the present position. At that meeting we were given to understand that the papers would be passed to the Yorkshire Regional Health Authority for an independent clinical review to be conducted but we do not appear to be able to obtain any confirmation of this or, indeed, the person to whom the papers have been sent.'

23 September-The business manager replied to the CHC officer saying that the surgical general manager had agreed to press

the consultant to refer the case to the RMO, as the RMO had said that the approach must come directly from the consultant. He said that the relevant paperwork would be sent immediately on the consultant's return from leave on 27 September.

10 January 1994-The surgical general manager referred the case to the RMO.

27 January-The adviser acknowledged the surgical general manager's letter and expressed concern about the delay in the complainant's case. He asked for a reply and a further complete set of medical notes and correspondence, as those sent had been illegible. (The business manager sent the notes and correspondence to the adviser on 8 July 1994.)

14 April-The adviser wrote to the consultant asking whether the complaint had been referred with his knowledge, and saying that as he had received no reply from the surgical general manager to his letter of 27 January he had contacted the chief executive to ask about progress.

An undated letter from the business manager to the adviser said:

> .... contrary to previous correspondence, the Consultant concerned .... does not now wish this complaint to proceed to [IPR].
>
> `The principal reason for this is that [the consultant] has subsequently seen [the patient] mobilising, without any apparent difficulty, whilst shopping and then suffering an immediate relapse when his presence was noticed.
>
> `He feels disinclined, therefore, to seek further clinical input into a matter which may not appear to warrant it.
>
> `I....would welcome your advice on the most appropriate method of proceeding.'

3 May-The chief executive, having received a reminder from the adviser, wrote to the surgical general manager asking for an explanation of his failure to reply to the adviser's letter of 27 January.

10 May-The surgical general manager replied that:

> `.... I referred [the patient's] complaint to the Regional Health Authority .... immediately following the meeting between [the patient], [the consultant] and myself. ....'

He said that, following the adviser's letter of 27 January, he had discussed the matter with the consultant, who was unwilling to co-operate with an IPR. He gave the consultant three or four weeks to change his mind, but he did not do so. The surgical general manager apologised for failing to tell the adviser of the consultant's decision.

22 June-The second RMO wrote to the adviser, copying his letter to the business manager, saying that he had examined the papers on the complainant's complaint and that the case seemed sufficiently serious to warrant an IPR. He did not consider that the undated letter from the business manager was a sufficient reason to prevent that. He asked the adviser to meet the complainant to find out which of her complaints remained unresolved.

1 July-The adviser wrote to the business manager:

> `As this is the first complaint that I have known to be turned down by both Consultant and a Trust, I sought the opinion of [the second RMO] as to how to proceed ....'

20 September-The adviser met the complainant to discuss her complaint.

21 September-The adviser wrote to the second RMO agreeing that the case merited an IPR, and suggesting that the second RMO or the regional director of the RHA should try to persuade the Trust to proceed.

7 October-The regional director wrote to the chief executive:

> `.... I have been contacted by [the adviser] who tells me that your Trust and [the patient's] former consultant .... are unwilling to refer her complaint for further investigation ....
>
> `I think it would be wise to reconsider your decision ....'

12 October-The adviser wrote to the chief executive, following a telephone discussion the day before, saying:

> `.... I must apologise for misinterpreting [the business manager's] undated letter. I wrongly assumed that in stating [the consultant's] reluctance to proceed with the Hospital Complaints procedure, that this had the Trust's agreement,

as it was not stated to the contrary ....'

18 October-The chief executive told the regional director that, while the consultant had been reluctant to refer the complainant's case for an IPR, that was not the position of the Trust. He said that the consultant had now agreed to co-operate with setting up the IPR.

8 November-The second RMO asked the Joint Consultants Committee (the JCC, whose actions are outside the Commissioner's jurisdiction) to appoint clinical assessors for the IPR. Assessors were appointed in **February 1995**, and the IPR was held on **24 May**, having been delayed because the son of one of the assessors had died.

The complainant's evidence

9. The complainant told the investigator that when the surgical general manager's reply to her complaint finally arrived in February 1993 it was inaccurate. She met the consultant the following April but did not find the meeting helpful. After she asked for an IPR there was more delay which she thought might have been because the consultant had not believed the seriousness of her condition. She recalled that on one occasion she had seen the consultant when she was out shopping. She had not needed her wheelchair then because she had recently had a pain killing injection and was using a shopping trolley for support. The incident was not typical of her restricted mobility. She did not consider that a decision as important as whether to refer her case for IPR should have been based entirely on what the consultant thought about seeing her out shopping. Once the case had been referred the adviser had kept her fully informed of progress and her meeting with him had been very helpful. No-one at the hospital had kept her or the CHC informed.

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comments

Case No. E.920/95-96-Standards of nursing care, record keeping and communication

Background and complaint

1. The background provided by the complainant to the complaint was that on 27 January 1995 her father suffered a stroke and was admitted to Princess Alexandra Hospital. He was unable to swallow, and a note on a board by his bed read `nil by mouth'. Despite that nursing staff continued to offer him food and drink. The complainant's mother noted that he had a very sore mouth, but when her mother asked a nurse for mouthwash tablets she was told that none were available. When members of the family asked nursing staff about his care, the staff were evasive and implied that the family were not entitled to ask questions. The complainant's father developed an eye condition, but no action was taken.

2. On 28 February the complainant's mother arrived in the ward to find her husband covered in excrement. A nurse said that she had not wanted to waken him because he had been very distressed the previous night by the behaviour of another patient. The family later found that there was no record of that incident in his nursing or medical notes. In the evening of 28 February the police informed the complainant and her mother that the complainant's father had died. The family were not aware that he had fallen from a balcony to his death until they were contacted by the Coroner the following day.

3. In an exchange of correspondence, and two meetings, the complainant and her family established that the medical and nursing records failed to record aspects of her father's condition and care. They remained dissatisfied with the explanations that had been provided, and the remedial action taken. Until 31 March 1995 the hospital was administered by North Essex Health Authority (the Health Authority). Since then it has been managed by Princess Alexandra Hospital NHS Trust (the Trust).

4. The matters investigated were that:

a. the standard of nursing care was inadequate and in particular there was a failure to meet the complainant's father's oral and personal hygiene needs;

b. there was a failure to maintain accurate clinical and nursing records; and

c. there was a failure in communication between hospital staff and the family, both before and after the complainant's father's death.

Investigation

5. The comments of the Trust were obtained and relevant papers were examined. The Commissioner's investigators interviewed the complainant and her mother, the chief officer of West Essex Community Health Council (the CHC officer) and the current and former Trust staff involved. The complainant was informed that her complaint might in part concern actions taken solely in the exercise of clinical judgment, which at the time were statutorily outside the Commissioner's jurisdiction.

National guidance

6. The 1992 Patient's Charter set out rights and standards that NHS patients could expect to be achieved. From 1 April 1992 nine National Charter Standards were introduced. They included respect for a patient's dignity and that arrangements should be in place to inform a patient's relatives about the progress of treatment, subject to the patient's wishes.

Ward Action plan

7. An action plan for the ward was devised in June 1995 after the complaint was received. It identified the areas for action as: standards of nursing care, staff morale and workload, communication and documentation. A series of actions to be taken were listed for each area. Meetings to review progress were held on 6 July, 20 October 1995 and

23 February 1996. A final report was produced in March 1996.

Complaint *(a) standard of nursing care was inadequate*

Complainant's evidence

8. When interviewed, the complainant told the Commissioner's investigators that her father had lost his swallowing reflex and risked a chest infection if food got into his lungs. There was a board above his bed which read `nil by mouth'. She and other family members had seen nurses offering him food and had had to point out that he should not be given any. Her father's tongue became swollen and he had sores in his mouth but the nurses did not give him mouth care-although mouth swabs seemed to be available. Her mother had been obliged to buy mouthwash and swab her husband's mouth herself. On the day that her father died her mother arrived at 3.00 pm to visit him and found him covered in dried excrement. The nurses said that he had been sedated as he had had a disturbed night, and they had left him to sleep off the sedative. There had been other aspects of nursing care which had also been inadequate.

Evidence of the Trust and the CHC officer

9. In his response to the Commissioner at the start of this investigation the chief executive of the Trust (the chief executive), who was the chief executive designate at the time of the issues complained about, wrote:

> `After investigation of a number of detailed aspects of [the complainant's father's] care, the Trust's Head of Nursing was asked to review the overall standard of his care, including staffing levels on the ward in question whilst [the complainant's father] was a patient. She concluded that:-
>
> `Staffing levels were sufficient, but a high level of sickness had led to increased use of temporary staff, and a consequent loss of continuity in [the complainant's father's] care.
>
> `[the] overall level of care was adequate, but a number of specific elements were unsatisfactory. These were:-
>
> `Mouth care Although efforts had been made to address [the complainant's father's] mouth care needs, these were insufficiently thorough, and [his] mouth condition had deteriorated.
>
> `Personal hygiene It was accepted that the incident where [the complainant's father] was left asleep although he had defecated was not appropriate, even though the staff involved had felt that it was better for [him] to remain asleep, given his general problems with insomnia.
>
> `Offering of food and drinks It is accepted that staff had not taken sufficient care in ascertaining [the complainant's father's] particular needs, in that they offered him food and drink when he was `nil by mouth'....
>
> and,
>
> `Remedial action Subsequent to [the] complaint, the Trust's Head of Nursing was asked to work with the staff on [the ward] to address these unsatisfactory elements. A detailed action plan was drawn up, and its achievement was then monitored. All elements of that action plan have now been achieved.'

10. I have seen that on 23 August 1995 the chief executive wrote to the complainant expressing his regret that her father had been offered food. He added that that was `inexcusable'. He expressed regret that her father's mouth condition had deteriorated, and noted that although the nurses should have given regular mouth care, there was only one entry in his nursing records showing that mouth care had been given. He apologised that her mother was told that no mouth care tablets were available: these should have been available in the ward and could be obtained from another ward if necessary. He further apologised to the complainant and her family for the distress caused when her mother found her father covered in excrement, saying that it was `inexcusable for [the complainant's father] to have been left lying in his own excrement'.

11. At interview the chief executive added that the number of permanent nursing staff in the ward had been increased, although staff turnover remained a problem. The staff sickness levels had been reduced. Arrangements had been made to increase the experience of nurses, and the system for obtaining bank staff to cover absences had been revised and improved. Turning to the action plan, the chief executive said that in March 1996, when the final report on the action plan was produced, he had been satisfied that there was a steady improvement and that the necessary

action had been completed. However, more recently he had received a new complaint which gave him cause for concern. As a result of that complaint an independent review of the ward was planned.

12. The Commissioner's investigators interviewed a staff nurse who worked in the ward at the time the complainant's father was a patient (the staff nurse). Since July 1995 she had been the ward sister. She said that in February 1995 the ward had high levels of staff sickness. She accepted that there were failures in the complainant's father's nursing care. She thought that was because inexperienced staff who were covering for staff shortages, sickness and absence did not know the correct procedures, and such staff changes made continuity of care difficult. The ward now carried a better stock of mouthwash tablets. When there was a need for mouth care, that was written in patients' care plans. Attention to patient hygiene had also improved following improvements in patient care planning. Although problems with the number of skilled nurses had not been completely resolved, the position had improved, and greater attention was being paid to staff training.

13. The ward manager (who has now left the Trust) was away during the complainant's father's stay as an inpatient, returning the day before he died. He told the Commissioner's investigators that on his return he was told by ward staff that it had been `horrendous' while he was away because of high levels of staff sickness and the ward being busy. He could not understand why mouthwash tablets had not been available because they could easily be obtained from the pharmacy or borrowed from another ward. He said that it was unusual to leave patients in excrement. If a patient was sleepy the normal practice was to clean him or her with as little disturbance as possible. He had spoken to the ward nurses about the complainant's father's care, and was told that he had been a non-compliant patient who could become aggressive and refuse care. The pressure of the needs of other patients had also caused difficulties. The ward manager said that he had been involved in implementing the action plan and monitoring its effectiveness. By the time of the last monitoring meeting in February 1996 he was satisfied that there had been improvements in the areas identified in the action plan.

14. At interview the directorate manager for medicine, who had been in post since July 1995 and was the ward manager's line manager, the director of operations and chief nurse (the director), and the CHC officer all expressed doubts about the effectiveness of the action plan in the light of the new complaint (see paragraph 11). The director added that with the benefit of hindsight there should have been a closer auditing system in place. The head of nursing practice and quality (the head of nursing), who had been closely involved with the development and monitoring of the action plan, now shared their concerns, and thought that fundamental issues of management and leadership were in question.

15. The consultant physician responsible for the complainant's father's care (the consultant) confirmed that the ward was very busy in February 1995. He remembered one occasion when he had to mention to nursing staff that the complainant's father's oral and eye care needed attention. He thought that the standard of nursing had since improved.

Findings *(a)*

16. The standard of nursing care received by the complainant's father was inadequate, and that has been accepted by the chief executive. I accept that the ward was busy at the time, and there was a shortage of permanent staff on duty. However, neither those facts nor the complainant's father's condition excused the poor standard of care that he experienced. I commend the development and implementation of an action plan as a means of addressing the inadequacies identified. I am, however, concerned to note that senior staff are now in some doubt about the effectiveness of the action plan. **I recommend** that the planned independent review of nursing care is carried out as soon as possible and then immediate action is taken to implement its recommendations. I uphold the complaint.

Complaint *(b) Record keeping*

Guidance

17. In April 1990 the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (the UKCC) published a booklet: `Standards for Records and Record Keeping'. It said that the nursing record:

> `.... will demonstrate the chronology of events and significant consultations, assessments, observations....'

That guidance was reflected in Essex and Hertfordshire Health Services' own nursing management policy on the use of nursing records.

18. In October 1995, after the events complained about, the General Medical Council (the GMC) issued guidance on

the `Duties of a doctor'. That included guidance on good medical practice which said:

> `In providing care you must .... keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatment prescribed ....'

19. I have seen a copy of the `Incident Reporting Procedure' in force at the time of the complainant's father's stay in the ward (and which is still in force). It required all accidents, however small, to be reported on an incident form.

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comments

Case No. E.1009/95-96-Delays in outpatient clinic and complaint handling

Background and complaint

1. The background provided to the complaint by the complainant was that his wife regularly attended a renal outpatient clinic at a hospital run by Salisbury Health Care NHS Trust (the first Trust). Because of her poor health he had to take time off work to accompany her.

2. On 29 August 1995 the complainant wrote to the chairman of the first Trust complaining that on 21 August his wife had waited over an hour to see a doctor. The chairman replied saying that there was an imbalance between the frequency of the clinics and the large number of patients to be seen but that urgent steps were being taken to improve the situation. On the woman's next visit in November the wait was two hours. The complainant complained again to the first Trust and was dissatisfied with their reply.

3. The complaint investigated was that the delays before the complainant's wife was seen by a doctor in the outpatient clinic were unacceptable and the first Trust's response to the complaint about those delays was unsatisfactory.

Investigation

4. The Commissioner obtained the comments of the first Trust and relevant documents were examined. The Commissioner's investigator took evidence from the complainant and from relevant staff at the first Trust. Evidence was also obtained from Portsmouth Hospitals NHS Trust (the second Trust) who employ the consultant providing treatment at the clinic, and Wiltshire Health Authority (the Authority) which succeeded the former Wiltshire and Bath Health Authority in April 1996 as purchasers of the service, although their actions are not the subject of the complaint. I have not put into this report every detail investigated but I am satisfied that no matter of significance has been overlooked.

National and local policy

5. The Patient's Charter, issued in January 1995, set a national standard for waiting times in outpatient clinics which was that: `When you go to an outpatient clinic you can expect to be given a specific appointment time and be seen within 30 minutes of that time.' It defined expectations as: `standards of service which the NHS is aiming to achieve. Exceptional circumstances may sometimes prevent these standards being met.' Health Service Guidelines HSG(92)4, issued in January 1992, on implementing the Patient's Charter said that the similar standard in the first version of the Charter was intended to put an end to block booking systems and long waits for patients attending outpatient clinics.

6. A guide for outpatients published by the first Trust said, `We hope that you will be seen by the doctor at your appointment time or within 30 minutes of that time. Occasionally there are delays which may result in you waiting longer. If this should happen, the clinic receptionist will keep you informed.'

7. The Authority's contracts with Trusts for 1995-96 specified that:

> `[Trusts were] required to continue to make available, in line with current provision, all necessary facilities and staff for the support of outpatients clinics held by consultants from other [Trusts]. The [Trust was] expected to support such other [Trusts] in their endeavours to achieve the standards set out in the Patient's Charter.'

The complainant's evidence

8. The complainant said that he expected the waiting time to be less than one hour and as near to the Patient's Charter standard of 30 minutes as possible. On 21 August, when he and his wife attended the clinic for the first time, his wife's appointment was for 10.20 am, but she was not seen until 11.40 am. Her appointment on 20 November was for 11.30 am but she was not seen until two hours later. He had complained to the first Trust after the first appointment to draw their attention to the unacceptable situation and to find out what they would do about it. He had accepted the chairman's letter of 4 September, which said that urgent steps were being taken to improve the situation, and had expected some improvement by the second appointment. The delay then was even longer. It became clear that nothing had been done. He complained again. In January 1996 they had virtually no wait at the clinic and were told by the first Trust's chairman that an extra clinic would begin in

February, which they hoped meant that shorter waiting times would continue. In April 1996 they waited an hour and a quarter. The delays made it difficult for him to make suitable arrangements for time off work. He considered that the first Trust could have taken steps to reduce the waiting time at the clinic and complained about being brushed off with excuses.

Documentary evidence

9. The records showed that 30 patients were booked to attend the clinic between 9.00am and 12.10pm on 21 August 1995; on 20 November 42 patients were booked between the same times. Most of the appointments were at five or ten minute intervals; 16 were at intervals of less than five minutes. No information was available about how long patients had waited. At the clinic on 15 February 1996, 25% of patients saw the doctor within 30 minutes, 25% within one hour and 50% waited for over an hour. The first additional monthly clinic session was held on 3 June 1996. Records for that showed that 60% of patients saw the consultant within 30 minutes, 30% within one hour and that 10% waited for more than an hour. At a clinic held on 19 August the figures were 52%, 26% and 22% respectively.

10. The reply from the chairman of the first Trust on 27 November 1995 to the complainant's second letter of complaint included:

> `.... our options to improve on waiting times are very limited. It seems that the choice is to be seen, but almost certainly with a long wait, or not to be seen at all. I know this is unsatisfactory and can only assure you that we are trying very hard to find a way to create the extra resource needed ....'

Evidence of the first Trust

11. In his comments to the Commissioner, dated 12 March 1996, the chief executive wrote:

> `.... there is no dispute about the unacceptable nature of the delays that some patients in the renal clinic experience .... We are very sorry about this .... and have apologised to [the complainant and his wife]. .... we have made efforts to resolve the problem and continue with those efforts because a solution has not yet been achieved.
>
> `What is required is an additional monthly clinic but .... setting up that additional clinic is proving difficult ....
>
> `.... A delay occurred in the autumn of 1995 when liaison between [the second Trust] and Salisbury was disrupted when [a manager at the second Trust] left .... and we have to apologise for this as we did not pursue progress as persistently as we should have done.'

12. The chief executive said that the funding arrangements for the clinic were complex and had been difficult to unravel. His Trust provided accommodation and support staff and the second Trust provided the services of the consultant. There was a difference of opinion about which Trust was responsible for the waiting times. Although the consultant from the second Trust ran the clinic and instructed the booking staff to make the appointments, the chief executive considered that the delays at the clinic were bad for his Trust's reputation and had tried to take action to improve matters. The schedule of appointment times at the clinic was a clinical matter but there should have been a dialogue between the consultant and the booking staff.

13. In August 1995 he discussed the complaint with the chairman and the general manager responsible for specialty services (the general manager). He had not previously been aware of problems with the clinic. There were difficulties over the funding for extra sessions and matching the consultant's availability to that of suitable accommodation. He was told that action was being taken. In November, when he learned that no progress had been made, he asked the general manager to pursue the matter. The chief executive said that action should have been taken sooner but they had been dealing with a number of very serious issues at the time. After an exchange of correspondence with the second Trust it was agreed that an additional clinic would start in February 1996. However, there were further problems with funding and the chief executive offered to fund the new clinic temporarily from his reserve budget. When the second Trust decided to bid for additional funding from the Authority he decided to await the outcome of those negotiations. The additional clinic sessions began in June 1996.

14. The general manager said that the second Trust `held the purse strings' as they employed the consultant who managed the appointments. Negotiations for the additional clinic were protracted. He thought that he had first become involved in September 1995. The business manager advised him that agreement was near on a number of occasions, and he passed that to the chief executive. He said the problem took too long to resolve but the involvement of so many people in the negotiations had added to the delay.

15. The business manager said that he joined the first Trust in October 1995. In November the general manager asked him to deal with the problem of the clinic. He assumed then that it was his Trust's responsibility. When interviewed during the investigation he was not aware that the second Trust had prepared a bid to the Authority for the funding for an additional

clinic in August 1995 and sent it to the first Trust for comment (see paragraph 24). In December 1995 he had tried to find a short term solution by arranging an extra clinic starting in February 1996, but was told by the second Trust that the first Trust would have to provide the additional funding until a formal arrangement could be agreed from 1 April. That and the difficulty over the consultant's availability prevented a speedy resolution of the complaint. He discussed with the booking clerks the possibility of giving patients more realistic appointment times. They told him that it was not as simple as that; the consultant often added seriously ill patients to the list after appointment cards had been sent out. He also discussed with the contracts development manager (the contracts manager) at the second Trust the possibility of formally extending the existing session into the afternoon but was told that the consultant would not agree. It was only in January 1996 that he knew about the contractual problems: had he known about them from the start he would have acted differently.

16. The chairman said that the uncertainty about the ownership of the clinic at the time and the associated complexities of funding extra sessions had caused difficulties in resolving the problem. He now understood that the clinic was provided by the second Trust. Despite that his Trust considered that they were responsible for the waiting times as local patients were involved. During the summer of 1995 he spoke to the consultant from the second Trust to find out what was preventing the new clinic starting. His own Trust tried to solve the problem but their efforts seemed to make little progress. Unnecessary bureaucracy had prevented a solution earlier. The first Trust had not pursued the matter as quickly as it should have done.

17. In his reply to the complainant of 11 January 1996 the chairman said that an additional clinic would start in February, as that was the information he had been given. In the event it did not happen because of a last minute problem with funding. He considered that the complaint should have been discussed formally with the second Trust.

18. The manager responsible for organisational audit (the audit manager) said that the first Trust now reported waiting times at the clinic to the Authority. Information about the renal clinic's performance formed part of the total for the medical unit. Monitoring of performance against Patient's Charter standards was done monthly, by random sampling. When the complainant complained the renal clinic was held monthly and often missed the sample. The only way that specific information about the waiting times at that clinic could be obtained was by requesting a special report. The Trust's methods for monitoring Patient's Charter standards were audited, but that had not identified the anomaly with the renal clinic.

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comments

Case No. E.1072/95-96-Communication with relatives after a patient's death

Background and complaint

1. The background provided by the complainant to the complaint was that on the evening of 24 September 1995 his mother was taken by ambulance to the Accident and Emergency (A and E) department at St George's Hospital, London (the hospital), which is managed by the Trust. His mother was suffering from chest pain. She was admitted to a ward at 2.00am on 25 September and died shortly afterwards. Her next of kin were not contacted and it was only three weeks later, when a cheque which she had sent to her grandson was returned marked `drawer deceased', that her son learned of her death. The complainant met the director of nursing at the hospital on 18 October and received a written account of events dated 2 November. He found that response unsatisfactory, and on 9 November complained to the Trust in writing through his solicitor. The director of nursing replied on 24 November but the complainant remained dissatisfied.

2. The complaint investigated was that the Trust made inadequate efforts to contact the complainant's mother's next of kin resulting in unnecessary distress to her son.

Investigation

3. The Commissioner obtained the comments of the Trust and relevant documents were examined. One of the Commissioner's staff took evidence from the complainant and a friend of his, and from Trust staff involved. The Commissioner also obtained evidence from the Metropolitan Police Service, although their actions are not within his jurisdiction. I have not put into this report every detail investigated but I am satisfied that no matter of significance has been overlooked.

National and local policy

4. In 1992 the Department of Health (DoH) issued guidance, HSG(92)8, on dealing with patients who die in hospital and with their relatives. It said that hospitals should provide written instructions for staff to include advice on:

> `-keeping accurate records of the address of and means of contacting relatives or friends of the patient;
>
> -ensuring as far as possible that relatives .... know of the clinical progress and possibility of death;
>
> ....
>
> -contacting the police when a patient's identity or next of kin is unknown;
>
> -arrangements for informing, as a matter of urgency, relatives and the general practitioner [(GP)] of the death ....'

The guidance also referred to the duty of local councils (usually local social services departments) to safeguard the property of persons admitted to hospital, if no other arrangements had been made.

5. The hospital's policy for the major injury area of A and E, issued in January 1995, said:

> `It is the .... nurse's responsibility to meet and prioritise all patients [who come] by ambulance. A brief triage [assessment] note will be written .... by the .... nurse. The top copy of the casualty card will be brought from reception when details have been entered on the computer.
>
> ....
>
> `.... Care must be taken to [obtain] full and accurate documentation including any missing information from the front sheet e.g. next of kin ....'

6. The Trust's nursing documentation standard refers to the need for nurses to complete records fully. The associated audit documentation specifically requires a check on whether details of a patient's next of kin have been entered.

7. The Trust's guidance about patients dying in hospital, issued in October 1991 by the Health Authority which then managed the hospital, said that when a patient's next of kin was unknown `if all other avenues fail .... the nursing staff may .... approach the local police who may be able to help'. The policy for arranging a private funeral for patients with no known next of kin said that: every reasonable effort should be made to contact the next of kin, using any documented details available; where the deceased lived in council property, social services or the council could be asked to enter the property to gain information; and the patient affairs officer could contact the deceased's bank or building society.

8. The complainant said that when he contacted his mother's bank they told him that they had been informed by the hospital that his mother had died. The complainant's friend said that she telephoned the hospital on his behalf and spoke to a man who promised to make enquiries and return her call. In the interim she telephoned the hospital again. She found out that the complainant's mother had died the day after being admitted and that the hospital had no record of her next of kin. When the man she had first spoken to telephoned back, he confirmed the complainant's mother's death and arranged a meeting with the director of nursing for the next day. The director of nursing said that when the complainant's mother arrived in A and E her first name was registered as Helen (rather than her correct name of Ellen) and that the details of her next of kin were not recorded. After her death the hospital had tried to trace her family without success. The director of nursing also told them that the hospital had now found a second set of notes-in the name of Ellen-which included next of kin details.

9. The complainant said that his mother preferred to use the name Helen and that that could have contributed to the confusion about the records. However, he believed that details of her next of kin should have been obtained in the A and E department and that the hospital could have done more to trace her relatives, especially by tracking down all her notes before he made contact via the police. He was concerned about what would have happened, including possibly his mother's funeral being arranged, if the bank had not returned the cheque. The complainant's friend said someone must have had the authority to enter his mother's property using the keys which were in her possession. They would then have found his mother's notebook, which contained her son's name and address, next to the telephone.

Evidence of the Trust

10. At the beginning of the investigation the chief executive of the Trust sent written comments to the Commissioner which included:

> `[The complainant's mother] arrived in the [A and E] Department on 24th September 1995 at 22.23 hours .... She was able to give the doctor a brief medical history at that time.
>
> `Unfortunately, [her] condition suddenly deteriorated and she was transferred to the Resuscitation Area for emergency care at 23.15 hours. Once stable she was .... transferred to Gray Ward at 02.00 hours where she sadly died shortly after arrival.
>
> `[Her] first name was given as Helen which was then entered into the A and E computer system by the receptionist .... and [an existing set of] notes [was] identified for her. The system did not identify a second set of notes under the name of Ellen. Regrettably, the next of kin was not recorded by the A and E staff at the time .... and no next of kin were previously documented in the case notes for Helen.
>
> ....
>
> `.... it is regrettable that further enquiries regarding the next of kin were not made whilst the complainant's mother was in the [A and E] Department. When a seriously ill patient is admitted to A and E life saving or emergency care is given urgently. The next of kin are contacted as soon as possible. Where no next of kin is given or where the patient is too ill the police are normally contacted. However, since [the complainant's mother] did require urgent care there was no time to contact the police immediately.
>
> `When [she] was transferred to Gray Ward the staff were aware that the next of kin had not been identified .... [she] died shortly after her arrival on the ward. [A staff nurse] telephoned [the local] Police Station at 8 am on 25th September and was informed that the matter should be dealt with by the Patient Affairs Department .... [The house officer] also telephoned [her] GP to try to trace the next of kin ....
>
> ....
>
> `.... The Patient Affairs staff followed normal procedure, but were unable to trace or contact the next of kin. Arrangements for the funeral were not made for a period of one month in case any relatives came forward.'

11. In a letter to the complainant's solicitors dated 24 November the Trust said:

> `The Patient Affairs staff do not personally go to the property of the deceased as they have no authority to do so. The Police are always contacted and every effort is made by the Patient Affairs staff to trace the next of kin ....'

12. Before her admission on 24 September, the complainant's mother had two separate sets of hospital notes. Those with her first name as Helen, dating from 1988, did not include details of her next of kin. Those with her first name as Ellen had entries for several years up to July 1995 and included, under next of kin, the complainant's name and address at the time of his mother's death.

13. A charge nurse who assessed the complainant's mother in the A and E department said that, after assessment by a nurse, patients who arrived by ambulance were taken to a cubicle in the major injuries area by the ambulance crew, who then went to the reception area to register them. A nurse completed an assessment form, which formed the second page of the casualty record, and left it in the cubicle. If the patient was not well enough to talk, information was provided by the ambulance staff. The charge nurse said that he did not usually ask patients about their next of kin; that was the responsibility of the reception staff. If information was missing, reception staff could ask a nurse to get it. He said that there was no written policy about obtaining details of next of kin. He had ticked a box on the assessment form for the complainant's mother to show that relatives or friends were aware that the patient was in hospital. He said that would have been based on information from ambulance staff. He did not remember the complainant's mother.

14. The receptionist who registered the complainant's mother said the information provided by the ambulance crew was checked on the computerised patient administration system. She entered the patient's surname, initial and age. If the patient had been to the hospital before, his or her hospital number was identified; if not, a new number was created. The details were printed and formed the front page of the casualty record. She did not usually check the system for similar sounding names if the information given by the ambulance staff matched an existing record, as was the case here. Reception staff tried to get as much information as possible but if information was missing they sometimes asked the patient, or more often, left the front sheet at the nurses' station for the nurses to get it. There was no clear policy about who was responsible for obtaining details of next of kin. She could not remember the complainant's mother or the events of that evening. Two other receptionists gave similar evidence.

15. The senior house officer, who examined the complainant's mother in the A and E department at about 10.45pm, said that she was fairly lucid but, because she was in pain, had to pause before she could answer questions. Her condition deteriorated and she was moved to the resuscitation area. The senior house officer knew from the replies to her questions that the complainant's mother lived alone and had friends nearby. The senior house officer was aware that they did not have a note of the next of kin. She considered that it was the responsibility of the receptionist or the named nurse to obtain that information. Her main concern had been to treat the woman.

16. The senior staff nurse who cared for the complainant's mother in the resuscitation area said that it was often left to nurses to obtain missing information. She usually asked patients for missing information about next of kin, especially if they were very ill, but sometimes they were not able to answer. Since this incident the importance of recording such information had been discussed at staff meetings. She knew from the records that when the woman was in the resuscitation area, between 11.15 pm-12.05 am, the woman was quite ill and had to be given a strong painkiller before she was returned to the main casualty area. She felt sure she would have asked for details but perhaps the complainant's mother was unable to tell her. The senior staff nurse could not remember her.

17. A staff nurse who was responsible for the woman's care on her return to the main casualty area at 1.00 am said that she would have been told then that details of next of kin were missing. If the complainant's mother had been well enough the staff nurse would have asked her about her family; she knew that was particularly important in the case of elderly patients with chest pains who came to A and E alone. She could not remember her. She considered that the woman should have been asked about her next of kin when she first arrived in the A and E department, but it was a busy department and the priority was to treat the patient.

18. Another staff nurse who attended to the complainant's mother in the ward said that she remembered her collapsing and dying very soon after her arrival. There had been no time for a handover (the A and E nurse was still there), so she had not known then that information about next of kin was missing. The usual procedure, when a patient whose next of kin was unknown died, was to check the patient's belongings. She went through the complainant's mother's property but did not find anything helpful. At 8.30 that morning she telephoned the local police and asked if they could speak to a neighbour or go to the patient's home to trace her relatives. The police told her that that was not their responsibility and referred her to the hospital's patient affairs office. She did not think she could have done any more.

19. A house officer who was on call the night the complainant's mother died said that he telephoned her GP and asked if he

knew her next of kin. He would have given the GP one version of the patient's first name and surname. The GP knew the patient. He did not have any details of next of kin but suggested that the house officer contacted hospitals in the Southampton area, as he thought that she had been treated there. The house officer rang two hospitals there but obtained no further information.

20. The patient affairs manager said that the usual practice when patients died was to look through their notes for details of next of kin. She checked records with the name Helen but there was no such information. She also examined the woman's belongings for names of relatives or friends but found none - only details of her bank from her cheque book. She had the woman's house keys. She telephoned the local police and asked if they would visit the woman's home or talk to a neighbour, but they said that that was not their function. She was surprised as they had helped in the past. She telephoned the woman's bank but they had no information. She tried the local council but was told that the complainant's mother was not a council tenant and that they could not do anything to help. She then put the case to one side as her one colleague in the department went on leave and she had other cases to deal with - there could be 17 or 18 deaths over a weekend. She hoped that someone might come forward within a short time. If that had not happened within a month, she would have registered the complainant's mother's death and arranged her funeral. She could not think of any other action she could have taken. When her colleague returned from leave the patient affairs manager went on leave and by the time she returned the complainant's mother's family had contacted the hospital. She said that she did not make a note of the action she had taken, but thought (she has been on sick leave) that there was now a system to make sure that all such action was recorded.

21. The director of nursing for surgical and clinical support services, with responsibility for the patient affairs department, (the director of nursing) said that the missing information should have been obtained in the A and E department, but that the complainant's mother might not have been well enough to be asked while she was in the resuscitation area. She was very concerned that the woman's next of kin had not been recorded and had asked the senior nurse in the department to review the procedures. She also discussed the matter at the sisters' meeting, and said that disciplinary action would be taken if details of next of kin were not recorded in future. It was usual for nurses to contact the police to trace next of kin. While she was investigating the complainant's concerns, she telephoned the local police and was surprised to learn that they no longer assisted in tracing relatives. They had been very helpful previously. She understood that the Trust intended to ask the police for a statement of their new policy. She did not believe that the patient affairs staff could have done any more. One member of staff was on leave at the time and there could be as many as 50 deaths a week. Previously there was no record of the actions taken by patient affairs staff but a new record system had now been implemented. She did not know of any previous similar problems.

22. In a letter to this office dated 24 October 1996 the director of nursing said that further measures had been taken in the A and E department to make sure that all staff were aware of their responsibilities for recording information. The issue had been discussed at staff meetings. It had been agreed that receptionists would obtain details (including information about next of kin) but if that was not possible the named nurse would take over that responsibility. The records would be checked by nurses after the initial assessment and any gaps completed. A written policy was being drafted about those arrangements.

23. In a letter to the Commissioner's office dated 31 July 1996 an acting superintendent of the Metropolitan Police Service said:

> `The Metropolitan Police does not have a policy .... for providing assistance in [tracing next of kin] .... there are ever increasing demands on our resources and officers .... often have to prioritise such requests .... I would expect assistance to be offered in such cases with the caveat that there may be a delay .... because of other commitments.'

Findings

24. The complainant was understandably very concerned not to have found out about his mother's death for three weeks, and then only because a cheque was returned by her bank. It seems possible that, if that had not happened, in a further week the hospital would have arranged his mother's funeral even though her family had not been contacted and without anyone having visited her flat or having spoken to her neighbours. How did that situation arise? First, no one obtained any details of the woman's next of kin when she was admitted to hospital. I criticise the Trust for that failure. The complainant's mother was seriously ill (which made it more important to know about her next of kin), but was able to communicate with staff with some difficulty. Although it was commonly understood that reception staff were responsible for obtaining such information, it was often left to nurses to obtain missing details. There was no clear and understood policy about who was ultimately responsible. While I accept that there will be times when patients are unable to provide information about their next of kin, it is essential that strenuous efforts are made by staff to make sure that important details are recorded, especially when the patient is seriously ill and unaccompanied. **I recommend** that the Trust complete development of their written policy on the arrangements for recording such information, to include clear guidance on where responsibility for obtaining the information

lies.

25. Second, the complainant's mother had two separate sets of hospital notes - one in the name of Ellen which included details of her next of kin, and one in the name of Helen which did not. She had given the name Helen and therefore only that set of notes was found. That is understandable and I do not criticise the staff for failing to link the two sets of records. **I recommend** that the Trust examine the possibility of making further efforts to avoid the creation of duplicate records; for example, by checking for duplicate addresses.

26. Third, the efforts made to trace the woman's relatives after her death were inadequate. Staff telephoned her bank and checked with the council whether she was one of their tenants but they provided no help in tracing her family. In accordance with national and local guidance the staff also contacted the local police. The apparent unwillingness of the local police to make enquiries created difficulties for the hospital. In his letter to the Commissioner's office the acting superintendent said that he would have expected assistance to have been offered although possibly not as a priority. The matter should not simply have been left after those fruitless enquiries. The Trust should have contacted the police more formally at a senior level about the apparent change in policy. Other actions open to them, such as contacting the woman's neighbours, entering her home using her keys, or seeking the involvement of the council's social services department to safeguard her property (paragraph 4) should have been considered at a senior level in the Trust. **I recommend** that urgent steps are taken by the Trust to agree new procedures with the local police and that written advice is given to staff on action to take if the police are unable to help. I uphold the complaint.

Conclusion

27. I have set out my findings in paragraphs 24-26. St George's Healthcare NHS Trust have agreed to implement my recommendations in paragraphs 24, 25 and 26 and have asked me to convey to the complainant through my report-as I do-their apologies for the shortcomings found.

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comments

Case No. E.1129/95-96-Complaint handling by a Regional Health Authority

Background and complaint

1. The account of the complaint provided by the complainant was that in September 1994 she sought the help of the chief officer of a Community Health Council (CHC) to pursue a complaint about the decision of the RHA's director of public health not to grant an independent professional review (IPR) of the clinical care of her late sister. The complainant believed that failings in her sister's care had ultimately led to her death. She met the chief officer of the CHC (the CHC chief officer) in December 1994 but no further action followed.

2. In March 1995 the complainant contacted the RHA about the delay by the CHC and on 5 September she wrote to the regional general manager (the general manager) of the RHA complaining about both the CHC's and the RHA's failure to act on her concerns. She received no reply and complained to her Member of Parliament (the MP) who wrote to the RHA on 7 November. The RHA sent her a reply on 1 December. The complainant remained dissatisfied with their response. On 1 April 1996 the RHA ceased to exist; some of their previous functions-including responsibility for handling complaints against CHCs-were transferred to the North Thames regional office of the NHS Executive (the regional office) in the Department of Health, and the Secretary of State for Health took responsibility for matters arising from complaints to me about the RHA's actions.

3. The matter investigated was that the RHA's handling of the complaint about their refusal to grant an IPR and about the failure by the CHC to act, was dilatory and inadequate.

Investigation

4. My predecessor obtained the comments of the regional office and the RHA's correspondence on the complaint was examined. My staff took evidence from the complainant, former RHA staff, and regional office staff. The chief officer of the CHC was interviewed, although the actions of CHCs are not within my jurisdiction. The chair of the CHC and her predecessor wrote jointly to this office about the complaint.

Relationship of the CHC and RHA

5. At the time of the events complained about CHCs were established by the then regional health authorities who appointed some members and all the staff.

National guidance

6. In September 1994, the Standing Committee of the Association of Community Health Councils for England and Wales (ACHCEW) agreed draft guidelines for handling complaints against CHCs. In July 1995, ACHCEW wrote to all member CHCs with a copy of revised guidelines, saying that the NHS Executive was keen that ACHCEW's proposals for internal complaints-handling procedures in CHCs should be circulated as soon as possible, but that there would be further consultation with the NHS Executive about arrangements for handling complaints at a level above the CHC after 1 April 1996, when RHAs would be abolished. The guidelines included:

> `Stage 1 [consideration by CHCs]
>
> .... The CHC Chair should handle complaints about the [CHC] Chief officer ....'

In a circular EL(95)142 issued in December 1995 (after the events complained about) the NHS Executive said that after 1 April 1996 their regional offices would be responsible for arranging for external review of complaints about CHCs, provided that the complaint had been addressed initially by the CHC and the complainant remained dissatisified. Further guidance in EL(96)17, issued in March 1996, said that each regional office was to agree detailed arrangements for that with CHCs in its region, based on the ACHCEW proposals.

RHA policy on handling complaints

7. At the relevant time the RHA guidelines for handling complaints said that routine complaints should be referred to the organisation responsible. Of complaints which appeared sufficiently serious for the RHA's intervention to be considered, those about medical issues were to be referred to the public health directorate and those about CHC issues to the manager of the CHC Unit in the corporate affairs directorate (the unit). The guidelines continued:

> `There may be occasions when directorates receive .... complaints .... direct from patients or their representatives. In these circumstances they should .... advise [the private office manager] in corporate affairs .... so that a central record can be maintained.
>
> `.... corporate affairs have a responsibility for ensuring that co-ordination takes place, and they should keep a record of the action taken, issuing reminders if necessary. ....
>
> `.... the complainant should be sent an acknowledgement within 2 working days and a full response normally within 3 weeks. The complainant must be advised if the response is delayed beyond 3 weeks and must be kept informed regularly of progress ....'

Sequence of events

8. A summary of the key events in the handling of the complaint, mainly taken from the RHA's records, follows.

1 March 1995-The complainant telephoned the RHA and complained to the assistant to the manager of the unit (the assistant) about the failure of the CHC chief officer to provide help in pursuing her clinical complaint. The next step was to have been for the CHC chief officer to draft a letter to my predecessor about it. The assistant said that she would telephone the complainant within two days. The manager of the unit (the manager) later spoke to the CHC chief officer about the complaint.

3 March-The manager telephoned the complainant. She apologised for the delay.

20 March-The assistant returned a telephone call from the complainant, who said that she had still not received the draft letter. The assistant told the complainant that the manager would look into it and she would call her the next day.

22 March-The manager wrote to the CHC chief officer asking her to attend to the matter urgently and let her know what action she had taken. The manager wrote to the complainant and apologised for the distress caused by the delay in drafting the letter and said that she had asked the CHC to let her know what action they were taking.

24 March-The assistant told the complainant that she hoped that the CHC chief officer would reply during the next week. She promised to telephone the complainant on 3 April.

3 April-The assistant telephoned the complainant but got no answer.

19 April-The complainant telephoned the assistant and told her that she had heard nothing. The manager wrote to the CHC chief officer that the RHA had received a further telephone call from the complainant and asked the chief officer to let the manager know what action she had taken.

25 April-The complainant wrote to the assistant that she had still heard nothing.

28 April-The assistant wrote to the complainant that the CHC chief officer was on sick leave and was expected to return to work on 1 May.

30 May-The complainant wrote that she still had heard nothing from the CHC chief officer and asked the assistant to transfer her case to another CHC.

2 June-The manager wrote to the CHC chief officer in the same terms as on 19 April.

20 June-The complainant wrote to the manager that she still had had no reply from the CHC chief officer and asked again for her case to be transferred.

28 June-The CHC chief officer wrote a letter of apology to the complainant in which she offered to transfer the case but also provided a draft letter to my predecessor about the RHA's refusal of an IPR. Those letters were copied to the manager.

1 July-The complainant wrote to the CHC chief officer that she was dissatisfied with the letter to her and confirmed that she would like her case transferred. She copied the letter to the manager.

18 July-A meeting took place between the manager and the CHC chief officer during which the complainant's case was discussed.

5 September-The complainant wrote to complain to the general manager that no further action had been taken. (The RHA have no record of receiving that letter.)

7 November-The complainant's MP wrote to the general manager putting her concerns again.

10 November-The RHA private office manager wrote to the complainant, saying that the RHA had not received her letter of 5 September. The CHC chief officer wrote to the MP that the manager had agreed on 18 July to contact the complainant.

November-The private office manager asked for and received the associate director of public health's views on the request for an IPR.

1 December-The general manager wrote to the complainant, in a letter signed for him in his absence by the private office manager. That letter included:

> `.... [the CHC chief officer] did delay advising you ....
>
> `.... my officers were placed in a difficult situation. They were obviously aware of your wish for the case to be transferred to another CHC. However .... it was felt that to continue would not be in your best interests. It is regrettable that this was not passed on to you and I will be ensuring that such a situation cannot occur again.
>
> `I have asked the director of public health to look again at your initial complaint and have been informed that the dosage of [a drug] given to [your sister] was within a range expected, given the clinical condition. I am reassured that there was no case for proceeding to an independent professional review ....
>
> `.... I realise that the delays caused by the CHC and my own organisation can only have added to your distress. .... can I give you my personal apologies ....'

The complainant's evidence

9. The complainant said that she first telephoned the RHA about her complaint and spoke to the assistant on 6 March 1995. She had asked then if the papers could be transferred to another CHC. The assistant was concerned and sympathetic. The complainant told my staff that she received no telephone calls from the RHA after 20 March and she received no replies to her letters to the RHA of 30 May, 20 June and 1 July. After writing to the regional general manager on 5 September and after the MP wrote to him on 7 November she did not receive a reply until that of 1 December. She was concerned that she had had no explanation of why her complaint had not been transferred to another CHC, why there had been such a lengthy delay, or in what way RHA staff were in a difficult situation. She considered that she had been subject to `administrative disregard and neglect' by the RHA.

Other evidence

10. In a letter to my office dated 7 October 1996 the former general manager (by then the director of the regional office) wrote:

> `I have every sympathy with [the complainant's] situation and accept that the former RHA failed to complete its handling of [the] complaint. The [unit] .... did contact the CHC on at least three occasions .... to ensure that [the] CHC provided [the complainant] .... with a draft letter .... [the complainant] finally requested that the RHA transfer her case to another CHC ....
>
> `The CHC manager decided that it was not appropriate to transfer the case .... The .... failure on the part of the .... manager to inform [the complainant] of this decision appears to have been the result of an accumulation of several factors including organisational upheaval, a very heavy workload .... and personal circumstances. I am aware that [the manager] .... very much regrets her oversight on this occasion.
>
> ....
>
> `I would repeat my apology to [the complainant] for the distress that has been caused her.'

11. The assistant said that when they first spoke the complainant stressed that she was expecting the CHC chief officer to draft a letter to my predecessor. The complainant might have mentioned the refusal to grant an IPR but the assistant did not

recognise that as part of the complaint. In September the private office manager asked her for details of what had happened and for copies of correspondence.

12. The manager said that she kept a record of complaints about CHCs and made diary entries of follow-up action. She could not recall having seen the RHA guidance on complaint handling. She remembered the complainant referring to her request for an IPR, but thought that what she wanted was for her to get the CHC to draft a letter for her to this office. She could not recall why she did not write to the CHC chief officer until 22 March but she did speak to her about the subject before that.

13. At the meeting with the CHC chief officer on 18 July they considered the possibility of transferring the case to another CHC and agreed that the manager should contact the complainant about that. The manager later decided that a transfer would not be in the complainant's interests or necessary, as the draft letter to this office had been provided. She tried once, unsuccessfully, to contact the complainant about that decision, but she could not say why she did not try again. It was entirely her fault that the complainant was not informed of the decision not to transfer the case. She had not considered the possibility of contacting the CHC chair about the complaint: she had not seen the ACHCEW guidelines.

14. The CHC chief officer said that after the meeting on 18 July she understood that the manager was to decide what action should be taken and contact the complainant direct. She was certain that her letter of 28 June, and its offer to transfer the case, had been discussed. Her next involvement was in late summer when the assistant telephoned her and asked her to send her papers on the case to the RHA. She faxed the information on 8 September.

15. On 16 December 1996 the CHC chair and her predecessor jointly wrote to my office complaining about several aspects of the RHA's handling of the complainant's complaint about the actions of the CHC. They said that until the chair found out about the complaint `by accident' on 7 October 1996, the only knowledge that the CHC had of the complaint was what the chief officer had told them-the RHA had failed to disclose information about it on several occasions. They considered that the RHA ought to have investigated the chief officer's failure to inform the chair in full about the complaint and that the RHA ought themselves to have informed her. They said that, when challenged about that, the RHA's officers had said that it was the chief officer's responsibility to tell the CHC. The letter included:

> `In our view, a failure to communicate with the CHC about the chief officer and a matter of such seriousness has had serious consequences for the CHC and for the complainant ....'

16. The private office manager said that, under the RHA's procedure (paragraph 7) the unit should have informed her of the complaint but she did not remember them doing so. She first became aware of it in November when the MP wrote. She could find no record of and had no recollection of the complainant's letter of 5 September being received. She understood the complaint was about the CHC chief officer and the actions of the RHA and that it concerned the refusal of an IPR. She obtained information from the unit about the complaint about the CHC chief officer and from the associate director of health about the IPR. She then drafted a reply which the general manager amended and authorised her to sign on his behalf. The private office manager explained to my staff that RHA staff were in a difficult position because there was nothing that could be done about the refusal of an IPR, and to prolong the complainant's hope by transferring the case to another CHC would have been no help to her. In January 1997 the private office manager wrote to this office that the NHS Executive were still in the process of producing guidelines on the role of regional offices in complaints against CHCs.

Findings

17. The complainant sought the CHC's help in pursuing a complaint about the RHA's refusal of an IPR but was dissatisfied with the CHC chief officer's response. In March 1995 the complainant complained to the RHA about that. Between then and 28 June when the CHC chief officer finally wrote to the complainant, the manager contacted the CHC chief officer several times, each contact apparently prompted by the complainant. At that stage the complaint was handled entirely by the unit as a complaint about the CHC. It was clear that the repeated difficulty in getting action from the chief officer was a major problem. I agree with the current and former CHC chairs that it would have been advisable for the RHA to have brought the matter to the attention of the CHC chair, although I acknowledge that under the ACHCEW guidance (paragraph 6) formal responsibility for doing that lay initially with the CHC chief officer.

18. The RHA's complaints procedure required that the private office manager should be notified of all complaints. The manager did not inform her. Had she done so, enquiries which were made only in November by the private office manager about the IPR might have been made earlier. Although the complainant's contacts with the RHA at that time focussed largely around her complaint about the CHC, it should have been clear to staff from the start that the RHA should also respond to the concern which had led her to contact the CHC-the RHA's own refusal of an IPR.

19. The manager also failed to contact the complainant after agreeing to do so at the meeting with the CHC chief officer in

July. The complainant was left with the expectation that her case would be transferred to another CHC although that option had been rejected. I criticise the manager for those failures. I am also concerned about the lack of awareness by RHA staff of the former RHA's guidelines on complaints or the ACHCEW guidelines and that, since the RHA's abolition in April 1996, despite the guidance in EL(96)17 that they should agree with CHCs their own arrangements for handling complaints, the regional office appear to have been awaiting further guidance from the NHS Executive about that. I invite the NHS Executive to make sure that all regional offices are clear whose responsibility it is to agree procedures for that and that any outstanding matters about complaints about CHCs are resolved as soon as possible.

20. It is uncertain when the complaint was put to the general manager. The complainant said that she wrote on 5 September; and the assistant and the chief officer remembered being asked for details of the complaint at about that time. RHA staff had no record or recollection of the letter. My investigation has not been able to resolve this conflict. The complainant received a detailed reply and apology within a month of the MP writing in November, but by then nine months had passed since the complainant first contacted the RHA. For the reasons given above I uphold the complaint.

Conclusion

21. I have set out my findings in paragraphs 17-20. The regional director for the North Thames Region has asked me to convey to the complainant through my report-as I do-apologies on behalf of the NHS Executive for the shortcomings I have identified.

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comments

Case No.1134/95-96-Inadequate nursing care in a private nursing home

Background and complaint

1. The background to the complaint provided by the complainant was that in October 1994 her husband was transferred from East Hertfordshire Hospital to a private nursing home (the home). His care there was funded by East and North Hertfordshire Health Authority. On 1 January 1995 the complainant was told that her husband had sores on both knees. On 3 January 1995 the complainant's husband was admitted to Queen Elizabeth II Hospital (the hospital) where it was noted that he also had a sore on his right hip. That appeared to have been dressed while he was in the home. There was no reference to the wound on his hip in the home's records.

2. On 6 January the complainant complained to the Authority about the care received by her husband while he was in the home. Despite investigations undertaken by the home and the Authority and a meeting with staff, the complainant remained dissatisfied. The complainant's husband died on 11 January 1995.

3. The complaint investigated was that, because of inadequate nursing care in the home, the complainant's husband developed sores on his toes, both knees and hip.

Investigation

4. My predecessor obtained the comments of the Authority and relevant documents were examined including the complainant's husband's nursing records. My staff took evidence from the complainant and from staff of the Authority, hospital and home. Evidence was also taken from a nursing consultant involved in a review of care at the home, although her actions were not the subject of this complaint. The complainant was told that the complaint might, in part, concern actions taken solely in the exercise of clinical judgment which were outside my statutory jurisdiction at the time of the events which gave rise to the complaint.

Jurisdiction and legal background

5. The actions of staff at private nursing homes providing care and treatment for patients paid for by the NHS are within my jurisdiction. The complainant's husband's care was funded by the NHS.

6. The home was registered with the Authority under the terms of the Registered Homes Act 1984 (the Act) and was subject to inspection by them. The staffing notice issued as a condition of registration required that each of the five thirty-bedded houses in the home should have as a minimum: two nurses and four auxiliaries on the morning shift, two nurses and two auxiliaries on the afternoon shift and one nurse and two auxiliaries on the night shift. The house in which the complainant's husband lived, the residents of which were described as `elderly mentally infirm', was to have registered mental nursing cover 24 hours a day. The regulations under the Act require that homes be inspected not less than twice a year.

7. The Authority had a contract with the home covering the arrangements for patients funded by the Authority: each resident was to have an individual plan reviewed monthly by an appointed key worker and primary nurse. Authority representatives could visit and inspect the home at all reasonable times without prior notice but formal monitoring against the contract would take place quarterly.

Complainant's evidence

8. The complainant said that her husband was diagnosed as schizophrenic in 1956 and for the past four or five years had also suffered from Alzheimer's disease. She had looked after him at home until he was admitted to hospital in 1992. He was transferred to the home on 11 October 1994 when that hospital closed.

9. When the complainant visited her husband in the home on 1 January 1995, she was told by a nurse that he had sores on his knees caused by friction from the bed clothes. The complainant said that the bed clothes consisted of a very light quilt, not rough blankets. On 3 January her husband was admitted to the hospital because of chest problems. On arrival in the accident and emergency department he was examined by a nurse who said he had a lot of pressure sores, some with broken skin. The complainant did not see them as she was not present at the examination.

10. When the complainant visited her husband in hospital on 9 January she examined his feet and legs and found that there were sores on the top of all his toes (across the joints) and on both knees; when she had visited him at the home on Christmas Day, she had seen his feet and they were free of sores. A nurse told her he had had the sores when he was admitted from the home and that he also had a sore on his right hip. The complainant could imagine situations in which an elderly person could get sore patches in one or two places but not on every toe and both knees.

11. The complainant met staff from the Authority and the home to discuss her concerns. The matron of the home (the matron) told her that the wounds could have occurred in the ambulance on the way to the hospital or when her husband knelt to pray. The complainant said her husband had been unable to kneel to pray for years; he always sat on the edge of the bed. She thought her husband's injuries could have been caused by him being dragged along a carpet, such as that in the home's lounge.

12. The complainant said that there seemed to have been very few staff in the house and that most were untrained care assistants. On Christmas Day only two members of staff were on duty to look after thirty patients and on 26 December all the staff on duty were from an agency. On 27 December she was told that her husband's behaviour had been particularly difficult the previous day.

Guidance

13. On 18 January 1994 the NHS Management Executive issued a guidance document (EL(94)3) entitled `Pressure Sores: A Key Quality Indicator'. The document included:

> `.... pressure sores are for the most part preventable if the circumstances likely to result in pressure sores are recognised, if those at risk are identified early and if appropriate preventive measures are implemented without delay.'

14. Guidance on standards for nursing records published by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (the UKCC) in April 1993 included:

> `Meticulous and timely documentation provides evidence of the practitioner's actions, the patient's .... response to those actions and the plans and goals which direct the care of the patient ....'

Documentary evidence

15. A form assessing the man's dependency rating dated 11 October 1994, completed as part of his nursing assessment on admission and revised on 8 November 1994, included:

PRESSURE	Necrosis/pressure sore needs dressing
SORES	Pressure sore in evidence/two hourly care
	Redness/two to four hourly care Skin intact

The scores against each of the last two lines have been circled and it is not clear which was the initial and which the revised score: but the way the rest of the form has been completed suggests that the initial score was one (ie that the man's skin was intact) and that the score of two (ie that some redness was apparent) was made in November.

16. The care plans completed by home staff on the man's admission included two references to pressure sores. The plans noted that because of his incontinence he needed to be washed and dried properly to avoid sores. A necessary action about personal hygiene was `[to] observe any skin changes eg bruises, pressure sores and report to nurse in charge'. There was no revision of the care plan coinciding with the change in the man's dependency assessment for pressure sores.

17. Nursing records from the home included only two entries about the man's sores. The first was made on 26 December and included:

> `.... [the patient] was attempting to get out from bed and when staff [were] assisting him observed two red blood shot patches on both [the patient's] knees and skin peeling off on [his] legs [and] toes. Cold sponge applied, but blood shot patches looked slightly purple and appeared old bruises as no bleeding present .... Cause or time unknown. (Note: The last four words appear to have been inserted later.) Night sister .... informed and examined same.'>

The second was a note that the man's general practitioner (GP) had visited to see his knees on 27 December and advised application of a dry dressing.

18. The GP's notes of that visit included `Carpet burns both knees. Continue dry dressings.'

19. The man's hospital records included a Waterlow score (an assessment of pressure sore risk) which recorded him as being at very high risk and a nursing care plan. Both were completed on his admission from the home on 3 January. The plan recorded:

	Mobility	*Nursing Action*
3/1/95	[the patient] has multiple pressure sores & red areas to skin on admission due to reduced mobility	[2 hourly pressure area care] Nurse on pressure relieving mattress .... observe pressure areas ....
	Granuflex [self-adhesive patch to promote healing] to both knees and right hip area (applied in [nursing] home)	
	also sores on top of toes both feet (Note: This was apparently added later)	

Evidence

20. The hospital nurse who completed the man's nursing care plan remembered that staff had thought it odd for a patient to have sores on the top of his feet and knees. A sore on the hip was not unusual. In hospital the man was nursed on a special bed and turned regularly to prevent the sores worsening or further sores developing.

21. A nurse (the first nurse), who had completed the man's care plan when he was admitted to the home, said that the entry on his dependency rating scale against `redness/two to four hourly care' meant that he was walked around during the day and turned every two hours at night; his being turned at night should have been documented by the night staff. She thought she would have completed a Waterlow score but as no such document was among his records she probably had not done so.

22. The first nurse had seen the sores on the man's knees, but not those on his toes or hip. She thought that the sores on his knees might have been caused by the quilt, by pressure when he knelt to pray, or by lying in bed with his knees pressed against the wall.

23. When interviewed by my staff, another nurse (the second nurse) who was on duty on the nights of 25 and 27 December, said that he remembered that around Christmas (although he could not remember when) a care assistant asked him to look at two red patches on the man's knees. The skin was not broken and he described the patches as pressure points rather than pressure sores. They might have been caused by the pressure of the quilt on the man's bed. He reported the sores to the nurse in charge. He had seen no injury to the man's hip. (Note: in comments passed to me by the Authority on 24 December 1996 the company running the home (Takare) said that the second nurse had informed them that he had `consistently maintained' that he was not informed of any red patches on the man's knees.) The second nurse told my staff that when the complainant's husband was in the home all the staff were new, there were very few qualified staff and turnover among them was high. The situation had improved. There was now a primary nurse named for each patient.

24. Another nurse (the third nurse), who made the first entry (paragraph 17) in the man's nursing notes about the sores on his knees and toes, said she had first seen them on the evening of 26 December when all the sores looked about 24 to 48 hours old. Whoever had helped him to the lavatory that day, and to dress and undress, should have noticed the sores; but when she asked the other nurses and care assistants they knew nothing about them. She did not know how the sores had been caused but suggested that the man might have fallen, tried to get up on his own and rubbed his knees and toes on the floor. Sometimes a very disturbed patient pushed others about.

25. When on night duty she always turned the man every four hours. She considered that the number of staff on duty at night was inadequate; one qualified nurse and two care assistants were not sufficient to care for thirty patients. When the home was first opened there was a high turnover of care assistants but that situation had improved.

26. Another nurse (the fourth nurse) who was on duty on the afternoon of 25 December remembered the complainant's husband. He confirmed that on that afternoon only he and a male care assistant were on duty in the house and that their efforts to obtain extra or female staff from other houses or an agency were unsuccessful. Relatives of patients had had to help serve meals. He could remember nothing which could account for the man developing the sores and was surprised by the suggestion that the patient might have knelt to pray. He would have recorded any fall in the accident book. He thought that the man might have had a sore on his heel but not elsewhere. (Note: in their comments in December 1996 Takare said that the fourth nurse had not notified the senior nurse at the home on Christmas Day about the shortage of staff. If he had it was likely that help would have been provided from other houses.)

27. The care assistant on duty on the afternoon of 25 December remembered the complainant's husband but had no recollection of any events that day, except that there had only been two staff on duty.

28. The senior sister for that part of the home at the relevant time did not think the man was at risk of developing pressure sores when he was admitted; he was mobile and spent a lot of time walking around. His health deteriorated later and that increased the risk of pressure sores. A Waterlow score should then have been done and he should have been nursed on a special bed, which would have been available, and turned regularly each night. In the morning he was always found in bed with his knees drawn up: but a bed cradle to lift the covers would have been more of a hazard than a help. She could not recall anything about the sores on his knees, toes or hip. As far as she could remember his skin had been intact. (She was on duty on the afternoon of 26 December and on both morning and afternoon shifts on 28 December.) If he had developed sores that should have been documented. She said that she remembered seeing him kneel to pray.

29. The matron of the home said that she had previously believed that a Waterlow score had been completed for the complainant's husband but in the absence of one she concluded that it probably had not been done. There should have been more entries in the nursing notes about the condition of the man's skin and any treatment given. The notes were not of the standard expected by the home but they had not been audited at the time. Now she audited each set of nursing notes every three months to make sure the care plan was updated and that the plan, together with the dependency rating scale, reflected the condition of the patient. A policy for the prevention of pressure sores was introduced in January 1995. She thought that the sores on the man's knees and toes might have resulted from his habit of sleeping with his knees drawn up or from his kneeling to pray. She denied the complainant's suggestion (paragraph 11) that she had told her they might have developed during the ambulance journey. The sore on his hip was never seen by any of the staff in the home; it was therefore never dressed or documented. He was not nursed on a special bed even after the sores developed. Although a special bed was available she did not think it would have benefited the complainant's husband because of the position of the sores on his body.

30. The matron said that there were sufficient staff but sickness meant that many agency staff had also been needed. Only two members of staff were on duty during the afternoon of Christmas Day - one staff nurse and a care assistant. Arrangements had also been made for two agency staff to work then but they did not arrive. At that time it was usual to have four staff in the afternoon; now there were always five.

31. The Authority's director of communications and performance (the director) said the Authority originally proposed to refuse to register the home because of concern about its intended staffing mix - the ratio of qualified to unqualified staff. However the Authority took legal advice which suggested that they might not be able to enforce the staff mix they had been seeking. They agreed to register the home in June 1994 and the home opened in September. At first the home had problems recruiting staff and relied very heavily on agency staff and care assistants with no experience but did not report to the Authority that there were problems over staffing. It was not until late 1994 that the Authority became aware that the home had breached the agreed staffing notice (paragraph 6).

32. The director said that the Authority had produced a draft policy on non-compliance with staffing notices which the director hoped would become policy by the end of 1996. It stated:

> `Where this is the first instance of non-compliance and there is evidence that the home has tried hard to maintain staffing levels .... the .... Authority will work with the home to rectify the matter, monitoring on a monthly basis to ensure compliance....
>
> `Where there have been repeated breaches of the Staffing Notice and where the .... Authority believes little action has been taken by the homeowner to comply with the requirement of the .... Authority, the homeowner will be prosecuted under .... [the Act] ....
>
> `Where repeated breaches of the Staffing Notice [have] led to an environment of care which is viewed to be detrimental to patients, a proposal to cancel registration should be served.'

33. She explained that a new home with 150 beds would normally admit patients over a period of six months. In this case, because of the delay in registration, the patients who were funded by the Authority were admitted over a three to four week period when other patients were also admitted. With hindsight she considered that the admissions should have been staggered.

34. The home opened in September 1994 and the first inspection visit was made in January 1995, though earlier visits were made in response to complaints made between September and December. (Note: Takare commented to me that one of those visits in October took place over three days, and that the matron had discussed the staffing problems with the inspectors.) The visits identified problems in matching staffing to dependency levels. As well as the inspection visits (paragraph 6) the

Authority also made quality monitoring visits in respect of the 60 patients whose care they funded. The first quality monitoring visit was made in February 1995. The director said that in her opinion there had been room for improvement in the monitoring of the home. The Authority had not realised how complex inspecting the home would be; it was impossible to check it adequately in the one day originally agreed. Changes were introduced in September 1996 and visits were now conducted over two to three days. During 1995 there had been three quality monitoring visits and four inspection visits (two of which were unannounced).

35. In February 1995, in response to the number of complaints about the quality of care in the home, the Authority set up an independent review. Its remit included, `to examine and report on the care provided in terms of quality and appropriateness based on the needs and dependency of patients against the standards specified by the [Authority] for contracting and registration'.

36. The nursing consultant involved in the independent review said that she had examined some of the home's nursing notes, including the complainant's husband's, and thought that the general standard of documentation was appalling. She did not believe that the complainant's husband's sores could have been caused by the bedding or that at the time he sustained the injuries he had been well enough to kneel to pray. She could not think of any way in which he could have sustained the injuries to his knees and toes without the intervention of another person.

37. The independent review found that:

> `.... the numbers and qualifications of staff on duty on many occasions during the period covered by the review were insufficient to provide the levels and quality of care required by the patients.
>
> `.... During the major part of the period covered by the review no records were kept which would allow the incidence of pressure sores to be determined. It is therefore not possible to make any reliable conclusions about the incidence of pressure sores prior to and after admission to the home. .... [Takare] introduced pressure sore audit programmes from January 1995.'

38. The Authority's response to the independent review included:

> `The .... Authority apologises unreservedly for its part in not insisting that [the company managing the home] slow down the process of opening the home. It will ensure through tighter monitoring processes that this situation does not arise again in the future.
>
> `The review team found that the contracting documentation and service specification did not define sufficiently clearly the categories of patients for whom care was being purchased, nor define adequately the standards of care required.
>
> `The contract states at para 4.1 that `staffing levels will need to take account of registration standards and the level of dependency of the clients. If the level of dependency changes, staffing requirements will have to be agreed with the .... Authority'. The management of [the home] appear not to have responded to this clause in the contract. The .... Authority accepts these criticisms and will review its contracts with nursing homes generally.
>
> `The .... Authority believes that [the home] experienced .... short term but significant problems which led to poor quality of care in the home during its initial six months of operation. These have been capable of rapid improvement .... [The Authority] believes that [the home] now does, and will continue to provide good care.'

39. Takare issued a statement on 8 January 1996 after the report of the review which included:

> `.... Please note .... that [the company] .... rejects much of the detail of the report - its flawed methodology has resulted in a very large number of inaccurate and inconsistent findings ....
>
> `Difficulties with the care delivery for a small number of residents at [the home] did occur in late 1994 and early 1995. These were due to the rapid admission of new residents .... and difficulties in recruiting sufficient high quality staff. [The company] .... regrets any distress caused during this period. The management of [the home] took concerted action to remedy these problems which have, since early 1995, been resolved.'

40. In a letter to me dated 24 December 1996 the Authority's chief executive said that the Authority had tried to achieve a balance between allowing the home to settle down after a difficult opening period and taking formal action over the issues involved.

Findings

41. There is no doubt that the complainant's husband developed sores on his knees and his toes. A sore on his hip was also recorded on his admission to hospital though none of the home's staff has any recollection of seeing that. Various theories were offered by the nurses as to how the complainant's husband acquired the sores: friction from the quilt; kneeling to pray; or that he might have fallen, tried to get up without help and rubbed his knees and toes on the floor. The GP described the marks on his knees as `carpet burns' and the complainant was concerned that her husband might have been dragged along a carpet. The nursing consultant did not believe the sores could have been caused by the quilt and she and the complainant did not consider that her husband had been well enough to kneel to pray. My investigation has not been able to establish exactly why the sores developed, but it has identified various failings in the arrangements for the complainant's husband's care which significantly increased the risk of sores developing.

42. The home has acknowledged the inadequacy of the nursing documentation. That inadequacy calls into serious doubt the standard of care given. No full assessment of the man's pressure sore risk was made-even when redness was noted during his revised dependency assessment on 8 November. The care plan was not then amended. The first entry in the nursing records about the sores on his toes and knees was made on the night of 26 December; even the nurse (paragraph 24) who made that entry suggested that the sores had been present for 24 to 48 hours and must have been apparent to staff earlier. The second nurse told my staff that he did see the sores as they were developing and before they were dressed-his shift pattern suggests that that must have been on the night of 25 December-but made no record. I note that changes in practice have been made and that notes are now audited quarterly. The nurses on duty on the afternoon of 25 December could not suggest any reason why the sores might have developed then. The professional regulatory body and my reports have emphasised the importance of full and accurate record keeping. I strongly criticise the inadequate level of record keeping and care planning in the home. Those who manage the home must be held accountable for that.

43. I turn now to the issue of staffing. Development of the sores seems to have begun on the afternoon of 25 December when, after two agency staff failed to arrive, there were only two staff (one unqualified) to care for 30 elderly mentally infirm patients. It is hard to imagine how the staff could possibly have provided adequate nursing care. The terms of the home's registration required a minimum of four staff on that shift. A key worker (or named nurse) system as required by the contract (paragraph 7) was introduced only later (paragraph 23). There were considerable problems with staffing in the home at the time: many unqualified staff had little or no experience, there was high turnover, sickness, and use of many agency staff. Any of these factors can diminish the quality of care.

44. The ability of the home to provide adequate care was jeopardised by the rapid rate of admission of residents when the hospital where they had been closed. The Authority have acknowledged and apologised for their failure in allowing too many residents to be admitted too quickly.

45. What about the Authority's monitoring of the care provided in the home? Under the Act the Authority had a statutory responsibility to make a minimum of two formal inspection visits each year. In this case, although the Authority had had serious misgivings about registration of the home, the first formal inspection visit was not made until January 1995-four months after the home opened. Some visits were made between September and December 1994 in response to complaints, but no concerted action about the home's problems began until the new year. As the registering body the Authority had a responsibility to all the home's residents: it also had a particular responsibility to make sure that the home met its contractual obligations concerning the 60 residents whose care they funded. The Authority have acknowledged that the service specification for the care of those NHS patients was inadequate (paragraph 38). While the terms of the Act may have prevented them from requiring the staffing levels they sought under registration procedures, there was nothing to prevent them from requiring higher standards in the contract. No formal visit to monitor the quality of the NHS patients' care was made until February 1995. The role of inspections and of contract monitoring visits by the Authority was an important safeguard for the interests of the patients, particularly as their dependence and their inability to represent their own interests made them vulnerable. I note that the Authority have recognised the inadequacy of the monitoring arrangements and that improvements have been made.

46. My investigation has not been able to establish conclusively how the complainant's husband acquired the sores but it is my conclusion that they were a result of inadequate nursing care and that serious administrative failings lay behind that. The Authority maintain that they now have confidence in the care provided by the home and have agreed to review its contracting and monitoring procedures. I uphold the complaint.

Conclusion

47. I have set out my findings in paragraphs 41-46. The Authority have asked me to convey through my report-as I do-their

apologies to the complainant for the shortcomings which I have identified.

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comments

Case No. E.1242/95-96-Preparation of deceased and complaint handling

Background and complaint

1. The account of the complaint provided by the complainant was that on 7 December 1994 her husband was taken to King's College Hospital (the hospital) which is managed by the Trust, where he died on 9 December. The complainant and her son arrived at the hospital shortly after her husband's death. Her son viewed the body which had not been laid out or covered properly. On 30 December the complainant complained to the Trust. She received two interim replies and, in a further letter, an invitation to attend a meeting. The complainant was told by the Trust in a letter dated 26 June 1995 that her husband's medical records could not be found. She attended a meeting with Trust staff on 3 July 1995. In a subsequent letter the director of the acute medicine care group (the director) told her that crucial parts of her husband's notes were still missing. The complainant was not satisfied with the outcome of the 3 July meeting. The chief officer of Southwark Community Health Council (the CHC officer) wrote to the Trust several times on the complainant's behalf. At a second meeting, on 18 September 1995, the director suggested a possible meeting with a nurse who had been identified from the prescribing book, and promised that every attempt would be made to identify and contact the nurse involved in the patient's care. That nurse was not identified. The complainant remained dissatisfied with the adequacy of the Trust's investigation.

2. The complaints investigated were that:

a. the complainant and her son were caused additional distress because of the failure to prepare the body;

b. the complainants' husband's medical records were lost because of inadequate monitoring procedures;

c. the Trust's investigation of the complaint was inadequate in that the nurse who cared for the complainant's husband was not identified and no explanation was given for that, and no meeting was arranged with the nurse identified from the prescribing book; and

d. the Trust were dilatory in dealing with the complaint.

Investigation

3. The statement of complaint for the investigation was issued on 17 July 1996. The Commissioner obtained the Trust's comments and relevant documents were examined. The Commissioner's investigating staff took evidence from the complainant, her son, the CHC officer and the Trust staff involved. I have not put into this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Appendix A sets out the main events and correspondence.

The Trust's formal response

4. On 16 August 1996 the chief executive of the Trust (the chief executive) wrote to the Commissioner's office setting out the Trust's formal response to the statement of complaint (paragraphs 1 and 2 of this report). He said:

> `.... [The patient] was admitted to [the hospital] on 7 December 1994 suffering from a very distressing condition known as Stevens-Johnson syndrome [(SJS)], a severe allergic reaction to antibiotics, the prognosis for which is extremely poor. [The patient] had been receiving treatment at [the hospital] for cancer which unfortunately had spread to his brain, and he sadly died at [the hospital] on 9 December 1994.
>
> `[The complainant's] complaint was received by the Trust on 6 January 1995. Unfortunately [the patient's] medical records for the period of 7-9 December 1994 could not be located which made the investigation of the complaint difficult and led to delays in addressing [the complainant's] concerns. The inpatient notes for the relevant period were eventually traced to the histopathology department where they had been sent following [the patient's] death for the purposes of the post mortem, but were never recorded as returned to medical records. Histopathology records show that they were booked to medical records on 12 January 1995. It was at this stage that the records appear to have gone astray.

`Subsequently, the records relating to [the patient's] admission to the Accident and Emergency [(A and E)] Department on 7 December 1994 were located. Further details were also obtained from the drug administration book on Sambrooke Ward [(the ward)] which provided information about [the patient's] pain relief.

`However, I would wish to emphasise that the Trust has tried very hard to address [the complainant's] concerns as fully as possible in the absence of the medical records. The Trust has acknowledged that it very much regrets the loss of these notes. The majority of the complaint issues have been addressed both in correspondence and at two meetings attended by [the complainant]. At the last meeting held on 18 September 1995, many of the clinicians who had cared for [the patient] were present in order to discuss [the complainant's] outstanding concerns as far as possible.

`.... It is extremely unfortunate that the nurse who cared for [the patient] could not be identified at the time of the [Trust's] investigation. The nurse could have been identified either from the nursing records or from the duty rota, by interviewing all staff on duty on the ward at the time of [the patient's] death. However, there was a reorganisation within the medical care group around this time, involving the relocation of staff and medical wards. As a result of this, the duty rotas for the relevant period appear to have been misplaced. It is therefore not possible for the Trust to address the specific issues relating to the preparation of [the patient's] body ....'.

The records

5. The Commissioner's investigating staff established that the patient's original medical file was mislaid before his admission on 7 December 1994, and that a temporary file was made up. That file was not available on 7 December 1994. (It was not found until April 1995.) Another temporary file was prepared and used in the ward between 7 and 9 December. It was also subsequently misplaced. Certain records have been found by the Trust. They include a copy of the A and E notes of 7 December 1994 and various drug charts. On 10 October 1996 (after the Commissioner had decided to investigate the complaint) the Trust confirmed that the ward's nursing rota had now been located. The Commissioner's investigators were therefore able to identify the nurses on duty on the afternoon of 9 December 1994.

Complaint *(a) Failure to prepare the patient's body*

Evidence of the complainant, her son and a family friend

6. In her letter of 30 December 1994 to the Trust the complainant wrote `.... on Friday 9 December I made four calls to the hospital to be told there was no change in [my husband's] condition. The last call was made at 14.15pm and I spoke to the nurse in charge of my late husband who again confirmed that there was no change regarding his condition and yet minutes later I received a call to be told my husband's condition had deteriorated dramatically. After contacting my son at work to come home immediately we eventually arrived at the hospital [at] 15.40pm, unfortunately to be told my husband had passed away at 14.50pm. [Note: the post mortem report stated that the patient died at that time.] What I would like an explanation for, is why one hour after his death was my husband's body not laid out properly, with his mouth still left open this was a very disturbing scene to witness as his wife. I can only assume that my husband had been dead for some time and was not found or taken care of ....'.

7. At an interview the complainant provided one of the Commissioner's investigators with a description of the nurse who had met them when they arrived at the hospital on 9 December 1994. The complainant said that she had been too distressed to see her husband and her son viewed the body.

8. On 7 June 1995 the complainant's son wrote to the CHC officer stating `.... when I arrived [at the hospital] I was informed it was too late and my father had died. My mother refused to see the body and thank God she made that decision because when I saw my father he had been left laying out, not covered over properly with his mouth wide open .... My father had been dead for some time as he was ice cold so why was he left laying in that state? My mother called the hospital at 14.15pm to be told my father's condition was still the same, yet 2 minutes later she was called back to be told his condition had seriously deteriorated. When we arrived at the hospital at 15.40 pm to be told that he died at 14.50 pm [sic]. I find this totally inexcusable and I am certain my father had simply been forgotten, when my mother made that call to the hospital it was the jolt they needed otherwise why would they call back after only 2 minutes to announce a serious deterioration. It is obvious they had left him and he had been dead for some time ....'.

9. The complainant's son told the investigators that when they arrived in the ward a nurse met them and said something like `He's gone'. The nurse asked them if they wished to see his father's body. His mother was too upset and was taken to a waiting room. The complainant's son and a family friend viewed the body. The nurse did not tell them what to expect, and did not ask them if they wanted her to accompany them. She waited outside the cubicle. The complainant's son said that his father was flat on his back with his mouth open; his mouth was `all black inside'. He did not know why, but he removed the blanket that was covering his father. When he touched his father's head it was `icy cold'. He and his mother felt that his father had died some time before that was noticed by the nurses and that his body had not been prepared in any way.

10. In an undated statement to the CHC officer in June 1995, the complainant's friend wrote `.... [the patient] looked grotesque his head jerked back his mouth wide open his face was twisted .... he was like marble. I find it very difficult to believe he had been dead only an hour ....'.

The Trust's formal response

11. In his formal response (paragraph 4) the chief executive wrote: `.... we can only reiterate the practice at that time on [the ward]. This would have been in accordance with the Marsden Nursing Clinical Procedures Book when the body would be washed and dressed in a shroud and clean sheets. Clearly we are very sorry if the appearance of [the patient] caused additional distress to [the complainant] and her son ....'.

Guidelines

12. The Marsden Manual of Clinical Nursing Procedures included: `.... Place the patient on his/her back. Close his/her eyelids. Remove any pillows. Support the jaw by placing the pillow on the chest underneath the jaw .... Straighten the limbs. Put a plastic or paper shroud or personal clothing on the body unless requested to do otherwise ....'. In regard to relatives not present at the time of the patient's death the procedure suggested `Inform the relatives as soon as possible of the death as they may want to view the body before last offices are completed'. The Trust's `Last Offices Guidelines' included `.... Inform the relatives if they are not in the hospital at the time of death and wish to be informed. If possible, give them the opportunity of seeing the patient before being transferred to the mortuary ....'. (Note: since the time of the patient's death the Trust have issued comprehensive guidelines on the care of dying and deceased patients. In part they state `.... If a patient dies without the relatives being present, when they arrive on the ward, they should be made welcome and the most appropriate nurse present should take the opportunity to talk with them in private as soon as possible. The relatives should be informed that they can view the body, either on the ward .... or in the Mortuary Chapel ....'.)

Staff evidence

13. A bank nurse who worked part-time (the bank nurse) said that she gave painkillers to the patient on 9 December at 8.45 am. (Note: they were the last painkillers given to the patient which were recorded in the drugs administration book.) She remembered that the patient was very ill when she finished duty at 1.15pm. She said that when a patient died the usual practice was to straighten the body, tidy it up and cover it to the chin with a sheet. It was not the practice formally to lay out the body until after the relatives had seen the deceased. A charge nurse in charge of the early shift (the charge nurse) confirmed that it was not hospital policy formally to lay out the body until relatives had seen it. Last offices took up to an hour and it was considered inappropriate either for relatives to be kept waiting or for them to see the deceased only partly prepared.

14. A senior staff nurse (the senior staff nurse) on the afternoon shift (1.15 pm to 9.30 pm) said that she did not recall the circumstances of the patient's death. (Note: her description fitted that provided by the complainant- paragraph 7.) She said that she was not the nurse in charge of his care and that she did not recall speaking to the complainant either on the telephone or in the ward. She also did not remember who had been the patient's named nurse. She said that normally, when a patient died, the nurse who had been responsible for that patient's care would clear away any equipment from the area around the bed and tidy up the bed and the body. A shroud would not be used before the relatives had seen the body. It was possible, if blankets had been used to cover the patient when he was alive, that a blanket, rather than a sheet, might have been left to cover his body after death. Three other nurses on duty at the time also said they did not remember the circumstances of the patient's death.

15. The ward manager said that she was unaware that the practice in the ward at the time had been to defer formally laying out the body until after relatives had seen the deceased.

16. In a letter to the complainant dated 20 July 1995 the director wrote `.... It is no longer practice to formally layout

bodies. However, the policy is to wash the body and dress them in clean sheets and a shroud, and certainly ensure they are prepared should anyone wish to view them before they leave the ward. Often a pillow is used to support the lower jaw to prevent the mouth opening, it may well have been the case in this patient's case and the pillow taken away before the body was viewed in order to avoid any additional distress ....'. At interview the director told the investigators that it was usual practice to make deceased persons look tidy before relatives saw them, but not to do more until later. She said that at the meeting on 18 September 1995 (see Appendix A) the senior registrar in dermatology had explained to the complainant how SJS could affect a person's appearance.

17. A house officer who was on duty on 9 December (the house officer) said that he could not recall events that day. He explained that the patient had been covered with lots of blankets to prevent loss of fluid and heat. The house officer explained how SJS affected the patient's appearance both before and after his death. He said that the patient's appearance had been most distressing.

Findings *(a)*

18. The complainant complained that she and her son were caused additional distress after her husband's death because of the failure to prepare his body. It is unfortunate that the nursing staff-and especially the senior staff nurse-cannot recall the events on the afternoon of 9 December 1994, and that the nursing records are missing. I have no reason to doubt that the patient died at 2.50pm as noted in the post mortem report (paragraph 6). Although the ward manager said she was not aware it had been standard practice to defer laying out the body until after the relatives had seen it, several nurses said that that was the normal practice. Their descriptions about the normal practice were reasonably consistent; and the position was also set out in the director's letter of 20 July 1995 to the complainant (paragraph 16). I am satisfied that it was mainly due to the patient's unfortunate condition that his appearance both before and after his death was so distressing. I cannot be certain what communication took place when the complainant, her son, and a family friend arrived in the ward. As a matter of good practice I would expect a nurse to have explained carefully the position and to have accompanied the complainant son and family friend to the bedside; it would then have been appropriate to leave them in private. On the available evidence, however, I can make no finding on the complaint as put.

Complaint *(b) The medical records were lost*

The complainant's evidence

19. In her letter to the Commissioner, the complainant said that she would like the loss of the records to be investigated.

The Trust's formal response

20. In the Trust's formal response (paragraph 4) the chief executive said: `.... It is accepted that [the patient's] inpatient records relating to the period 8/9 December 1994 were lost. This was despite extensive searches made by various staff .... the records were available after [the patient's] death, and were sent to the histopathology department for the purposes of the post mortem. However, there is no record of them arriving back in the medical records department. The Trust clearly regrets the loss of the records and has apologised for this. [The Trust] has a very large medical records library, with around 420,000 annual record movements. A major review has been undertaken to examine the policy and procedures for the storage and retrieval of medical records at [the Trust] and work is continuing in this area ....'.

Staff evidence

21. The manager of the histopathology department (the histopathology manager) said that the patient's records would have been sent to the histopathology department for the purposes of the post mortem. After the post mortem the pathologist would bring the records to her office. They would later be secured in an envelope and taken by hand to the post room, where they would be placed in a box for delivery to the medical records department. The histopathology manager said that there was a booking out system which she considered to be very reliable. (Note: I have seen a copy of the page from the histopathology booking out record; it showed that the patient's records were sent to the medical records department on 12 January 1995, which was the date of the post mortem report.)

22. The medical records manager said the booking out system in the medical records library at the time consisted of a tracer card being substituted for any file which had been removed. The card would show who had removed the file. When the file was returned, the card was removed and used for another patient's records. There was an open library

policy and it was possible that someone had taken the file without putting a tracer card in place. A district audit report in July 1995 had highlighted certain problems and the system had been improved. For example, the Trust now operated a closed library policy and staff wishing to consult the records for research purposes had to do so in the library. A permanent tracer card was now used for each patient's records and a new computer system had been installed. Secretarial staff had been trained to enter details so that movements of all files could be tracked.

23. The medical records manager said she first knew the patient's records were missing when she received a note from the customer care section on 28 March 1995 (Appendix A). She did not document the searches which were conducted at the time but she was able to recall some details from memory. Searches were made by herself, her staff and others. Staff looked under alternative spellings of `[the patient's name]' and under the names of other patients whose records had been sent to the histopathology department around the time in question. Some records were found (paragraph 5) but not the file containing the notes relating to the patient's care and treatment from 7 to 9 December 1994. She said searches were still carried out about every four to six weeks.

24. The customer care manager said that she was responsible for the management of complaints until 31 July 1995, when the task was transferred from the business manager to the chief executive. The customer care manager had three staff who dealt with the handling of complaints. However, each care group nominated a separate investigating officer; and the complainant's complaint was sent to the accident and emergency and admissions manager (the A and E manager) to co-ordinate the investigation and draft a reply. (Note: the complainant had also complained to the Trust about her husband's treatment in the A and E department.) The customer care manager said that her (the customer care manager's) staff were involved in the search for the patient's records.

25. The ward manager said that she first became aware that the records were missing when the director wanted them for the meeting in July 1995. The A and E manager, who reported to the director, said that she, two of her staff and the medical records manager spent several hours searching for the notes in the medical records library. The director said she also searched for the patient's records.

26. The chief executive said that systems were in place in December 1994 for safeguarding records. He considered that it had been a failure to follow them that had resulted in the records being lost.

Findings *(b)*

27. At this remove it has not been possible to establish how or when the records were misplaced. They were last marked to the medical records department on 12 January 1995. It is possible they were lost in transit between the histopathology department and the medical records department. However, it is also clear that the system for safeguarding records and the monitoring procedures in the medical records department were inadequate. I am satisfied that searches were made by various members of staff for the records. It would have been preferable if the searches had been documented. I note with approval that after the district audit report in July 1995 the Trust made a number of changes to improve the safeguarding of records. **I recommend** that they closely monitor and audit the effectiveness of their revised procedures. I uphold this complaint.

Complaint *(c) Inadequate investigation of the complaint*

28. The complainant said that the nurse who met them on 9 December 1994 (paragraph 7) was the only nurse she remembered seeing that afternoon. She said that she did not provide a description of that nurse to the Trust staff. The complainant said that she first mentioned the nurse at the meeting with Trust staff on 3 July 1995. When she asked them at the second meeting on 18 September 1995 why the nurse was not present they did not respond. The complainant told the investigators that a nurse who signed the drugs prescription book on 9 December (paragraph 13) was the last nurse recorded as caring for her husband; and at the meeting on 18 September 1995 she understood the director to say that that nurse had been in charge of her husband's care. The director had therefore suggested a possible meeting with that nurse and promised that every attempt would be made to identify her. However, the Trust neither supplied her with that nurse's name nor arranged a further meeting.

The Trust's formal response

29. In his response the chief executive said `.... In [the director's] letter of 25 September 1995 (see Appendix A) she stated that every attempt was being made to identify the nurse who had cared for [the patient] on 9 December 1994. However [the director] was unable to identify the nurse in question .... [The director's] letter specifically states that [the complainant] would be contacted if there was any further information to report. However with hindsight, it may have been more sensitive to write to [the complainant] to confirm that the nurse could not be identified ....'.

comments

Case No. E.1275/95-96-Communication with relatives, mortuary procedures and complaint handling

Background and complaint

1. The account of the complaint provided by the complainant was that on 17 January 1995 her mother was admitted to Barnsley District General Hospital (the hospital) for breast surgery. The hospital is managed by Barnsley District General Hospital NHS Trust. An infection in the patient's left foot became worse and on 1 February she experienced difficulty in breathing. An unconfirmed diagnosis of a pulmonary embolism (a blood clot in the lungs) was made. Although the patient was very ill, and nursing staff were aware that the complainant had travelled from a distance to see her mother, the complainant and her brother were restricted to usual visiting hours. The patient died on 5 February. After her mother's death the complainant was advised by an undertaker, on 9 February, not to view her mother's body. He explained that the patient's body had not been placed in cold storage from the time of her death until the body was released by the hospital to the undertaker. The complainant also learned that in the week after her mother's death a nursing auxiliary gossiped with another patient about matters relating to the patient. The complainant wrote to the Trust's chief executive on 6 April 1995 but was dissatisfied with his reply dated 19 May 1995.

2. The complaints subject to investigation were that:

a. there were failures in communication in that:

i. the medical staff did not communicate adequately with the complainant and her brother about the diagnosis of the pulmonary embolism and the potential seriousness of that condition;

ii. the nursing staff did not explain that the policy on visiting hours could be applied flexibly;

b. the hospital mortuary procedures were unsatisfactory in that the patient's body was stored unrefrigerated after her death; and

c. the Trust did not deal adequately with the complainant's complaint about a breach of confidentiality by a nursing auxiliary who discussed the patient's case with another patient.

Investigation

3. The statement of complaint for the investigation was issued on 26 April 1996. The complainant was told at the beginning of the investigation that the complaint might, in part, concern actions taken solely in the exercise of clinical judgment, which at the time of the events complained about were outside the Commissioner's jurisdiction. The Commissioner obtained the Trust's comments, and relevant documents, including the patient's clinical and nursing records, were examined. The Commissioner's investigator took evidence from the complainant, her partner, her brother and his wife, and the Trust staff involved. Evidence was also taken from staff employed by the undertakers who made the funeral arrangements although their actions are not within the Commissioner's jurisdiction. I have not put into this report every detail investigated but I am satisfied that no matter of significance has been overlooked.

Complaint *(a)(i) Inadequate communication by medical staff about the patient's condition*

Evidence of the relatives

4. The complainant and her partner told the Commissioner's investigator that they travelled from Torquay and visited the patient twice on Friday 3 February 1995. That evening a male staff nurse told them that, although a pulmonary embolism was suspected, the patient was stable. The staff nurse did not express any concern about her condition. On Sunday 5 February the patient looked unwell and uncomfortable but there were few staff in the ward and the complainant and her partner were given no information about her. They said that they did not seek information as the staff were very busy, and they assumed that, if there had been any concerns about the patient, they would have been told. They therefore travelled back to Torquay that evening, only to learn on their arrival that the patient had died. Had they known how serious her condition was, they would

have stayed in Barnsley to be near her. The lack of information was made worse by the fact that the hospital staff knew how far they had travelled to visit her. The complainant's partner said that none of the patient's family was told about the implications of the pulmonary embolism.

5. The complainant's brother said that he visited his mother regularly after her admission to the hospital, but no doctor ever spoke to him. On 1 February he learned at second hand that his mother was unwell; and on visiting her he discovered that she had collapsed earlier that day. A nurse explained that the patient was stable, but that she might have a blood clot and was due to have a scan. He did not press for further information and did not ask to see a doctor as he was given no indication that his mother's condition was potentially serious. His wife said that she visited the patient on several occasions, but was never given any information about her condition.

National and local guidance

6. The Patient's Charter (1992-revised in January 1995) set the standard that: `If you agree, you can expect your relatives and friends to be kept up to date with the progress of your treatment'. The Trust's policy on communications and complaints included: `Good communication depends crucially upon everyone, both patients and staff, knowing who is responsible for giving information ...'. A booklet entitled `At Your Service' issued by the Trust to all patients included: `Friends and relatives who enquire about your condition will be given a very general indication of your progress, unless you request otherwise'.

Evidence of Trust staff

7. The consultant surgeon responsible for the patient's care (the first consultant) said that she was given anticoagulants after she had what was thought to be a minor pulmonary embolism on 1 February 1995. She was not placed on the `dangerously ill' list; and her death could not have been foreseen. When a patient suffered an embolism and recovered it was very unusual for a further embolism to develop. He said that, ideally, one of the doctors treating the patient should have told her family about her condition; but a doctor's duty was to patients rather than their relatives. The first consultant said that discussions with relatives should, in theory, be recorded in patients' clinical notes, but it was difficult to get junior doctors to do so. (Note: there are no references in the patient's clinical or nursing records to discussions with her relatives.)

8. A medical registrar (the registrar) said that on 1 February 1995 one of the surgical doctors had asked him to see the patient, who was in ward 29-a surgical ward. He examined her at 7.30pm and strongly suspected that she had suffered a pulmonary embolism. (Note: I have seen that he wrote in the patient's clinical records `This is most likely to be pulmonary embolic disease'.) The registrar said that the patient's condition was serious; but she was not in immediate danger and stood a good chance of recovery. Had she been his patient he would probably have told her relatives about her condition immediately. He would have discussed the patient with the surgical staff: it was their responsibility to liaise with her family. Discussions between doctors and patients' relatives would normally be recorded in the clinical notes. There was no specific rule about the responsibility for communication with relatives, but the first point of contact was usually the ward nurses. The patient would have been aware of her condition and would have been able to inform her family.

9. An enrolled nurse, who was the patient's named nurse, said that she could not recall the patient's relatives asking about her condition; but, had they done so, she would have asked a senior nurse to speak to them. She thought that a senior nurse would have spoken to the family as a matter of course. Such conversations were not normally recorded. She was not aware of any written protocols about communication with relatives.

10. A staff nurse, who was the senior nurse on duty in the evenings during the patient's admission, said that he was not present when she suffered breathing difficulties on 1 February. He could not recall speaking to the patient's relatives about her condition although he thought he might have done so. The nurses were guided by the medical staff when communicating clinical information to patients or their families. If relatives were concerned about a patient's condition the nurses would arrange for them to see a doctor. The staff nurse was not aware of any written protocols about communication, and said that it was generally accepted that the senior nurse on duty would deal with such matters.

11. The ward manager said that he was on duty when the patient had breathing difficulties on 1 February. He doubted whether her relatives would have been informed immediately; but he would have expected them to have been told about her condition when they next visited. He said that he might have spoken to the relatives himself as he was also on duty on 2 and 3 February; but he could not now recall doing so. He would have said that a blood clot was suspected but that confirmation was awaited. He would have avoided saying anything to alarm the relatives, and would almost certainly have asked whether they wished to talk to a doctor. Such a conversation would not necessarily be recorded in the patient's notes. The ward manager was not aware of any written guidelines about communication with patients and relatives, but said that all ward staff had attended courses which included that subject.

12. The clinical nurse manager (the CNM) said that she had not been able to find out whether the patient's relatives were told about her pulmonary embolism. She would have expected a nurse to have mentioned the embolism to the relatives. Any significant discussions should have been entered in the nursing records. The CNM said that the nurses might have assumed that the patient was capable of asking her own questions and informing her family. The nurses could not have foreseen the patient's death.

13. The Trust's deputy chief executive said that he accepted that communication between the ward staff and the patient's relatives must have been inadequate given their different perceptions of what had taken place. The Trust had recently begun auditing communication with patients, and two retired nursing officers were conducting telephone interviews with former patients. A working group had also been established with a remit to act as a source of expert advice to staff on the content and presentation of information to patients.

14. In her formal reply to the statement of complaint (paragraphs 1 and 2 of this report) the Trust's chief executive (who was not in post at the time of this complaint) wrote:

> `With the patient's permission the medical staff .... are very happy to discuss the patient's condition with relatives. Considerable discussions took place with the patient herself .... We are not aware of any request made by [the patient's] relatives to discuss [her] treatment further with any of the Doctors ....'

15. The chief executive said that staff were often placed in a difficult position as patients did not always want others to know about their condition. The Trust were taking various steps to improve communication. They included a review of patient information, the inclusion of information on communication in recruitment literature, questionnaires issued to patients, and incorporation of the subject of communication into training sessions.

Findings *(a)(i)*

16. On 1 February 1995 the registrar suspected that the patient had suffered a pulmonary embolism. However, he has said that she was not in immediate danger and stood a good chance of recovery. The first consultant has confirmed that her death could not have been foreseen. On balance, I do not consider that the medical staff warrant criticism for not telling the patient's relatives about the potential seriousness of her condition. Nonetheless, should the medical staff have told the complainant and her brother about the diagnosis? The first consultant has said that ideally a doctor should have told the family about the patient's condition, but a doctor's duty was to patients rather than their relatives. The registrar has explained that the patient would have been aware of her condition and would have been able to inform her family. He has also said that there was no specific rule about the responsibility for communicating with relatives, but the first point of contact was usually with the ward nurses. In the circumstance of this particular case, I consider that it was reasonable for the doctors to have relied on the nursing staff to have alerted them to any particular concerns expressed by the relatives. The Trust's deputy chief executive has accepted that communication between the ward staff and the patient's relatives must have been inadequate. I note with approval that the Trust are taking steps to improve communication and **I recommend** that they give guidance to medical staff on when they should reasonably be expected to communicate with the relatives of patients. Although I consider that there were some communication failures in this case, I do not uphold the complaint, as put, against the medical staff.

Complaint *(a)(ii) Flexibility of visiting hours not explained*

Evidence of the relatives

17. The complainant and her partner said that they were made to feel uncomfortable when, having travelled from Torquay on 3 February to see the patient, they arrived shortly after visiting time had finished. The nurses made it clear that they could stay only for a few minutes. As they were in Barnsley for the weekend they would have liked to have spent longer with the patient. They saw no posters or other information about alternative visiting arrangements. The complainant said that without such information or any indication by the ward staff to the contrary, she assumed that all visitors were restricted to normal visiting hours. The complainant's brother said that on a few occasions he visited his mother on his way to work in the morning before normal visiting time started. He was made to feel uncomfortable and in the way.

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comments

Case No. E.1312/95-96-Mislabelling of test result

Background and complaint

1. The account of the complaint provided by the complainant on behalf of his father was that on 15 February 1995 his father had an operation at Hammersmith Hospital, which is managed by The Hammersmith Hospitals NHS Trust (the Trust). A histology specimen taken during the operation was mis-labelled under the name of another patient, which resulted in the complainant's father's further treatment being based on an incorrect diagnosis. On 31 July the complainant's father had a second operation. The complainant complained to the Trust on 6 September about aspects of his father's care and it was only when they replied on 23 October that he learned that the specimen had been wrongly labelled.

2. The complaints investigated were that the Trust failed to:

a. take adequate steps to make sure that the complainant's father's histology specimen was correctly labelled;

b. check whether results of tests on the specimen had been received;

c. make sure that doctors knew of the error as soon as it was discovered; and

d. inform the complainant's father or his family of the error for several months.

Investigation

3. The Commissioner obtained comments from the Trust and relevant papers were examined, including the medical records of the complainant's father and another patient (the other patient). The Commissioner's investigator took evidence from the complainant, with his father present, and from Trust staff.

Background to the complainant's father's care

4. In February 1995 the complainant's father was referred to a consultant cardiologist (the consultant cardiologist) after an echocardiogram (heart scan) revealed a left atrial mass (a lump in one of the chambers of his heart). The scan suggested that the lump was a myxoma (a benign growth). On 15 February he was transferred to the care of a consultant cardiothoracic surgeon (the consultant surgeon) and the growth was removed. He remained under the surgeon's care while he was in hospital and until an outpatient appointment in April. At that appointment he was seen by the consultant surgeon's registrar (the surgical registrar) who arranged for him to have another scan. That scan was done in June and again showed a left atrial mass, but this time suggested that it was a thrombus (a blood clot). The consultant cardiologist re-admitted the complainant's father to hospital in July. He remained under the consultant cardiologist's care until his operation (to remove the second lump) on 31 July, when he was transferred to the care of a second consultant surgeon (because the original consultant surgeon was on holiday).

Complaint *(a) Specimen incorrectly labelled*

5. The complainant said that during the operation on 15 February a specimen of the growth was taken and sent to the histology laboratory for tests. On 6 September the complainant complained to the Trust about various aspects of his father's care. He asked why his father had not been given anti-coagulant drugs (to prevent blood clots) after the first operation. He considered that, particularly when the tests on the specimen had shown that the first growth had been a blood clot (not a myxoma as first thought), treatment with anti-coagulants then might have avoided the need for a second operation. He discovered, when the Trust replied in October, that the specimen had been mis-labelled. He was not satisfied that enough had been done to prevent similar mistakes in future.

6. The Trust's reply to the complainant dated 23 October said:

> `.... it appears that the histology specimen .... was unfortunately incorrectly labelled. In fact the label applied was that of a second patient operated upon that same day and the report was therefore filed incorrectly. In the absence of this histology report the cardiothoracic surgeons treated your father as having an atrial myxoma due to the cardiological

referral note stating that the mass was consistent with a myxoma. During surgery the mass also appeared to be consistent with these findings and therefore anti-coagulants were not prescribed.'

7. In formal comments to the Commissioner at the beginning of the investigation the Trust said:

> `.... [the other patient] did not have a histological sample taken. Sheets of pre-printed labels are kept in each patient's case-notes. In [the complainant's father's] case it appears that either the sheets of labels from the two patients had been put in the wrong case note folders or that a member of the theatre staff had used a label from the wrong patient's case notes. We were not able to identify the staff member who had labelled the specimen ....
>
> `As a direct result of [the complainant's] complaint the procedure for labelling specimens in theatre has been changed to include a check of the patient's name on the wrist band with the name on the label.
>
> `....
>
> `The Trust very much regrets the incident regarding the mislabelling of [the complainant's father's] specimen and has apologised to his family for this unfortunate event.'

Medical records

8. The records show that on 15 February the other patient underwent a double valve replacement operation in the same operating theatre as the complainant's father and immediately before him. Both men had been in the same hospital ward.

9. A nursing `theatre care plan', undated but referring to the complainant's father's operation on 15 February, had been left blank where the sending of a specimen and the names of nurses involved should have been recorded.

10. An entry in the complainant's father's medical records, referring to the operation on 15 February, said `large myxoma .... found .... sent for histology'. A register of specimens collected from theatres has a record on 15 February of a specimen from the other patient but not one from the complainant's father.

11. The histopathology department's records contained a request made on 15 February for examination of a myxoma. A label with the other patient's details was attached. The initials of a senior house officer in the consultant surgeon's team (the SHO) were entered in the space for a signature. A report on that specimen was issued in the other patient's name on 17 February 1995. When, in 1996, the Commissioner's investigator examined the medical records of the other patient she found that they still contained a copy of that report. A second copy of that report, with the other patient's name crossed out and the complainant's father's added in manuscript, was found in his medical records. The report said `Sections show acute thrombus .... without evidence of myxoma.' An identical report, headed by the complainant's father's name and personal details, was printed on 12 July 1995.

Trust policy

12. A Trust document, entitled `Operating Theatre Specimen Policy', described as having been reviewed in November 1995, says that `If a pre-printed label is used this must be checked against the identification of the patient.' An earlier version, dated January 1995, does not include that sentence. Neither version refers to a policy that only one set of notes should be in theatre at a time.

Staff evidence

13. The senior surgical registrar said that on 15 February 1995 he operated on the complainant's father to remove the growth, which had all the features of a myxoma. He would have handed it to the scrub nurse who would have given it to an operating department assistant (the ODA) to put in a container to be sent to the laboratory. The ODA may have labelled the container but the accompanying request form would have been completed by a member of the medical staff, who should have checked that the details were correct. (Note: the ODA has left the Trust and efforts by the Commissioner's investigator to contact him were unsuccessful.)

14. The consultant surgeon said that he assisted the senior surgical registrar during the complainant's father's operation. He gave similar evidence about the process when a specimen was taken. It had been the responsibility of the SHO to complete the request form. There were a number of ways the mistake in labelling the specimen might have happened. The wrong labels might have been filed in the complainant's father's medical notes - he had seen that happen on a number of occasions. Sometimes staff stuck labels from a patient's notes on the side of a trolley in theatre in preparation for labelling a specimen. The other patient did not have a specimen taken, so his labels might have been left on the trolley when the complainant's

father had his operation. The SHO might have failed to check the details, assuming that they were correct, as there should only ever be one set of notes in the theatre at any time. (Note: the SHO has left the Trust and efforts by the Commissioner's investigator to contact him were unsuccessful.) If they had known that the first growth was a thrombus not a myxoma he would have been prescribed anti-coagulant drugs.

15. The senior cardiac sister said that she was in the theatre because she was overseeing the specialist training of the scrub nurse during the complainant's father's operation. The ODA would have labelled the specimen container and put the patient's details on the request form. The scrub nurse was responsible for checking the ODA's work and when the SHO filled in the rest of the request form he should have checked that the patient's details were correct. She said that, as the scrub nurse was an experienced sister, she (the senior cardiac sister) would not have checked her documentation.

16. The scrub nurse said that she was responsible for checking that the specimen had been labelled correctly by the ODA, that the form had been completed accurately by a doctor and that the specimen and form were sent to the laboratory. The theatre care plan would have been filled in by the ODA during the operation and she had been responsible for checking that it had been completed properly. Each patient's medical notes should have left the theatre with the patient. There should not have been two sets of notes in the theatre at the same time. Staff should only take labels from the main file when they were needed, although she had known some staff remove a few labels for use during the operation. She would not have done that. She had no recollection of what had happened in this case. Now she always made sure that the doctors had checked the details on the form.

17. The consultant pathologist said that when a specimen arrived in the laboratory the labels on the specimen container and on the request form were checked to make sure they matched. If that had not been the case here, the person who signed the request form would have been contacted to check the details.

18. A statement prepared by the pathology business manager said:

> `In July 1995, [the consultant surgeon] was asking for the report on his patient [the complainant's father] with a clinical diagnosis of myxoma. We had no record of a sample from this patient. [The consultant surgeon] insisted that he had sent a sample. As the clinical diagnosis was not common, [we] conducted a search of the data base for this clinical diagnosis. The .... sample from [the other patient] was found. As this was the only myxoma specimen received in February, the surgeon declared this to be his missing sample .... .'

Findings *(a)*

19. It seems clear that in the theatre a label for the other patient was attached to the request form for the tests on the complainant's father's specimen. How did such a serious mistake occur? It is possible that some of the other patient's labels had been put into his file when the two men were in the same ward. It is also possible that the confusion occurred in theatre- perhaps because the other patient's records were left there during the complainant's father's operation. In either case checks by theatre staff should have identified and corrected the problem- but did not do so. The ODA apparently did not notice that the labels used did not match the patient on the operating table and neither did the SHO when he completed the request form. The scrub nurse either did not check that the details were correct or did not notice the mistake. The theatre care plan did not record that a specimen had been sent. I note that the operating theatre specimen policy has been changed to require an additional check that the specimen label matches the patient. If implemented diligently, that should reduce the risk of a similar mistake. **I recommend** that staff are reminded of the importance of checking that theatre documentation is accurately completed, that periodic audits of theatre documentation are carried out and that the policy of keeping records in theatre for only one patient at a time is formally documented. I uphold the complaint.

Complaint *(b) Failure to check whether results received*

20. The complainant said that he was told that the mistake was not discovered until July 1995. He was concerned that no one had checked to find out why a test result had not been received. Again he believed that that might have avoided the need for the second operation.

21. In comments to the Commissioner at the beginning of the investigation the Trust said:

> `The [labelling] error was not discovered until July when [the complainant's father] had further symptoms and [the consultant surgeon] suggested that the previous histology report should be checked ....
>
> `....
>
> `The Trust considers it likely that no check was made to see whether the results of the tests on the specimen had been

received. However, the registrar involved has now left the hospital .... . The consultant medical staff in the cardiothoracic unit now bring the importance of checking for results to the attention of all new junior staff.'

22. Entries in the complainant's father's medical records included the following:

8 March 1995-A letter to his GP from a registrar in the consultant surgeon's team, after his discharge from hospital on 24 February, said the diagnosis was a myxoma. It did not mention any histology test result.

19 April-A letter to his GP written by another surgical registrar said: `I reviewed this gentleman in the clinic today following excision of left atrium myxoma. He is doing reasonably well and he is recovering slowly from his operation. .... I have .... arranged for him to have an echocardiogram. He is going to be seen again in our clinic in three months time.'

20 June-An echocardiogram showed a mass, suggestive of a thrombus, in the complainant's father's left atrium.

7 July-A more detailed echocardiogram showed a thrombus. The complainant's father was re-admitted to hospital.

12 July-His clinical notes said: `On review of histology from [first] operation .... no evidence of myxoma. Clot only.'

23. The original report, filed in the other patient's notes, had not been signed or initialled by a reviewing doctor. It referred to the initial diagnosis (before testing) of myxoma as well as the new finding of a thrombus. It has the word `file' written on it (see paragraph 25).

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comments

Case No. E.1315/95-96-Patient care and communications with relatives

Background and complaint

1. The account of the complaint provided by the complainant was that on 8 January 1995 his mother was admitted in a confused state to Berwick Ward, at Eastbourne District General Hospital (the hospital). The hospital is managed by Eastbourne Hospitals NHS Trust (the Trust). The next day she was transferred to Pevensey Ward where she remained until she died on 27 January 1995.

2. The complaints subject to investigation were that while the complainant's mother was a patient in Pevensey Ward:

a. insufficient care was taken to make sure that she received adequate amounts of fluids;

b. nursing observations and care were often omitted (or not recorded) and a doctor's specific instruction on 11 January-to carry out observations every two hours-was not followed; and

c. no-one consulted the patient's family before instructions that she should not be resuscitated in the event of cardiac failure.

Investigation

3. The statement of complaint for the investigation was issued on 4 April 1996. (That statement was later amended and a revised version confirming the complaints set out in paragraph 2 of this report was sent to the complainant and the Trust.) It was explained to the complainant that the Commissioner would need to examine the circumstances to enable him to decide whether any part of the complaint concerned action taken solely in the exercise of clinical judgment which, at the time of the events complained of, was outside the Commissioner's statutory jurisdiction. The Commissioner obtained the Trust's comments and relevant documents, including the patient's clinical and nursing records, were examined. The Commissioner's investigator took evidence from the complainant and his brother, and the Trust staff involved. I have not put into this report every detail investigated but I am satisfied that no matter of significance has been overlooked.

Complaint *(a) Insufficient care taken to make sure the patient received adequate amount of fluids*

Evidence of the complainant and his brother

4. The complainant told the investigator that he, his wife and his brother visited his mother in hospital every day. A member of the family was always present from about 2.30 pm until the end of visiting time (9.00 pm), and sometimes as late as 10.00 pm. After her transfer to Pevensey Ward his mother was nursed on a mattress on the floor. He often found that her meals and unopened cartons of drink had been left out of her reach. He complained to nursing staff and asked if she was getting enough fluids. Staff said that she was not able to take anything. He therefore asked whether she could have intravenous (IV) fluids but was told that would be impractical while she was being nursed on the floor. He tried giving her drinks but she was unable to sit up and could not swallow. He said that his mother did not have IV fluids from the evening of 9 January until the late evening of 17 January at the earliest. By 18 January she had been placed in a bed and had an IV drip. The complainant acknowledged that the nursing records stated his mother had taken a small amount of fluids on 13 January (see next paragraph), but he thought that the records were inaccurate. The complainant's brother gave similar evidence.

The Trust's formal response

5. In the Trust's formal response to the Commissioner's office at the beginning of this investigation the chief executive wrote `.... The prescription chart confirms that IV 5% Dextrose was given over 8 hours on 9th January, 1995. This suggests that [the patient] was taking oral fluids in the interim period and an entry in the nursing records on 15th January, 1995 which states `` .... she has not eaten or drunk for 24-48 hours'' also indicates that she was drinking prior to that. The nursing records confirm that IV fluids were restarted on 15th January as per prescription. We did apologise to [the complainant] for the fact that we could not trace any fluid charts for 8th, 9th and 15th January 1995 because the inadequacy of the nursing documentation made it virtually impossible to carry out a satisfactory investigation [sic]. Nevertheless we do not consider the complaint .... is justified'.

Documentary evidence

6. The patient's clinical and nursing notes showed that she was sedated, drowsy and confused for much of her time in hospital, but was sometimes more alert and agitated. According to the drugs records she was not able to take oral medication on most days while she was in hospital. A nursing care plan prepared on her admission to hospital included `Assess with ADLs [activities of daily living] whilst unwell'. No other care plan was prepared while the patient was in hospital. She received IV fluids from 8 to 9 January and then from 15 to 26 January. Fluid charts were kept from 16 to 26 January. An evaluation sheet showed that she took a small amount of fluids on 13 January.

Staff evidence

7. The senior charge nurse said that he would have seen the patient every day that he was on duty and the nurses should have told him if there was a problem with her fluid intake. He could not explain why there was no care plan to deal with her problems with eating and drinking.

8. A student nurse (the student nurse) said that as the patient's care plan said `Assess with ADLs' staff should have noted whether she had been eating and drinking. She had made the entry on the evaluation sheet on 13 January (paragraph 6). An enrolled nurse (the first enrolled nurse) said that she did not think that the patient took oral fluids while she was on the mattress as she was not in a sufficiently conscious state to swallow fluids. It was for the doctors to decide whether or not to prescribe IV fluids. In theory, the patient's lack of consciousness and inability to swallow should have been recorded as a problem on the care plan.

9. A sister (the sister) said that when she came on duty on 15 January the patient was unconscious. Having seen that she was not drinking, the sister checked with other nurses but found it difficult to establish when the patient had stopped drinking. She referred the patient to the on-call doctor, who prescribed IV fluids. She made an entry on the special occurrence sheet but omitted to make one on the care plan. (Note: the entry made by the sister on the special occurrences sheet on 15 January said `I am concerned about [the patient's] condition as she has not eaten or drunk for 24-48 [hours]. IV commenced over 12 [hours]'.)

10. The clinical nurse manager said that if the patient was taking oral fluids between 9 and 15 January staff would not necessarily have recorded that. Fluid charts were not always used if a patient was sedated. She would have expected matters such as the patient's nutrition and fluid intake to be highlighted on the care plan with details of a proposed programme of care. There was no evidence one way or the other as to whether staff took steps to prevent the patient from becoming dehydrated.

11. A senior house officer (the first SHO) said that between 9 and 15 January doctors were carrying out tests on the patient. If she had been given IV fluids during that time they could have interfered with the tests. He would normally have seen the patient once a day during ward rounds and he would have relied on nursing staff to tell him if she was not receiving enough fluids.

Findings *(a)*

12. The records show that the patient received IV fluids from 8 to 9 January and then from 15 to 26 January, and that she took a small amount of fluids on 13 January. I am concerned that no record was made of any potential problems with her fluid intake, especially between 10 and 15 January when she was not receiving IV fluids. I would have expected staff to record any steps they took to make sure that the patient was able to eat and drink at times when she was not receiving those fluids. The Trust have acknowledged the inadequacy of the nursing documentation; and I comment on that further in paragraph 25. I do not consider that there is sufficient evidence to establish whether the patient did or did not receive adequate fluids. However, the absence of a proper care plan, the lack of certain fluid charts and the unsatisfactory nursing records together constitute a failure of care in this matter because there was no clinical management structure in place to make sure that such care was given. **I recommend** that the Trust give clear guidance to staff about the monitoring of fluid intake for patients who are sedated, drowsy or confused and also remind staff of the need to make full records about fluid intake. I uphold the complaint.

Complaint *(b) Nursing observations and care*

The complainant's evidence

13. The complainant said that he never saw anyone take his mother's blood pressure and temperature or give her drugs. He had made it clear to staff that he was not satisfied about the nursing care given to his mother. He had obtained his mother's records; and there was no record that a doctor's request on 11 January for two-hourly checks had been carried out. Also, there was no documentation of nursing care or observations after 10.00 am on 26 January.

The Trust's formal response

14. In the Trust's response to the Commissioner's office the chief executive wrote `We accept that the quality of nursing documentation was poor. Our Medical Services Manager suspects that the night nurses assessed that [the patient] was not in need of such regular observations and, having consulted the Night Sister, discontinued the observations. However, as there was no entry to that effect in the nursing notes we must accept that the doctor's instruction appears not to have been carried out. We have apologised to [the complainant] for this and informed him that the staff have been reminded of the importance of maintaining a contemporaneous and accurate record, including any prescribed care which is not given and the reason why'.

Guidance

15. Guidance issued in April 1993 by the United Kingdom Central Council (UKCC) for Nursing, Midwifery and Health Visiting - `Standards for Records and Record Keeping' - referred to the risk of care being omitted or duplicated if records were not kept satisfactorily and emphasised the importance of records as evidence that appropriate care was delivered.

16. The Trust's `Protocol for Patient Observations' stated:

> *`1. Base Line Observations on Admission*
> `Each patient will have blood pressure, pulse and temperature recorded twice daily for 48 hours from the time of admission. If the patient requires more frequent observations, this will be requested by the admitting doctor and communicated to the nurse assigned to the patient. The requesting doctor will record the frequency of observations required in the clinical notes.
>
> `It will be the responsibility of the assigned nurse to initiate, with the admitting/attending doctor, a review of observations after the expiration of the base line period.
>
> `Similarly after 48 hours, the frequency of observations will be decided by the nurse assigned to the patient and the attending doctor in response to the patient's condition and treatment ....
>
> `The responsibility for implementing this protocol will rest with the Ward Managers in respect of nursing staff and Consultants in respect of junior doctors'.

Documentary evidence

16. The clinical records showed that the patient was admitted to the hospital with possible hypothermia (low body temperature) and probable hypoglycaemia (deficiency of sugar in the blood), and that she was in need of rehydration. Her temperature was to be taken rectally and her blood sugar monitored (no frequency was stated). On 11 January there is a note requesting two-hourly observations after the patient had banged her head against a cupboard.

17. The nursing care plan included instructions to record blood sugar hourly while the patient was unstable; observe her condition closely and report any deterioration immediately to doctors; and to record temperature and blood pressure four-hourly. Other entries in the patient's nursing records showed that her blood sugar was measured twice on 8 and 9 January, and then once a day between 11 and 14 January. Recording stopped on 16 January. Her temperature was taken twice on 8 and 9 January, and then once on most days during the rest of her stay in hospital. Her blood pressure was taken on admission and then on 9, 10, 12, 18 (twice) and 21 January. There is no record of two-hourly observations being done on 11 January as requested in the clinical records, and there are no entries on the evaluation sheets for 11, 15, 23 or 26 January. The records showed that the patient's pressure areas were assessed regularly.

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comments

Case No. E.1344/95-96-Cancellation of a child's test at short notice, no new appointment offered

Background and complaint

1. The account of the complaint provided by the complainant was that her son has a vitamin B12 deficiency. He had not been allowed food or drink for 17 hours when he attended an appointment at the vitamin B12 Unit (the B12 unit) at Chelsea and Westminster Hospital (the hospital) on 19 December 1995 for a food absorption test. The hospital is managed by Chelsea and Westminster Healthcare NHS Trust (the Trust). Preparations for the test were completed at 2.30pm. At 5.00pm the complainant was told that the test would not take place because the chief executive of the Trust (the chief executive) had refused to meet the cost.

2. On 20 December the complainant telephoned the chief executive to complain about the cancellation. The complainant said that the chief executive told her that, as her son was having his last test before treatment, he would be offered another appointment for the test. The complainant wrote to the chief executive on 23 December asking for written confirmation. On 9 January 1996 the chief executive replied that the Health Authority responsible for purchasing the complainant's son's health care from the Trust (Western Surrey Health Authority, which was succeeded from 1 April 1996 by West Surrey Health Authority (the Health Authority)) were prepared to fund the test, so the chief executive had written to the consultant paediatric neurologist responsible for her son's care at the Trust (the consultant) and the doctor in charge of the B12 unit (the doctor) to see if they were prepared to admit the complainant's son; he was awaiting their reply. On 10 January the consultant wrote to the chief executive, and sent a copy of his letter to the complainant. He stated that the chief executive had known when he declined to reimburse the doctor for the cost of the test that the Health Authority had agreed to pay. On 9 February the chief executive wrote to the complainant saying that the future of the B12 unit had been discussed, but unresolved issues about the doctor's contract meant that the complainant's son's future treatment had not been decided. He suggested that an independent medical expert should assess the complainant's son's condition and advise whether the Trust should continue to treat him or refer him to another hospital. The complainant declined the independent assessment. She told my investigator that a new appointment had not been offered for the test to be carried out.

3. The complaints which I investigated were that:

a. there was a failure in service when the test was cancelled without warning;

b. conflicting explanations were given for that cancellation; and

c. the Trust had failed to offer a new appointment for the test to be carried out.

Investigation

4. The comments of the Trust were obtained and relevant documents were examined. One of my investigators took evidence from the complainant, the Health Authority, the Trust staff involved and the doctor. I have not put into this report every detail investigated but I am satisfied that no matter of significance has been overlooked.

National guidance

5. Where a patient (such as the complainant's son) seeks treatment from a provider unit (such as the Trust) which is not included in a contract with the purchasers of a patient's care-in this case the Health Authority-an arrangement may be made which is known as an extra-contractual referral (ECR). National guidance to the NHS on the handling of extra-contractual referrals was provided in September 1992 by the NHS Management Executive in a letter (EL(92)60). The guidance was reissued in February 1993 as a further letter (FDL(93)07). It included a booklet entitled: `Guidance on Extra Contractual Referrals' which states:

> ` .... The following general principles should be applied to ensure that systems for managing ECRs are sensitive to the needs of delivering good quality health care:

i. the procedures for handling ECRs should be simple, quick and non-bureaucratic .... ;

ii. any system for handling ECRs should complement, and not distort, good clinical practice in deciding to admit or make appointments to see patients;

iii. as far as possible patients should not be aware of the administrative process of managing ECRs .... '

Complainant's evidence

6. The complainant told my investigator that at 2.30 pm on 19 December 1995 she was told by the doctor that the equipment was set up for her son's food absorption test, and that he was now waiting for the chief executive to sign a form to proceed. She had not understood what he meant. Later that afternoon the consultant apologised to her and said that the chief executive had refused to sign the form. Until that point she had no idea that her son's treatment might be in jeopardy. The family went home quite distraught. The complainant said that, the following day, she telephoned the chief executive to complain. He said that because her son was due to receive his last test he would be treated as an exception and would be offered another appointment. The chief executive had given different explanations why the test could not take place. Initially the complainant thought it had been a question of funding, although she had been told by the consultant on the day of the cancelled test that the Health Authority were prepared to pay. She was then told that there were ethical questions about the B12 unit's work that had to be answered. Most recently she had been told there was a contractual problem between the doctor and the Trust. The doctor, she had been told, was not prepared to treat her son because the contract the Trust had offered to him was inadequate.

7. The complainant said that she was not prepared to let her son be treated elsewhere or to accept an independent opinion. She and her son were happy with the consultant's care and she did not see why she should be forced to make the change. A follow-up appointment had not been offered and she still did not know if treatment would recommence.

Evidence from the Health Authority

8. The Health Authority's ECR manager (the ECR manager) told my investigator that the complainant's son had originally been referred by his GP to the consultant. The consultant then referred the complainant's son for specialist treatment to the B12 unit and notified the Health Authority. This was a tertiary referral (normally a referral from a consultant responsible for a patient's care to another consultant) and, as far as the Health Authority were concerned, did not require the Health Authority's further approval.

9. The ECR manager said that the Health Authority's computer records showed that two notifications of referral had been received for the complainant's son: in April and July 1995. He said that only one notification had been needed for the Health Authority to pay for the entire course of care. Finance department records showed that the Children's Medical Charity (the Charity) had invoiced the Health Authority for the April referral. The money allocated by the Health Authority for the second referral had not been paid because no invoice was received. The ECR manager was not sure whether he had discussed the ECR with someone from the hospital by telephone in December 1995 (see paragraphs 10 and 12).

Evidence of the chief executive

10. In the Trust's formal response to the statement of complaint, the chief executive wrote:

> `The Vitamin B12 Unit is part of the Academic Department of Child Health of Charing Cross and Westminster Medical School [(the Medical School), which is outside my jurisdiction as Health Service Commissioner] .... Until the middle of 1995 the unit was funded by the [Charity who] reimbursed the Medical School for the staff salaries .... The work of the B12 unit is not an integral and mainstream part of the children's services which are managed and run by this hospital Trust ....
>
> `On 16 August 1995 the Press Association released statements extensively quoting [the doctor] who indicated a link between vitamin B12 deficiencies and autism and other neurological disorders in children .... which brought the work of the unit to the attention of the Trust management. This was followed by an approach from [the doctor] saying he now had 300 referral letters and asking whether the Trust would invest in the unit in order that these referrals could be tested and treated.
>
> `By this time some individual complaints had been received from parents of children who had been tested and treated by the unit and it was clear that because the work of the unit was not an integral part of our

services many of the junior doctors and nursing staff caring for the children were not properly aware of the work of the unit .... It also became clear that no papers had been published in peer review journals establishing any link or the possibility of any link between vitamin B12 and neurological disorders and that before arranging the testing of 300 children whose parents had their expectations raised by media coverage the Trust should ensure that the work of the unit was subject to independent peer review. It also became apparent at the end of October 1995 that there was no current ethical approval by the Riverside Research Ethics Committee relating to any work of vitamin B12 and children. Accordingly on 8 November 1995 the Trust wrote to the medical school and [the doctor] laying down certain conditions which were to be fully met before the Trust would consider future funding arrangements.

`It was while the Trust was awaiting a response to this request that the first complaint regarding [the complainant's son] was raised .... At lunch time on 19 December [the doctor] spoke to my secretary demanding a letter of permission to treat [the complainant's son] .... I wrote a letter saying it was a clinical decision of the responsible consultant .... and that I was quite happy for the child to be tested if [the consultant] agreed. I noted in my letter that it should not be taken as agreement to pay any charges which might be levied. In saying this I was bearing in mind the scale of costs which had been previously submitted to the Trust from [the doctor] earlier on that month. Such charges had never been agreed with the Medical School although they were submitted on the Medical School letterhead. Upon receipt of my letter [the doctor] advised [the consultant] that I had refused to approve funding for the test and consequently the parents were advised and the child was discharged .... [The doctor] informed me on the afternoon of the 19 December 1995 that he had spoken to [the Health Authority] and they had approved an ECR for [the complainant's son]. It is the Trust's view that by accepting charges from [the doctor] and then invoicing [the Health Authority], the Trust [would be] recognising the B12 unit as one of its services without the unit having met the conditions it had previously laid down in November. ECR approvals are not normally given verbally to doctors and upon checking the following morning [the Health Authority] indicated they had not given firm approval on 19 December [but] had informed [the doctor] of their procedure for a rapid turnaround ECR approval.

`The B12 unit was under review from the time of the letter dated 8 November which was sent to the Medical School and to [the doctor]. [I] had not been alerted to the fact that [the complainant's son] was returning for further testing on 19 December 1995. The time scale had afforded [the doctor] over one month to respond to the Trust's requests for certain information but this had not been forthcoming. I responded to [the doctor's request] for written authorisation to carry out the food absorption test on the day of request. I was unable that day to contact [the consultant] .... and I explained to [the doctor] that it is difficult for a manager to interfere in clinical decision making. I confirmed on the day of [the complainant's son's] test that I had no objection [to] the food B12 absorption test being carried out if it was on the instruction of [the consultant] or his registrar, that is, if it was being managed by medical employees of this Trust. I went on to explain that the letter should not be construed as agreeing to any financial charges for such a test to be carried out and that as [the doctor] was aware, that issue was the subject of separate correspondence between myself and the medical school.

`[The complainant] was misinformed by being told that I had cancelled [her son's] test .... in the knowledge that [the Health Authority] had agreed to fund it ....

` .... [I] discussed the events [of] 19 December with the Chairman and Medical Director of the Trust. It was agreed that consultants in the Trust be asked to make no further referrals to the B12 unit until the conditions set down by the Trust in its letter of 8 November had been met ....

`The Trust Board decided on 25 January 1996 that it would not renew [the doctor's] full honorary contract until its conditions had been met. The Trust recognised that this may take some considerable time, and wanted to initiate arrangements for children such as [the complainant's son], whose testing had been interrupted, to have their testing resumed.

`Three members of the [Trust] Board met with [the complainant and her husband] on 23 February 1996, and on 26 February 1996 I wrote to the Medical School offering a restricted contract for six named children.

[Note: I have seen that the complainant's son was one of the children named.] Following further correspondence, the Medical School agreed our proposed contract on 13 March 1996. A detailed contract was handed to [the doctor] on 18 March 1996, and I await his decision on whether to accept and sign the

contract, so that [the complainant's son] may have his testing resumed ....' [Although there have been further discussions, at the time that this report is issued I understand that no contract has been agreed.]

11. When interviewed by my investigator the chief executive said that he had written to the secretary of the Medical School on 8 November 1995 and to the doctor on 24 November. The letters set out the conditions that had to be met before the Trust could consider investing in the B12 unit, and formed part of discussions about the terms of an honorary appointment that might be offered by the Trust to the doctor. (I have seen copies of both letters and I set out extracts from the 24 November letter in the Appendix.) The letter of 8 November set four conditions which would have needed to be met for an extension to the terms of the doctor's honorary appointment with the hospital. The letter dated 24 November (see the Appendix) to the doctor set out five terms in greater detail. The chief executive said that all the conditions needed to be met. There was no suggestion in either letter that the Trust could be invoiced for B12 unit services before those conditions were met. The chief executive said that the Trust had never previously made payment to the doctor and had always assumed his work was funded research. The setting of conditions did not imply that the Trust had found the doctor at fault. They were safeguards the Trust considered to be necessary for its patients. The chief executive said that he had no intention of stopping the Trust's contact with the B12 unit at that time.

12. On 19 December 1995 the doctor asked the chief executive to agree payment for the complainant's son's test. Such requests were not normal practice-the chief executive thought the letter of 24 November had probably put the doctor on his guard. The chief executive agreed to the test (subject to the consultant's approval) but not to funding. Later that day, the doctor told the chief executive that he had telephoned the Health Authority, and they had agreed to pay for the test. The chief executive had thought that unlikely-it was not usual to approve such requests by telephone. He remained reluctant to agree to pay for the test: for the Trust to invoice the Health Authority was to imply that the B12 unit was one of the Trust's services before all the terms of the honorary appointment had been met. When he telephoned the Health Authority the following day-to see what could be done to allow the test to take place-the ECR manager told him that he had not given approval to the doctor the previous day but said that the treatment could be carried out under the previous ECR approval. The problem was not simply a question of money, although that was the impression that the clinicians had conveyed to the complainant. During a second interview with my investigator he accepted that the complainant's son would not have been given a hospital admission date unless the Health Authority was prepared to fund his care by the consultant. He later added that the Trust had a block contract with the Health Authority for paediatric admissions including those of the consultant. The admissions office would not seek specific authority in such cases: the chief executive had not been sure that the funding extended to the services of the B12 unit.

13. The chief executive said that to overcome the problems with the invoicing arrangements he agreed on 20 December with both the Health Authority and the Medical School that the Medical School would invoice the Health Authority direct. He did not, however, know that the complainant's son had been discharged. The chief executive said that he wrote to the doctor on 9 January 1996 setting out the financial arrangement on which the test could go ahead as an exception to the restriction, which was by then in place, on referrals to the B12 unit. However when the Medical School received a copy of that letter the Medical School's Secretary replied in a letter dated 11 January that he had agreed to the exceptional arrangement `under pressure of the events of that day', and was no longer prepared to invoice the Health Authority. Because of that, and because the Trust would not agree to be invoiced for the B12 unit's services while the conditions laid down in the letter of 24 November remained unfulfilled, the complainant's son's test did not go ahead before the doctor's honorary appointment at the hospital for research purposes expired on 31 January 1996. The chief executive said that with hindsight he could have done more to arrange the test before then.

14. The chief executive said that he was concerned that the complainant's son's test had been used to pressurise the Trust into collecting money from health authorities on behalf of the B12 unit. That practice was not acceptable and had led to his decision to stop the Trust's involvement with the B12 unit until matters were resolved.

15. The chief executive thought that all the information he had given the complainant about the reasons why her son's test could not take place was correct. Funding was an issue on the day, to the extent that he was not prepared to collect the money on the B12 unit's behalf until the conditions laid down in the November 1995 letters were fulfilled. The contractual issue between the Trust and the doctor had not become clear until the doctor's honorary appointment had expired on 31 January 1996. Since then the contractual issue was relevant because the Trust were seeking special arrangements to treat the complainant's son under a limited contract. He added that all of the conditions set down in the letters in November 1995 had not been met by the doctor. Because of disagreements about the necessity for some of the conditions, the doctor would not agree to the appointment terms.

comments

Case No. E.419/96-97-Trust's communications with a patient's GP and complaint handling

Background and complaint

1. The account of the complaint provided by the complainant was that on 18 August 1995 he attended North Tyneside General Hospital (the hospital) for tests. On 1 September he learned that he had been removed from the list of his general practitioner (GP). The GP told him that he had received a letter of complaint from the Pathology Department of the hospital about the complainant's conduct on 18 August. The hospital is managed by the Trust.

2. The complainant wrote to the Trust on 19 September asking for information about the complaint which had been made against him. The Trust replied on 10 October that an investigation had been carried out and confirmed that they had written to the GP because of the complainant's threatening behaviour on 18 August. The complainant continued to request details of the allegations and investigation, and to deny he had behaved in a threatening manner. On 15 March 1996 he told the Trust that he was willing to attend a meeting. The Trust replied that they had no reason to question the recollection of their staff and that they could no longer be of assistance. The complainant remained dissatisfied.

3. The complaints subject to investigation were that:

   a. the Trust conveyed to the GP unsubstantiated allegations about the complainant's behaviour; and

   b. the Trust's handling of the complainant's complaint was unsatisfactory.

Investigation

4. The statement of complaint for the Commissioner's investigation was issued on 5 August 1996. The Trust's comments were obtained and relevant papers were examined. The Commissioner's investigators took evidence from the complainant and the Trust staff involved. Evidence was also obtained from the GP, whose actions at the time of the events complained about were outside the Commissioner's jurisdiction. I have not put into this report every detail investigated but I am satisfied that no matter of significance has been overlooked.

Complaint *(a) Unsubstantiated allegations conveyed to the complainant's GP*

Complainant's evidence

5. In his letter to the Commissioner the complainant said in part:

> `.... I regard the .... Trust .... to have had a total disregard for a customer's i.e. myself, basic right of a defence of my character.
>
> `This whole experience arose when my employer required that I have a salmonella test and immediately obtain the results before I would be allowed to return to my work place, which happened to be in the offshore oil industry. The time scale was so tight that I only had 4 working days, weekend excluded, to organise and report back with the test results. I managed to obtain samples and to save time I took them directly to the pathology Dept .... where I emphasised that I needed the results urgently to be able to get back to work ....
>
> `Unbeknown to myself the receptionist [(the receptionist)] at [the hospital] had taken offence at me and reported to her superior that I used threatening behaviour.
>
> `Now instead of the superior investigating this matter and dealing with me direct a defamatory letter was sent to my GP. The exact contents I cannot relate as I have not been allowed a copy of this letter, but according to my G.P. (Ex) it accused me of using threatening behaviour, but in no definition.
>
> `My G.P. (Ex) then decided to refuse to have me on his N.H.S. list and I have since been refused admission to another 2 surgeries ....'.

6. The complainant told the investigators that he went to the Pathology Department on Friday 18 August 1995 with his 11 year old daughter. He handed the samples to the receptionist and asked her how long the results would take because he needed them as soon as possible. The receptionist said that the results would be ready by Monday and would be sent by courier to his GP. The complainant told the receptionist that if the results were not ready he would `come back and see you'. By that he meant he would come back to get the results himself because they were needed urgently.

7. The complainant said that he was in the Pathology Department for no more than five minutes. He had no idea why the receptionist thought he was threatening: it could have been either because of his size or because of the tone of his voice. The complainant acknowledged that at times his manner could be abrupt. He did not gain the impression from the receptionist that anything was wrong. He said that he would never exhibit any threatening behaviour in front of his daughter because it would shock her.

8. The complainant said that when he later returned home from the oil rig he found a letter dated 1 September 1995 from Newcastle and North Tyneside Health Authorities (the Health Authority) telling him that he was being removed from his GP's list. He telephoned the GP who told him that he had received a letter from the hospital complaining about the complainant's behaviour in the Pathology Department. The GP did not mention any subsequent conversation he had had with a member of staff at the hospital. The complainant said that initially he did not try to get on another GP's list because he hoped to be reinstated by the GP. He later tried two or three other surgeries who refused to take him when he explained why he was changing his doctor. The last surgery advised him not to tell the next surgery why he was changing doctors. He took their advice, and he was accepted at the next practice which he tried.

The Trust's formal response

9. In the Trust's response to the Commissioner the then acting chief executive wrote: `.... The Trust has maintained its view that the member of staff felt threatened by the conduct of [the complainant], and in particular by a remark to the effect that he would be back to see her if certain test results were not ready by the following Monday. There is no evidence to suggest that the receptionist was not telling the truth when she reported this matter to her senior colleagues. Following this incident [the] G.P. was asked to ensure that patients be asked to have a realistic understanding of the turnaround time for test results. The question of removal from the list of the G.P. was entirely a matter for [the GP] and not the Health Care Trust ....'.

The letter to the GP

10. The letter to the GP in question was dated 22 August 1995 and was written by the biochemistry departmental manager (the departmental manager). It read: `I am writing to you concerning the threatening behaviour shown by a patient on your list, [the complainant] .... towards one of our reception staff. [The complainant] was bringing in some .... samples .... on Friday afternoon 18th August and threatened the member of staff on reception that he would be ``back to see her'' if the results were not ready by Monday. Clearly, his behaviour is unacceptable. Please could you ensure that patients have a realistic understanding of the turn-round times for tests required on their behalf ....'.

Evidence of the staff

11. The receptionist told the investigators that the complainant was quite pleasant when he first arrived in the Pathology Department. His attitude changed when he found out how long the tests would take: he expected the result to be ready the next day and he did not seem satisfied that it would take two to three days. He said `mind, if you say 2-3 days, I expect it to be 2-3 days'. The receptionist smiled and said `don't worry, it will be ready'. The complainant replied `mind, if it's not ready in 2-3 days I'll be back to see you and whoever is doing the test'. The receptionist said the complainant was not shouting but spoke in a very firm voice with a threatening tone. There was no other member of staff in the room at the time.

12. The receptionist said that she was worried that the complainant might return. She believed that he would not be very happy if he came back. The matter was reported to the departmental manager, who told the receptionist to complete an incident form. (Note: The incident form prepared by the receptionist and dated 18 August 1995 read: `Patient had a bad attitude towards me. Threatened to come back to me if his results weren't ready on time.')

13. The receptionist explained to the investigators that she had not been too upset by the incident, but she had been worried and afraid that the complainant would return when the other receptionist was on duty. She said that the departmental manager did not tell her at the time that she was going to write to the GP. The receptionist was surprised to learn that the GP had removed the complainant from his list.

14. I have seen an incident report form dated 22 August 1995 which was completed by the departmental manager. It read: `....

I spoke to [the receptionist] immediately afterwards, she was not distressed .... I also wrote to [the GP] reporting this incident ....'.

15. The departmental manager said that the receptionist had a calm and confident manner. This was the first incident which had ever upset her. The departmental manager said that she decided to write to the GP to prevent his patients coming to the Pathology Department with misconceptions about when their test results would be ready: she had been under the impression that the complainant had been given wrong information at the GP's surgery. She also wanted to inform the GP in case the complainant's behaviour had been relevant to his diagnosis. A further reason for writing was to show staff that she supported them. She did not write to the complainant because certain people were anxious when they attended the Pathology Department and his behaviour might have been uncharacteristic.

16. The departmental manager said that the GP later telephoned her and asked how the receptionist was. The departmental manager replied `okay, not hugely distressed, but alarmed'. The GP then said that the complainant was also like that with everyone at the surgery and that he would remove him from his list. The departmental manager gained the impression that as far as the GP was concerned the incident was `the last straw that broke the camel's back'. During her telephone conversation with the GP the departmental manager did not raise her concern about patients having an unrealistic idea of when their test results might be available because the GP did most of the talking.

The GP's evidence

17. The GP told the investigators that in his 17 years of general practice he had never received a letter similar to the one from the departmental manager. He thought that it was a letter of complaint about the complainant, and he believed that the Trust felt very aggrieved by the complainant's behaviour. He confirmed that he telephoned the departmental manager because he wanted to clarify the situation which he thought must have been serious to warrant sending the letter. The departmental manager told him that the receptionist felt personally threatened. The departmental manager might also have said that more than one member of staff had been involved. The GP told the investigators that he had been concerned that a member of staff had been threatened; and he might have mentioned to the departmental manager that he would remove the complainant from his list. He would not have removed him from his list if he had not received the Trust's letter. The GP said that the complainant had never been aggressive either to the GP or to any member of his staff.

Findings *(a)*

18. The complainant has complained that the Trust conveyed to the GP unsubstantiated allegations about his behaviour towards the receptionist when he attended the Pathology Department on 18 August 1995.

19. The complainant and the receptionist have a different impression of events. The complainant said he had no idea why the receptionist thought that his behaviour was threatening; and that his remark to her that he would come back and see her if his test results were not ready merely meant that he would return and collect the results himself. He has acknowledged that at times his manner could be abrupt. The receptionist's evidence about what the complainant said is not significantly different; but she said he spoke in a threatening tone. In evidence, she said that she had not been too upset by the incident but had been worried that the complainant would return when the other receptionist was on duty.

20. At this remove, I cannot establish the manner in which the complainant spoke to the receptionist. However, I am not persuaded that there was sufficient evidence to justify the type of phraseology used in the departmental manager's very short letter. The departmental manager has maintained that one of the main purposes of writing to the GP was to prevent his patients coming to the Pathology Department with misconceptions about when their test results would be ready. If that is so, that concern could have been more clearly expressed. As it stands the letter lacks balance. I consider that before writing the letter in the terms they did the Trust should have raised their concerns with the complainant and have given him the opportunity to respond.

21. In the circumstances, I can understand why the letter caused the GP concern. I am disturbed that during his subsequent telephone conversation with the departmental manager there appears to have been a failure in communication. The departmental manager gained the impression from the GP that similar incidents had occurred at the GP's surgery. In his evidence the GP said that the complainant had never been aggressive at his surgery. Although the Trust cannot be held responsible for the GP removing the complainant from his list, it is evident that the removal was a direct consequence of the departmental manager's letter. I uphold this complaint to the extent indicated.

Complaint *(b) The handling of the complaint was unsatisfactory*

22. An appendix to this report sets out a chronology of the main events and correspondence.

comments

Case No. E.587/96-97-Response to request for access to records

Background and complaint

1. The account of the complaint provided by the complainant was that on 3 September 1994 she gave birth at home to a daughter. During the delivery she was attended by two midwives from Greenwich Healthcare NHS Trust (the Trust). The baby was admitted at once to Greenwich District Hospital (the hospital) where she died the next day. The hospital is managed by the Trust. On 23 November 1994 the complainant was allowed to see the records of her delivery at home and the baby's treatment in the hospital, and on 29 November after a meeting with the consultant paediatrician (the first consultant) responsible for the baby's treatment in the hospital, she was given copies of the records. On 16 December she asked for corrections to be made to the records. After meetings and correspondence, on 24 October 1995 a friend of the complainant, complained to the Trust on her behalf about aspects of her care and treatment during her labour and the response to her requests for alterations to the records. The chief executive replied on 9 November but the complainant remained dissatisfied.

2. The matters investigated were that:

a. hospital staff insisted the complainant should meet the first consultant before they would give her copies of the records, and the first consultant's manner towards her at the meeting was intimidating; and

b. the Trust's response to the complainant's request for a correction to the record of the baby's treatment in the hospital was dilatory and inadequate.

Investigation

3. The Commissioner obtained comments from the Trust and relevant documents, including the complainant's midwifery records and her baby's paediatric records, were examined. The Commissioner's staff took evidence from the complainant and her husband, the complainant's friend, Trust staff and the chief officer of Greenwich Community Health Council (the CHC). I have not put into this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An appendix summarises the main events and correspondence relevant to the second head of the complainant's complaint.

Statutory background and guidance

4. The Access to Health Records Act 1990 (the Act) gives individuals the right of access to information about themselves in records made on or after 1 November 1991 in connection with their care by health professionals. Applications for access are to be made in writing and the Act sets out circumstances in which access to all or part of a record may be refused. These include cases where the record contains `information likely to cause serious harm to the physical or mental health of the patient or of any other individual'. Where access is agreed, the applicant is to be allowed to view the record and may ask for a copy. Section 6 of the Act provides that:

1. Where a person considers that any information contained in a health record .... is inaccurate, he may apply to the holder of the record for the necessary corrections to be made.

2. On an application under subsection (1) above, the holder of the record shall-

a. if he is satisfied that the information is inaccurate, make the necessary correction;

b. if he is not so satisfied, make in the part of the record in which the information is contained a note of the matters in respect of which the information is considered by the applicant to be inaccurate; ....'

5. Guidance issued by the then NHS Management Executive in August 1991 states that when an application for access to records is received the holder of the records should send them to the appropriate health care professional, who should advise on:

`whether access should be allowed or limited to prevent the disclosure of seriously harmful information ....

`whether it is necessary for the health professional to be present when the record .... is inspected (in order to provide any explanation or counselling) or if this can be supervised by a lay administrator;'

6. The Trust's code of practice on access to health records, issued in May 1994, states that the manager dealing with an access application is to pass the record, together with a progress sheet (a form for monitoring the progress of an application under the Act), to the health care professional in charge of the case, `for advice on disclosure of information, and any counselling arrangements thought to be necessary'. The progress sheet makes provision for the health care professional to indicate the extent of access to be granted and whether counselling is required. The code states that `in the event of a patient wishing to make a complaint relating to the completeness and/or accuracy of a record .... the patient should be advised of the Trust's Complaints Procedures.'

Complaint *(a) Insistence that the complainant meet the first consultant and his manner at meeting*

Evidence of the complainant and her husband

7. The complainant told the Commissioner's staff that during September 1994 she wrote to the Trust's community midwifery manager (the midwife manager) seeking access to the record of her delivery at home and her baby's treatment in hospital. She then made several telephone calls to the hospital to check on progress. At no time during these was it suggested that she would have to meet the first consultant before the records would be released. The complainant and her husband viewed the records on 23 November 1994 in an office at the hospital. A woman, who was not introduced to them, sat nearby while they looked at the records. After they returned home the complainant thought that she remembered seeing something in the records about her having refused hospitalisation. She therefore arranged to see the records again and went to the hospital for that purpose a few days later. On that occasion she saw only her own records and was told that her baby's records were with the first consultant. There was nothing in her records about her having refused hospitalisation so she then asked for copies of both sets of records. The Trust's records manager (the records manager) told her that the first consultant would have to give his consent before she could receive copies of the records. In a telephone conversation the first consultant's secretary (the secretary) told the complainant that it was up to the first consultant whether she received a copy of the records and he wanted to meet her before he decided whether to hand them over. She did not mention counselling. The secretary made an appointment for 29 November 1994. The complainant understood from what the records manager and the secretary said that if she did not attend the meeting she would not be able to obtain copies of the record.

8. The complainant and her husband said that when they went to the hospital on 29 November 1994 they were kept waiting in the children's ward until the first consultant arrived. The complainant found that very distressing as she could hear children and babies crying. They met the first consultant in a side ward and had to sit on beds during the meeting. The first consultant began by asking what he could do for them. The complainant had to remind him that it was he who had called the meeting and that they had read the notes and wanted copies. The first consultant told them that it was an unusual request and asked why they wanted the records and what they intended to do with them. He asked whether it was their intention to sue him. The complainant told him that she was satisfied with the care and treatment given to her daughter but that she believed the notes might be inaccurate. The complainant found the consultant's manner intimidating: he was abrupt and matter of fact until she said that she did not intend to sue him, then his attitude changed and he no longer appeared to be interested in the meeting. His behaviour had been different at a previous meeting, on 28 September. Then he had been calm and gentle; he had spoken to them in soft tones and his body language had been more relaxed. The complainant's husband believed that the consultant made a deliberate attempt to intimidate them by seeing them in a side ward and making them wait in the main part of the children's ward until he arrived. The meeting on 28 September had been held in an office.

Staff evidence

9. The records manager told the Commissioner's staff that the records department did not hold a copy of the Trust's code of practice on access to medical records (paragraph 5) and the progress sheet to which it referred was not used. When an application for access to health records was received, the application form was attached to the front of the medical records together with a compliments slip and passed to the relevant clinician for advice on disclosure of information. If the clinician agreed that access could be given, he or she signed the compliments slip and returned the documents to the records department. (The compliments slip for the complainant's request could not be located by the Trust). The records manager said that she had no recollection of telling the complainant that unless the consultant gave his permission she would not be able to see her records. However, the clinician's permission was always sought before access to records was granted and she explained that when answering telephone enquiries. In the complainant's case, permission for access to the paediatric records was sought from the first consultant and permission for access to the midwifery records was sought from a consultant obstetrician (the second consultant).

10. The secretary said that it was unusual for patients to ask to see their own records. Such requests normally came from solicitors. She could remember nothing about her telephone conversation with the complainant.

11. When asked to respond to the complainant's complaint to the Commissioner the first consultant wrote in relation to his request to meet the complainant:

> `It is .... good practice for paediatricians to counsel parents following the death of a child, and I think that I was simply seizing an opportunity to attempt to do that ....'

In relation to the suggestion that he found a request for a copy of the records unusual and wanted to know whether he was to be sued, he wrote:

> `I think this is probably substantially correct. I think it was reasonable for me to enquire whether legal action was to take place .... I would absolutely deny that I was placing any pressure on the parents. I was in no way refusing to give them the notes, but merely asking them what the purpose was of them having the notes. I would absolutely refute the suggestion that I was intimidating. It is not in my nature to intimidate parents. It is of course possible that the parents nevertheless felt intimidated, though I am not sure why. If that is the case, then I am sorry that I made them feel so.'

12. When interviewed by the Commissioner's staff the first consultant said that he had no recollection of being approached when the complainant first asked to see her baby's records. Her request for a copy of the records surprised him as it was the first time that he had received such a request from a parent rather than from a lawyer. The request made him feel uneasy because, in his experience, copies of notes were only requested by persons considering legal action. He decided that before he handed over the records he wished to see the complainant to try to establish why she wanted them. He did not know in what terms that message was conveyed to the complainant but he told the secretary that he wanted to hand over the records personally and she should have made it clear to the complainant that he wanted her to come into the hospital to see him. A meeting would also provide the opportunity to talk through what had happened at the birth and explain the notes. When he had met the complainant and her husband on 28 September they had seemed to be in a state of shock. On 29 November, his impression was that once the complainant had received the notes she did not see the need to continue the meeting. The meeting had been held in a room in the children's ward because he had thought that it would be inappropriate and upsetting to bring the complainant and her husband back to the special care baby unit and no other space was available that day. The first consultant said that he had not intended to be intimidatory at the meeting and was willing to apologise if that was how he had been perceived. He had been anxious to know why they wanted the notes and what action they intended to take. He accepted that he had been relieved when the complainant told him that she did not intend to take legal action.

13. In his official response to the Commissioner the chief executive wrote:

> `From the records there is no indication that staff `insisted' that [the complainant] should meet with [the first consultant] before having copies of the notes. It is normal practice to `suggest' the patient sit with a clinician or someone else who is able to explain the complexities of what is often written in medical notes before copies are made for the patient.'

When interviewed by the Commissioner's staff the chief executive said that he could not explain why the standard forms contained in the Trust's code of practice for access to health records were not being used by the records department. He considered that it was inappropriate to use compliments slips and said that that would be rectified as part of a risk management review which was underway at the Trust. Unnecessary barriers should not be put in the way of patients wishing to exercise their right of access to their records. There might have been legitimate reasons for the first consultant wanting to meet the complainant before he handed over the records. However, if the first consultant merely wanted to allay his fears about legal action that was an inappropriate reason for a meeting. He did not believe that the first consultant had set out to intimidate the complainant and her husband but, on the basis of their evidence, the first consultant's manner might have been open to misinterpretation.

Findings *(a)*

14. The first consultant said that he thought he had sought a meeting as an opportunity to counsel the parents following the death of their child. The complainant and her husband were allowed to see the records without counselling or explanations being provided. Only when they asked for copies of the records was a meeting suggested. There is no evidence that the complainant was told that counselling was the purpose of the meeting. Nor, when the meeting took place, was any counselling offered. The first consultant has admitted that he was anxious about the possibility of legal action and wanted to know why the complainant and her husband had asked for copies of the records. I conclude that that was his main reason for seeking a meeting. The Act does not require applicants such as the complainant and her husband to give reasons for requesting access to

records and I share the chief executive's view (paragraph 12) that it is inappropriate to seek a meeting for that purpose. As to whether staff insisted the complainant should meet the first consultant before they would give her copies of the records, her recollection is that she was told that it was for the first consultant to decide whether she should be given copies of the records and that he wished to see her before he made that decision. I see no essential conflict between that recollection and the record manager's account (paragraph 8) of how she would respond to telephone enquiries about access to records and the first consultant's account (paragraph 11) of the message which he told the secretary to convey to the complainant. Given what hospital staff said to her, I consider that it was reasonable for the complainant to infer that a meeting with the first consultant was being made a precondition for her receiving a copy of the records.

15. The meeting on 29 November, unlike the earlier meeting with the first consultant, took place in a room in the children's ward and the complainant found that distressing. The first consultant has said that he was worried the complainant might be contemplating legal action and relieved when she said that she was not. Both the initial concern and the subsequent relief were apparent to the parents. I criticise the first consultant for allowing such considerations to affect his behaviour so markedly in a meeting with recently bereaved parents. He has said that he did not intend to be intimidating and apologises if that is how he was perceived. Whatever his intentions, I find that given the basis on which the meeting was called, the surroundings in which it was held, and the first consultant's obvious preoccupation with the possibility of legal action, it was entirely understandable that the complainant should have felt intimidated.

16. **I recommend** that the Trust:

a. remind clinicians of what action they can properly take when approached to give advice on applications under the Act; and

b. make sure that when those making applications under the Act are asked to attend a meeting they receive a clear explanation of its purpose.

I uphold both aspects of this complaint.

Complaint *(b) Response to request for corrections dilatory and inadequate*

17. An appendix to this report summarises the main events and correspondence.

18. The complainant told the Commissioner's staff that she considered the Trust had been insensitive in making them wait so long and attend so many meetings before agreeing to amend the records. When the Trust said that they could not contact the senior house officer who had written in the paediatric notes (the SHO) the complainant's husband decided to make his own enquiries. He contacted the General Medical Council (GMC) who gave him an address for the SHO in Australia. After some further enquiries he traced the SHO to a hospital in Wales and spoke to him on the telephone. The ease with which he was able to contact the SHO made them think the Trust had made no serious effort to do so. They considered that it was only their action in contacting the SHO and their friend's pressure which led the Trust to accept that what was stated in the records was untrue. Without such pressure the Trust seemed disinclined to take any action.

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comments

Case No. E.591/96-97-Convener's decision not to convene an independent review panel

Background and complaint

1. The account of the complaint provided by the complainant was that on 29 January 1996 the North Staffordshire Community Health Council (the CHC) complained on his behalf to North Staffordshire Hospital NHS Trust (the Trust) about the care and treatment received by his mother, at North Staffordshire Hospital (the hospital), which is managed by the Trust. The complainant complained that on 18 November 1995 a consultant neurosurgeon (the consultant neurosurgeon) told the complainant's mother's family that tests, which she required before surgery could be considered, would not be carried out because no intensive therapy unit (ITU) bed was available for her aftercare. When the tests were done the complainant's mother was already brain dead.

2. The chief executive of the Trust (the chief executive) wrote to the complainant on 29 March 1996. He said that an ITU bed had been available from the early evening of 18 November but that, after the test, surgery was inappropriate because of the complainant's mother's deteriorating condition. The complainant was dissatisfied with the reply. A meeting was arranged between the family and Trust representatives on 23 April to discuss matters further. At the meeting the consultant neurosurgeon denied that he had told the family to complain about the lack of an ITU bed. On 7 May the chief executive wrote again to the complainant. He told him that he had the right to seek an independent review if he felt that his concerns had not been satisfactorily resolved. On 2 July the complainant asked the Trust's convener (the convener) to arrange an independent review of his original complaint and of some additional concerns about the nursing care his mother had received. On 18 July the convener replied to the complainant. He said that he did not consider an independent review of the medical treatment his mother had received would be of any benefit, and that her care had been proper, appropriate and consistent with normal practice in such cases. An independent panel was offered, however, to review the nursing issues.

3. The complaints investigated were that the convener:-

a. failed to show that he had adequately dealt with all the medical aspects of the complaint made to the convener by the complainant and to set out his reasons for rejecting the request for an independent review panel by reference to the specific complaints put by the complainant including;

   i. that the complainant's mother was not medically assessed from the day of her admission until the events on the day of her death and that there was no documentation from 10 to 18 November to indicate that any assessment took place;

   ii. that no ITU bed was available and that, despite requests, there was not an earlier medical intervention;

   iii. the allegation that the consultant neurosurgeon lied to the complainant; and,

b. failed to explain sufficiently the basis on which he had reached the view that the medical treatment of the complainant's mother was consistent with normal practice in such cases.

Investigation

4. The comments of the Trust were obtained and relevant papers were examined. I have not put into this report every detail investigated but I am satisfied that no matter of significance has been overlooked.

National guidance

5. On 1 April 1996 new national procedures for the handling of complaints in the NHS were introduced. The NHS Executive produced guidance on the implementation of the new procedures in a booklet entitled `Complaints, Listening ... Acting ... Improving'. The guidance, published in March 1996, sets out mandatory requirements and guidance for trusts in the operation of the complaints procedure. It includes the following advice to conveners:

> `The convener must inform the complainant .... in writing of his/her decision as to whether or not a panel should be appointed, setting out clearly .... the reasons for any decision to refuse a panel, and whether or not he/she believes there is further action the trust .... could take'.

6. The guidance goes on to say:

> `Where a complaint appears to relate in whole or in part to action taken in consequence of the exercise of clinical judgment, the convener must take appropriate clinical advice in deciding whether to convene a panel.
>
> `This process will be important in informing the convener about any particular clinical considerations which he/she should take into account, and whether, for instance, there is any further practical action which could still be taken through the Local Resolution process ....'

Complaint *(a) The convener failed to show that he had dealt with all the medical aspects of the complaint and to set out his reasons for not convening a panel with specific reference to the complainant's complaint*

Documentary evidence

7. I have set out at Appendix A to this report the main points of the complainant's letter to the convener requesting an independent review into the medical aspects of his mother's care.

8. In his letter of 18 July to the complainant the convener wrote:

> `.... I have now had an opportunity to consider all the papers in respect of your complaint and to take advice from experts in both medicine and nursing who were not involved in the case ....
>
> `.... All the advice which I have received and my reading of the papers leads me to the conclusion that your mother received proper and appropriate treatment and that all the doctors concerned acted in her best interest based on their own professional judgement at the time. The advice which I have received is that their actions were also consistent with normal practice in such cases.'

9. In his formal response to this office at the start of this investigation the chief executive wrote:

> `I have had the opportunity to consider [the convener's] response [to the statement of complaint] and would concur with his explanation of the events. However, with the benefit of hindsight, it may have been more helpful to [the complainant] had the letter from [the convener] .... given a more detailed explanation of the reasons why he declined an independent review of the medical issues. In this context only, [the complainant's] complaints are partly justified. That stated, I accept [the convener's] rationale for his decision as set out in .... his letter to you.'

10. In his response to the statement of complaint the convener wrote:

> `With regard to point [(a)i] of your statement I have been able to establish that medical entries were made in [the complainant's mother's] notes daily from the 10th to the 18th November inclusive. I was satisfied therefore that there was ongoing medical assessment of [the complainant's mother's] condition ....'

[Note by the Deputy Health Service Commissioner: I have seen that there were entries in the complainant's mother's medical notes made by the doctors in charge of her care from 10-18 November inclusive. The entries comment on her medical condition and whether it was possible to perform an angiogram test. She was reviewed on 11, 15 and 17 November by the consultant neurologist in charge of her care (the consultant neurologist).] The convener went on to say:

> `.... This point together with points [ii] and [iii] were I believe addressed during the meeting held on 23rd April as detailed in [the chief executive's letter of] 7 May 1996 ....'

The main points of the chief executive's first letter of reply dated 29 March to the officer from the CHC (the CHC officer) who was helping the complainant with his complaint against the Trust are set out at Appendix B to this report. The second letter dated 7 May set out the events discussed at the meeting on 23 April and gave a substantive response to the complainant's complaints about the medical aspects of his mother's care. The main points of that letter are set out at Appendix C. The convener also wrote:

> `I took general advice from [the] Medical Director of the Trust at this stage on the medical treatment received by [the complainant's mother], noting that he had not been involved in her care. He confirmed that the care given to [the complainant's mother] followed normal practice in similar cases and that it would not have been wise to move her to

another hospital when it became apparent that an operating theatre was not immediately available due to other emergencies.

` .... I did not give a full explanation of the reasons to [the complainant] at this stage as I wished to have his agreement to the terms of reference for the review of the nursing issues ....

`.... I received a file note of [the complainant's] .... dissatisfaction with the decision not to hold an independent review on the medical care received by his mother .... [I] agreed to take further advice on the medical care from [the medical director] asking him to consult the medical notes and advise as to whether there was any case, in his opinion, for the external review. [His] advice, having consulted the notes, was that there was not.

`.... I do not believe that it is appropriate to enter into a public debate whilst the issues are being considered by the due process and I considered that in the circumstances, it would be better to keep any correspondence with [the complainant] to a minimum.'

Oral evidence

11. The convener told the Commissioner's investigator that, in seeking independent medical advice, he had explained the details of the complainant's mother's condition to the medical director and asked him what would be considered as appropriate care for her to receive. The convener said that the medical director's answer was entirely consistent with the care the complainant's mother had received. It was only when the complainant had been dissatisfied with the convener's decision that the convener had asked the medical director to look at the complainant's mother's medical records and suggest whether there was scope for an independent panel to be convened.

Findings *(a)*

12. The convener told the complainant that he had sought independent medical advice about the care the complainant's mother had received and that in consequence he concluded that she had received proper and appropriate care. When the complainant was dissatisfied with the decision not to convene a panel, the convener asked the medical director to review the complainant's mother's medical notes to advise whether there was a case for external review. Having received that advice he decided not to reverse his earlier decision. It is surprising that the convener did not show the medical director the complainant's mother's medical notes in the first instance, because I do not accept that an effective assessment could have been made of the medical aspects of the complainant's mother's care without reference to her notes.

13. The complainant said in his letter of 2 July to the convener (Appendix A) that there was no documentation to indicate that his mother had been assessed from 10-18 November and that he considered that she ought to have received earlier medical intervention. The convener said (paragraph 10 above) that there were daily entries in the complainant's mother's medical records and that he was satisfied that those entries formed part of an assessment of her condition. Having myself seen the records I have no reason to disagree with his conclusions. However, in his reply to the complainant he made no reference to either of these points as reasons for not convening a panel.

14. There seems to have been conflicting information about the availability of an ITU bed. The complainant was told in the first letter from the chief executive (Appendix B) that there had been a bed available on 18 November. The second letter from the chief executive (Appendix C) states that the complainant's family claimed that they had been told by the consultant neurosurgeon that the bed was unavailable for six hours. The consultant neurosurgeon refuted that at the meeting, saying it was an operating theatre which was unavailable, not an ITU bed. The conflict in these two letters was not dealt with by the convener. The complainant asserted that the consultant neurosurgeon had lied to him about the availability of an ITU bed and in denying that he suggested the complainant should complain about that matter. That aspect was not referred to in the convener's letter to the complainant.

15. The convener said that he did not fully set out the reasons for his decision not to convene a panel in his letter to the complainant because he wanted first to agree the terms of reference on the separate nursing issues. He also said (paragraph 10) that he did not think it appropriate `to enter into a public debate whilst the issues are being considered by the due process' and that `it would be better to keep any correspondence with the complainant to a minimum'. The convener's decision not to inform the complainant fully of his reasons for his decision did not conform with national guidance. His reasons for not giving an explanation I find inadequate.

16. The convener has said in his response to the statement of complaint that the issues raised by the complainant had been addressed in the letters from the chief executive and at the meeting on 23 April. In his letter to the complainant he did not refer to those letters or to the meeting, and he made no comment on whether he thought further local resolution would be

useful, even though some matters were clearly unresolved. The convener made no specific reference to the complainant's concerns about his mother's assessment for an angiogram, the failure to respond to requests for earlier medical intervention, the availability of an ITU bed or to what the consultant neurosurgeon may or may not have said about that. He made his initial decision not to convene a panel on incomplete independent medical advice, in that the medical director was not shown the complainant's mother's medical notes until the convener agreed to review his decision. The method of obtaining independent medical advice was flawed. Therefore I find that the convener did not give due consideration to the medical aspects in assessing whether it was appropriate to convene an independent panel. I uphold the complaint.

Complaint *(b) The convener failed to explain sufficiently the basis for his view that the complainant's mother's medical treatment had been consistent with normal practice*

17. The relevant parts of the convener's response to the complainant are set out in paragraph 8 above and his response to the statement of complaint is at paragraph 10.

Findings *(b)*

18. The convener told the complainant that he took medical advice in coming to his decision but he did not say what that advice was. At the meeting of 23 April (Appendix C) the complainant said that he had been advised that an early operation should have been performed, while the consultant neurologist said that he preferred the complainant's mother's condition to stabilise in order to achieve the best chances of success in further treatment. It is not within the scope of this investigation to consider the differing clinical views raised by this complaint; nor is it the Commissioner's role to question the clinical judgment of the consultant neurologist in charge of the complainant's mother's care, as the events complained about took place before 1 April 1996 and are therefore outside his jurisdiction. The convener should have recognised that this matter was unresolved and that a bald assertion that the complainant's mother's care was consistent with normal practice was unlikely to satisfy the complainant. The convener's approach to obtaining independent medical advice was flawed. Since the medical director could not have given a properly informed opinion on the detail of the complainant's mother's care without sight of her records, it was rash of the convener to conclude that her care was consistent with normal practice. I uphold the complaint that the convener did not explain sufficiently the basis on which he reached his view.

Conclusion

19. The public has a right to expect that trusts will act in accordance with the requirements of the new complaints procedure on which national guidance has been issued. The Trust did not do so in this case. I invite the Trust to consider afresh the decision of the convener not to grant an independent review, and to give reasoned decisions on each of the grievances, identified in paragraph 3 at (i), (ii) and (iii), and on whether there should be further efforts at local resolution or whether a review panel should now be convened.

20. I have set out my findings in paragraphs 12 to 16 and 18. The Trust have agreed to the invitation in paragraph 19 and have asked me to convey to the complainant-as I do-their apologies for the shortcomings which I have identified.

APPENDIX A TO E.591/96-97

The complainant's letter to the convener requesting an independent review into the medical aspects of his mother's care includes:

> `.... Further to my meeting with the Neurosciences Directorate I am writing to complain that our questions were not answered and that no attempt was made to resolve our complaint regarding the treatment received by my late mother.
>
> `.... [the consultant neurosurgeon] .... had encouraged us .... to complain after he had informed us that he could not consider operating on my mother until an intensive care bed had become available .... Six hours had elapsed when one did become available and [the consultant neurosurgeon] was able to proceed, however, after all this time there was no blood flow to my mother's brain. When we were informed of this we said how disgusted we were that over six hours had elapsed and we had to wait for a bed, he agreed and said that it was something that we might wish to complain about at a later date. When we brought this up with [him] at the meeting he denied saying this, he also denied saying that there was no intensive care bed. I am disgusted that after saying this he denied it. I am appalled that [he] blatantly lied .... Neither [the consultant neurosurgeon nor the consultant neurologist] was able to answer why an intensive care bed was not available or why they did not transport my mother to another hospital where one would have been available.

`.... As my mother was only fifty one we had expressed to the medical staff that we preferred an early intervention. [The consultant neurologist] stated that he had visited my mother on a number of occasions. Our family was with my mother fourteen hours a day. We did not see [the consultant neurologist] once during the week leading up to my mother's death. In addition, there is no documentation from the 10th until the 18th to indicate that my mother's condition was assessed ....'

APPENDIX B TO E.591/96-97

I set out below the main points of the chief executive's first letter of reply to the complainant, dated 29 March 1996 and addressed to the CHC officer.

`.... I have now had the opportunity to investigate the comments raised by [the complainant] ....

`.... [the complainant's mother] was admitted to Ward 24 on 10 November 1995 under the care of [the consultant neurologist], having suffered a sub-arachnoid haemorrhage.

`Having examined [the complainant's mother], [the consultant neurologist] decided to defer the investigation of Cerebral Angiography due to her fluctuating condition, taking into account the risks and complications associated with such an invasive procedure.

`[The complainant's mother] was also seen by the neurosurgical team on 10 November 1995 who continued to monitor her condition in conjunction with the neurological medical team. She was reviewed by [the consultant neurosurgeon] on the afternoon of the 18 November 1995 who informed her relatives at that time that she could undergo surgery subject to certain tests ....

`An Intensive Care bed was available but due to an emergency case the neurosurgical theatre suddenly and unexpectedly became unavailable until early evening. However due to [the complainant's mother's] deteriorating neurological condition throughout the course of the day surgical intervention became inappropriate. [The consultant neurosurgeon] discussed this with her relatives on the evening of 18 November 1995 and [the complainant's mother] died peacefully on 19 November 1995.'

APPENDIX C TO E.591/96-97

I set out below the main points of the letter to the complainant from the chief executive dated 7 May, about the medical complaint.

`I write further to the meeting held on Tuesday 23 April 1996 attended by members of [the complainant's mother's] family .... and Trust representatives.

`The following is a summary of the points discussed during the above meeting.

`.... [the consultant neurologist] was going to arrange for an angiogram to be undertaken later that week, dependent on [the complainant's mother's] condition .... [He] felt that the best course of treatment was to delay the angiogram, and to treat [her] with drug therapy to minimise the risk of re-bleed and stabilise [her] condition in order to create a situation whereby further treatment would have the best chance of success, which is standard medical practice in cases of this nature.

`[The complainant] indicated that he had taken advice from others (he did not state whom) who had indicated that in their opinion an operation should have been undertaken at an earlier stage. [The consultant neurologist] confirmed that in his opinion the treatment regime he had designed for [the complainant's mother] was entirely appropriate and followed standard procedures.

`[The consultant neurosurgeon] acknowledged that there are differing views amongst medical staff nationally as to which is the most appropriate course of treatment of cases of this nature. Some advocate early intervention, whilst others prefer to treat the condition medically in order to stabilise the patient prior to intervention.

`The relatives expressed their opinion that [the complainant's mother] steadily improved throughout the week, and questioned why [the consultant neurologist] did not elect to undertake an angiogram, with a view to surgical intervention. [The consultant neurologist] stated that he had visited [the complainant's mother] on a number of occasions, and that his observation and the information recorded in the notes did not suggest that [her] improvement was sufficient for him to proceed with intervention .... It was [the consultant neurologist's] judgment that it was not appropriate to proceed to angiography, and subsequently on to surgery ....

`.... The family claimed that an ITU Bed was not available for a period of 6 hours, [the consultant neurosurgeon] explained that when he originally enquired about an ITU Bed, one was not available but that he established that one would be available once surgery was complete, some hours later .... Members of the family claim that they were given the impression by [the consultant neurosurgeon] that an ITU bed was not available, and that this was the reason why surgery did not take place ....

`.... The family were very distressed that a period of 6 hours elapsed during which they felt that [the complainant's mother] had deteriorated, leading up to her eventual death, and asked why there was such a delay. [The consultant neurosurgeon] further explained that the emergency theatre facilities available within the Trust on that day were all occupied by other cases. He stated that the on-call team for the neuro[surgical] theatre also covered the cardiothoracic theatre. [The consultant neurosurgeon] had been involved in an emergency case in the neurosurgical theatre early on in the day, and received a call from the neurological [senior house officer] to visit [the complainant's mother]. After he had completed his emergency case the theatre team immediately transferred to cardiothoracic theatre to undertake another case, and therefore the theatre team was not available to undertake surgery on [the complainant's mother] at that time.'

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comments

Case No. E.859/96-97-Convener's decision not to convene an independent review

Background and complaint

1. The background to the complaint provided by the complainant was that on 22 May 1996 he visited his then general practitioner (the GP) to discuss having some tattoos removed. Following that consultation the complainant wrote to the GP's practice on 5 June. He complained about: the GP's assessment of his clinical condition; the GP's failure to discuss that assessment; an allegation made by the GP that the complainant had acted inappropriately in the waiting room (which was disputed by the complainant and his girlfriend); and the action taken by the GP following the consultation. The GP's actions led to serious and, the complainant claims, unexpected and unwarranted, consequences for him. (I understand that those events are the subject of an independent professional review established by another NHS Trust after the complainant complained to them.) The complainant also requested copies of the medical records made by the GP at the time of the consultation.

2. The GP replied on 7 June. He disputed the complainant's concerns about the consultation and refused to give the complainant access to the medical records. The complainant was dissatisfied because the GP's letter gave a version of events which was grossly at odds with his recollections and did not answer his question about his alleged inappropriate behaviour in the waiting room.

3. Despite a further exchange of correspondence the complainant remained dissatisfied with the conflicting accounts of his visit to the practice on 22 May, the GP's failure to answer all his questions, and the refusal to release his medical records. On 9 August the complainant asked Croydon Health Authority (the Health Authority), who have arrangements with the GP for the provision of general medical services, for an independent review of his complaints. On 4 September the convener of the Health Authority wrote to the complainant that his request for an independent panel had been refused.

Complaints investigated

4. The complaints which I investigated were that the convener:

a. failed to show that he had taken all the possible steps to inform himself about the matters put to him by the complainant including the allegation that the GP had accused the complainant of acting inappropriately; and,

b. failed to explain the role of the NHS complaints procedures in respect of access to health records.

Investigation

5. The comments of the Health Authority were obtained and relevant papers were examined. One of my investigators took evidence from the convener. I have not put into this report every detail investigated but I am satisfied that no matter of significance has been omitted.

Complaint *(a) The convener failed to show he had taken all possible steps to inform himself about the matters put to him by the complainant*

National guidance

6. On 1 April 1996 new national procedures for the handling of complaints in the NHS were introduced. The NHS Executive produced guidance on the implementation of the new procedures in a booklet entitled `Complaints, Listening ... Acting ... Improving'. The guidance, published in March 1996, sets out mandatory requirements and guidance for health authorities in the operation of the complaints procedures. It includes:

> `The convener's role is to .... ascertain whether all opportunities for satisfying the complainant during Local Resolution have been explored and fully exhausted and what issues, if any, could be referred to a panel. To this end the convener will need to obtain a full picture of the events relating to the complaint ....'

and,

> `The convener must inform the complainant .... in writing of his/her decision as to whether or not a panel should be appointed, setting out clearly .... the reasons for any decision to refuse a panel, and whether or not he/she believes there is further action the health authority/family health services practitioner could take.'

Complainant's evidence

7. The complainant's letter dated 9 August 1996 to the Health Authority requesting an independent review detailed the differences between his recollection of the discussion during the consultation with the GP on 22 May and the account given by the GP. It includes:

> ` .... [The GP] has refused to allow me access to my medical records. There can be no valid justification for this. It is not credible to argue it would be harmful to my health, as I already know what I have been accused of .... I hope that the records will help prove that my version of events was more accurate than [the GP's].
>
> `.... The consultation was not as long or detailed as [the GP] describes. He is mistaken about me saying I was unemployed. I do not recall being asked the general questions he says he recorded the answers to on the computer records. (Access to these records would help establish this).
>
> `.... [The GP] does not address the point I made as to whether or not he continues to suggest that I acted inappropriately in the waiting room .... This false impression, together with others [the GP] had gained, helped trigger the totally inappropriate actions that then took place.'

The significance of these points is that they provide the basis of the complainant's claims that nothing that went on during his visit to the practice provided justification for the actions taken by the GP afterwards and the consequences that resulted, and that he has been obstructed unfairly by the GP from accessing the evidence that might support his claims.

Evidence of the Health Authority

8. In his formal response to my office at the start of this investigation the chief executive of the Health Authority wrote:

> `We do not agree that [the first complaint subject to investigation (paragraph 4 a)] is justified .... [The] Convener is required to take advice from an Independent Chairman and, also, where appropriate, clinical advice, before reaching his decision .... After taking advice, and considering the correspondence very carefully, [the convener] wrote to [the complainant] on 4 September 1996 advising him of his decision not to convene a review panel. I should like to point out that the Convener's decision is made on the basis of the correspondence alone. The Convener does not talk to the parties involved in the complaint ....'

9. In his letter dated 4 September 1996 the convener told the complainant of his decision to refuse an independent review panel. He wrote:

> `As a non-executive director of Croydon Health Authority, I have the responsibility to consider whether there should be an Independent Review of your complaint by a special panel. I should explain that it is not my role to try, single-handedly, to resolve the complaint but I do have to obtain a full picture of the events relating to the complaint. I have to ascertain whether all opportunities for resolving matters have been explored and what issues, if any, could be referred to a panel.
>
> `I have carefully considered all the correspondence in this case, and I have also taken independent advice. I have borne in mind the professional skills and experience of those who were involved on the day in question. It is my opinion that it would be extremely difficult to resolve the direct conflict of evidence, apparent from your letter dated 5 June 1996 and [the GP's] letter dated 7 June 1996, at a panel meeting. As no independent witnesses were present at the consultation on 22 May 1996 .... it would be difficult for panel members to reach a decision in the light of the available evidence.'

10. When interviewed, the convener told my investigator that when considering the complainant's request for an independent review he had not spoken to the GP or anyone else involved in the events of 22 May 1996 which had triggered the complainant's complaint. The convener thought that there was no point in speaking to those health professionals, including the GP, as they were likely to defend the action they took. In saying in his letter to the complainant (paragraph 9) that he had `borne in mind the professional skills and experience of those who were involved' he had meant that he had no reason to doubt that the GP and the others involved had been acting in a professional manner. The convener said that he had obtained

independent clinical advice on the complaint and had consulted a lay chairman. The lay chairman had concluded that a panel should not be convened. The clinical adviser had not had access to the medical records, but had concluded on the basis of the correspondence which he had seen that he did not believe that there was a case for a panel, nor that a panel could throw any more light on the issue. The convener considered the national guidance unclear on the necessity for a clinical adviser to see the medical records.

11. Since the complainant and the GP had differing recollections of the consultation on 22 May the convener said that he considered there would be no point in holding an independent review: it was a case of one person's word against that of another. The convener acknowledged that the GP had not answered the complainant's complaint that he had been falsely accused of inappropriate behaviour in the GP's waiting room. The convener explained that he had concluded that there was no scope for further efforts at local resolution on that point as the GP refused to meet the complainant. Again, because of the conflicting evidence presented by the GP and the complainant, he saw no scope for a panel review. Moreover, he would not have granted a panel review of that issue alone. The convener accepted that his letter to the complainant had not made specific reference to the points raised by the complainant and that it might have provided a fuller explanation of his decision.

Findings *(a)*

12. The complainant complained about the GP's assessment of his condition, and the GP's account of their consultation. The background correspondence which I have seen shows that there is a substantial difference between the complainant's account of events, and that of the GP. The convener considered that those differences could not be resolved. I do not agree that that was necessarily the case. A review panel would have been able to examine the GP's record of the consultation, and to talk to the parties involved. That action alone might have resolved the conflict. I am surprised that the clinical adviser did not ask to see the GP's record before providing advice to the convener. I cannot see how he could be confident that his advice was well founded without examining such evidence. While the national guidance does not cover this point, I consider it a matter of self evident good practice that a clinical adviser should normally ask to see any relevant medical records when asked to advise on clinical issues. Even if the GP had refused the patient access to the records, that does not seem to me to prevent the clinical adviser seeing what had been written. That could have been arranged with the patient's consent, without prejudice to any unwillingness by the GP to disclose the relevant records to the complainant.

13. The chief executive says that it is normal practice for the convener to base decisions on the correspondence alone. That may be adequate in some cases but I consider it unduly restrictive to apply it to all. While a convener must not investigate a complaint himself with a view to resolving it, he does have a duty to obtain a full picture of events relating to the complaint. That does not restrict him to considering the correspondence. The convener says that he did not speak to any of the staff involved in the complainant's care on 22 May, partly because he saw no reason to doubt that they acted in a professional manner. In doing so the convener called into question his impartiality.

14. When telling the complainant of his decision not to convene an independent review, the convener did not address the complainant's complaint that the GP had failed to answer his concern about the allegation of inappropriate behaviour in the waiting room. I accept that it might have been reasonable for the convener to take the view that there was little scope for further resolution of this issue. At interview the convener gave two reasons for refusing an independent review on that question: the conflict in the evidence and that he did not wish to grant a review on this point alone. On the first point, the complainant says his girlfriend was present and it is possible that there were other witnesses, for example, the receptionist or other practice staff, or other patients. The GP's record may also have covered it if he thought the incident material to the actions he took later in the day. The convener took no steps to discover whether there were witnesses who might help to resolve the different accounts, or whether the medical records might do so. On the second point, I accept that conveners have discretion to have regard to the relevant importance of the issues in deciding when to convene a panel but I question whether the convener gave due weight to the significance of this part of the complaint in the context of the complainant's concerns about the serious events that followed.

15. I conclude that the convener failed to take all the steps that he could reasonably have taken to consider whether an independent review panel might have been able to resolve the conflicts in the accounts of both events during the GP's consultation with the complainant, and in the GP's waiting room. I uphold the complaint.

Complaint(b) the convener failed to explain the role of the NHS complaints procedures in respect of access to health records

National guidance

16. The guidance referred to in paragraph 6 includes advice on complaints about access to health records under the Access to Health Records Act 1990. Paragraph 3.9 says:

> `Any person who has a complaint about any aspect of an application to obtain access to health records under the Act may now make a complaint under the NHS complaints procedure as an alternative to making an application to the courts .... Where the complaint relates to a decision to withhold access to all or part of the record, the Independent Review Panel's role is to advise the record holder of their opinion. It remains the responsibility of the record holder to decide whether access should be granted ....'

Legislation

17. The Access to Health Records Act 1990 established a right of access to health records by the individuals to whom they relate and provided for the correction of inaccurate health records. It defines a `holder' of a health record as:

a. in the case of a record made by .... a general practitioner-

i. the patient's general practitioner, that is to say, the general practitioner on whose list the patient is included; or

ii. where the patient has no general practitioner, the Family Practitioner Committee [now the Health Authority] .... on whose medical list the patient's most recent general practitioner was included ....'

Complainant's evidence

18. In his letter of complaint to my predecessor, the complainant wrote:

> `The main reasons I have requested access to my medical records is that this may provide evidence to support my case that the GP's consultation with me was cursory and did not cover the range of issues he states ....'.

Evidence of the Health Authority

19. In his letter of 4 September the convener wrote to the complainant:

> `Regarding your request for access to your medical records, I must explain that it is not the role of any Independent Review panel to release records to patients. If you wish to pursue the matter of your medical records, as their release is governed by the Access to Medical Records Act 1990, I would suggest that you take legal advice.'

20. The chief executive's response to the statement of complaint at the beginning of this investigation included:

> `With regard to the access to the medical records, I should point out that the Convener does not have access to the records at the decision making stage. Medical records may be made available to the doctor who advises the Convener, subject to appropriate patient consent being available. The adviser did not have access to the records in this case. [The complainant] had already sought access which had been refused by the General Practitioner on the basis that such access might harm him. This decision was made on clinical grounds by the doctor and, because it was a clinical decision, neither the Convener, nor the review panel, could change or overrule it. We might have explained more fully to [the complainant] that if he believed that his General Practitioner had failed to comply with the Access to Medical Records Act he would need to apply to the courts for a decision on that point.'

In a later letter at the end of this investigation the chief executive said:

> `We can now confirm that the GP, with the benefit of advice, refused access on the grounds that access might be injurious to the patient's mental welfare.'

21. The convener told my investigator that he had concluded that the reason the GP refused the complainant access to his health records must have been because the GP considered that access would be injurious to the complainant's health. He said that he understood that that was the only reason that such access could be denied. [Note: That is not the case. There are other circumstances where access can be denied under the Act, for example where the holder considers that granting access to a record would disclose information relating to or provided by an individual, other than the patient, who could be identified from the information. Such a decision would not be a matter of clinical judgment.] The convener said that he did not contact the GP to establish the reason that access had been denied. The independent clinical adviser told him that if the GP had refused access on clinical grounds, that decision should not be challenged - it was the GP's prerogative to prevent access. In the light of that advice, and the national guidance which says that it is not the role of the independent review panel to release medical records, the convener told the complainant that an independent review was not appropriate. He added that, even if the release of records was something that could have been considered by a review panel, he did not consider that it was a matter which on

its own merited consideration by a panel. He also had doubts whether such a panel would be beneficial to the complainant as it would need to take into account the complainant's past, which might cause him concern. The convener said he was not sure whether the complainant remained a patient of the GP. I understand from the complainant that he is no longer the GP's patient.

Findings *(b)*

22. The convener told the complainant that it was `not the role of any Independent Review panel to release records to patients'. That is so, but the NHS Executive guidance (paragraph 16) also says that, where there has been a refusal to release medical records, an independent panel can give its opinion to the record holder. The convener was told by the independent clinical adviser that, if the GP had refused access on clinical grounds, then the refusal ought not to be challenged. In the course of my investigation it became apparent that neither the convener nor the clinical adviser had any evidence to suggest that the GP had refused access on clinical grounds. Moreover, even if that were the case there is nothing in the guidance which suggests that such a refusal cannot be considered by an independent panel. The guidance does say, however, that it remains the final decision of the record holder whether or not to allow access. The convener did not find out whether the GP was the current holder of the complainant's records. According to the Access to Health Records Act 1990 (paragraph 17) that information should have determined the correct advice to the complainant. I consider that the convener did not establish the basis on which the complainant's request for access had been refused by his GP, or explain fully the NHS complaints procedure in respect of access to health records. My comments about `proportionality' in paragraph 14 above apply also to the convener's comments to my investigator, that the question of access to records would not, of itself, merit consideration by a panel. I uphold the complaint.

Conclusion

23. Some elements of the national guidance on the new complaints procedure are mandatory, others are not. Where the guidance is not mandatory, the convener has to exercise his or her judgment. For the reasons I have explained in the findings above, I conclude that good judgment was not exercised in this case. **I invite** the Health Authority to arrange for the convener, or a different convener, to consider afresh the decision to refuse an independent review of the complainant's complaint including that about the alleged incident in the waiting room, taking into account the advice of an independent clinical adviser who has looked at the records made by the GP on 22 May 1996, and the possibilities to which I refer in paragraphs 13 and 14.

24. I have set out my findings in paragraphs 12 to 15 and 22. The Health Authority have agreed to reconsider the decision of the convener not to set up an independent panel to review the complainant's complaint (paragraph 23) and have asked me to convey to the complainant-as I do-their apologies for the shortcomings which I have identified.

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comments

Case No. E.944/96-97-Convener's decision not to convene an independent review

Complaint as put by the complainant

1. The account of the complaint provided by the complainant on behalf of his daughter, was that on 24 August 1995 she was experiencing pain in her left thigh. The man's daughter was due to travel to Australia the following day; and her general practitioner (the GP) decided that she should be examined at the accident and emergency department (the A&E department) of Epsom General Hospital (the hospital) before she travelled. The hospital is managed by Epsom Health Care NHS Trust (the Trust). She was examined in the A&E department by two doctors; and x-rays were taken. The cause of her pain was not identified; but the doctors concluded that the nerves in her leg were inflamed. She was given an anti-inflammatory injection and pain-killers. During the journey to Australia her symptoms worsened. On her arrival in Australia on 27 August she was taken to hospital. Following a blood test, leukaemia was diagnosed. The complainant wrote to the hospital on 28 August to complain about their failure to carry out a blood test when his daughter attended the A&E department and the assurance that was given to her that she was fit to travel. He also enquired about reimbursement of the cost of repatriating her. The chief executive of the Trust (the chief executive) replied on 11 October. After an exchange of correspondence the complainant remained dissatisfied, and asked the chief executive to pass his complaint to the Regional Health Authority for an independent professional review. The complainant declined an offer of a meeting with clinicians and, on 22 December, repeated his request for an independent professional review of his daughter's clinical care. After a further exchange of correspondence between the complainant the Trust and the Regional Health Authority, the complainant requested an independent review of his complaint under the new NHS complaints procedures which were introduced on 1 April 1996. He confirmed the issues which he wished to have considered. The convener informed him on 12 July that she had decided not to convene a review panel.

Complaints investigated

2. The complaints investigated were that the convener:

a. misunderstood her role by telling the complainant that a review panel was available only if a complainant had not received a full explanation of the issues complained about;

b. further misunderstood her role by trying to resolve the complaint herself and by defending those complained against; and,

c. failed to make clear whether she had taken appropriate clinical advice from someone not associated with the complaint, and how any such advice related to the reasons for her decision.

Investigation

3. The statement of complaint for the Commissioner's investigation was issued on 14 November 1996. The comments of the Trust were obtained and relevant papers were examined. The Commissioner's investigators were told by the Trust that the convener was no longer a non-executive director of the Trust, and no longer worked as the Trust's convener.

National guidance

4. On 1 April 1996 new national procedures for the handling of complaints in the NHS were introduced. The NHS Executive produced guidance on the implementation of the new procedures in a booklet entitled `Complaints, Listening ... Acting ... Improving'. The guidance, published in March 1996, sets out mandatory requirements and guidance for Trusts in the operation of the complaints procedures. It includes in paragraph 6.7:

> `When dissatisfied with the outcome of Local Resolution, a complainant does not have an automatic right to move to Independent Review. There may be occasions when the convener feels that Local Resolution has been adequately pursued-in that the complaint has been properly investigated and an appropriate explanation given-and that nothing further can be done, although the complainant remains dissatisfied.'

5. The guidance goes on to say:

> `In deciding whether to convene a panel, the convener will consider .... whether:
>
> > the trust .... can take any further action short of establishing a panel to satisfy the complainant
> >
> > the trust .... has already taken all practical action and therefore establishing a panel would add no further value to the process.
>
> `If either of the circumstances referred to above apply, the convener should not convene a panel. A panel should only be convened if the convener considers that it may be able to resolve the complaint and that nothing short of setting up a panel will do so.'

6. The guidance also sets out the role and responsibilities of a convener. Paragraph 6.8 says:

> `It is important that [the convener] distances him/herself from those involved in the complaint. The convener's role is to ensure the complaint is dealt with impartially at the convening stage. It is not the function of the convener .... to defend those complained against, but rather to ascertain whether all opportunities for satisfying the complainant during Local Resolution have been explored and fully exhausted and what issues, if any, could be referred to a panel. To this end the convener will need to obtain a full picture of the events relating to the complaint. It is not the convener's role to try and resolve the complaint on his/her own.'

7. The guidance concerning clinical complaints states:

> `Where a complaint appears to relate in whole or in part to action taken in consequence of the exercise of clinical judgement, the convener must take appropriate clinical advice in deciding whether to convene a panel.
>
> `This process will be important in informing the convener about any particular clinical considerations which he/she should take into account .... It is for the convener to decide whether a complaint appears to be a clinical complaint and from whom to seek appropriate clinical advice .... conveners are recommended to seek this initially from the medical or nursing director on their board, or the appropriate local professional head.'

8. Paragraph 6.21 of the guidance says that when telling a complainant of the convener's decision on the request for an independent review, the convener:

> `.... must inform the complainant .... in writing of his/her decision as to whether or not a panel should be appointed, setting out clearly .... the reasons for any decision to refuse a panel ....'

Documentary evidence

9. On 24 August 1995, the GP wrote a letter to the `Orthopaedic SHO [senior house officer] on call [at the hospital]'. The complainant's daughter took that letter with her to the A&E department on 24 August 1995. The letter read:

> `Thank you for seeing this 30 yr old lady who has had a slight twinge in her [left] hip for [four days]. Today it is painful and she feels hot + cold. She is limping. She also injured her [left] little toes last Sat[urday]. Temp[erature] 37.5o. [On J examination] Tender [left] hip ++. [Range of movement down when subjected to] internal rotation. [Left] little toe-tender-swollen-[normal range of movement]. ?infection ?cause'

10. Following the complainant's complaint about his daughter's care and treatment, and an exchange of correspondence with the Trust, the complainant told the Trust on 3 June 1996 that he wanted an independent review of his complaint. He provided a statement of his outstanding grievances to the convener on 29 June 1996 which set out the reasons for his dissatisfaction with the Trust's investigation into his complaint. He said that he considered that the examination of his daughter should have gone beyond orthopaedic tests and should have included a blood test, which would have established that his daughter had leukaemia. In his view, the overly narrow orthopaedic approach had continued when the Trust asked a consultant orthopaedic surgeon (the first orthopaedic consultant) to review the complaint. The complainant wrote: `such an investigation may be the right starting place .... it does not go far enough and was too narrowly based to dispose of the issues which are raised by this case'. He sought an independent investigation to establish whether there had been a failure in the diagnostic procedure.

11. On 18 June a second consultant orthopaedic surgeon (the second orthopaedic consultant) provided clinical advice to the convener on the complaint. The advice included:

> `It surprises me that [the complainant's daughter's] pain was judged to be so severe as to warrant an injection of

analgesia at approximately 4.00pm and yet ascribed to a trivial musculoskeletal problem which would resolve spontaneously. I believe that had [the complainant's daughter] been examined by an Orthopaedic Surgeon with greater experience .... it is likely that she would have been-

a. Advised to delay her flight to Australia

b. Given a supply of a stronger pain killer

c. Possibly admitted to hospital for further investigations including blood tests'

The second orthopaedic consultant explained that the error of judgment by the orthopaedic registrar who cared for the complainant's daughter on 24 August 1995 was `one which would be made by a proportion of Orthopaedic Surgeons at his grade and experience'. The second orthopaedic consultant concluded: `I believe that the Trust could .... avoid such unfortunate incidences by ensuring that when a patient is referred by a General Practitioner for an urgent opinion in the hospital, that opinion is given by the Consultant on call and not one of his juniors'.

12. On 12 July 1996 the convener wrote to the complainant. She told him that she had decided not to convene an independent review into his complaint. The convener said that she had consulted a lay chairman; but she did not tell the complainant that she had obtained clinical advice; and her letter gave no indication of the comments made by the second orthopaedic consultant. The convener wrote:

> `An Independent Review is only suitable in those cases where, from a study of the records of the earlier investigations by the Trust, there appears to be substance to the complaint that there may have been a failure to provide a full explanation to the complainant in all aspects of their initial complaint .... I do not consider that such a failure has been demonstrated in your daughter's case and, therefore, establishing a panel would add no further value to the process.
>
> `I have studied the background correspondence and the medical notes made at the time of [the complainant's daughter's] visit very carefully. Her GP's referral letter asking the hospital to see her simply referred to `slight twinges' in [the complainant's daughter's] left hip for four days following a stubbed toe 6 days earlier. [The complainant's daughter] was therefore, quite correctly, seen by the Orthopaedic team .... At no time during her examination did your daughter give a history of any symptoms that could have even slightly been interpreted as a sign that she was suffering from leukaemia or from any condition that would have warranted, at that time, a blood sample ....
>
> `.... in respect of your complaint regarding [the complainant's daughter's] treatment at [the hospital] I must stress that there was no error or fault in her care and she was treated along conventional lines. Had she been referred to any similar centre in the country, presenting a history as has been described, she would have been treated in the same way ....'

13. The complainant replied to the convener's letter on 1 August 1996. He then obtained a copy of the GP's referral letter (paragraph 9). On 10 September the complainant wrote again to the convener. He questioned four points made by the convener in her decision letter. First, he challenged her conclusion that a full explanation had already been provided by the Trust. He pointed out that he had received no explanation why, when an orthopaedic approach failed to explain his daughter's condition, a wider perspective had not been taken; why no blood test was ordered; and why the Trust's own investigation of his complaint was `confined to the hospital's orthopaedic practice' when he had specifically requested that a wider view be taken. Second, he complained that by referring to `slight twinges' the convener had quoted selectively from the GP's referral letter. The complainant said `this is a gross distortion of what my daughter suffered, what she told her GP, what he thought, and what he wrote'. Third, he complained that it was inappropriate that a narrow orthopaedic view was taken when considering the question of whether his daughter was fit to travel to Australia. Finally, he challenged the grounds on which the convener had concluded that his daughter's condition would not have been diagnosed had she attended a similar centre anywhere else in the country. He said that in his view the convener had supported rather than tested the hospital's defensive responses.

14. In his formal response to this office at the start of this investigation the chief executive wrote:

> `The Convener .... and Independent Lay Chairman .... believed that the investigation carried out initially .... had been thorough, they did not believe that a further investigation could provide [the complainant] with any different explanation for the Trust's actions than the one already given to him. [The convener] was guided in her letter by paragraph 6.7 of the Guidance .... [See paragraph 4.]

`The Convener was very concerned, whilst dealing with this her first referral, that there was no established good practice yet for her to refer to when writing to Complainants. Her wish therefore, when reiterating the explanations which [the complainant] had already received regarding the actions of the Trust's staff was to comply with the Guidance (para 6.21) [see paragraph 8] and set out clearly her reasons for refusing [the complainant's] request. It was not her intention at any time to resolve this complaint herself or to defend those complained against.

`The Guidance does not mention that we should explain to the complainant that we have received an independent report, only that we must seek one. We have noted the comments [recently] made by the .... [Commissioner] regarding this area and will ensure in future that all complainants are always made aware that this part of the procedure is observed by the Trust.

`Our advice from the independent report was that a proportion of Orthopaedic Surgeons of Registrar level and with [the registrar's] experience could have made the same diagnosis. Our adviser also explained (even writing with hindsight) that if a Senior Registrar or Consultant Orthopaedic Surgeon had seen [the complainant's daughter] there was still only a possibility that blood tests would have been taken.

`The Trust can only offer their unreserved apologies to [the complainant], if their understanding of the Guidance is flawed and has led to any distress or inconvenience to both he and his daughter. This was certainly not the Trust's intention.'

Findings *(a)*

15. The test to be applied by a convener in deciding whether to convene an independent review is not, as the convener suggested in her letter to the complainant (paragraph 12), simply whether a full explanation has been provided. The appropriate test set out in the national guidance (paragraph 5) is whether there is any further action that could be taken to resolve the complaint and, if not, whether all practical action has been taken so that establishing a panel would add no further value to the process. The complainant did not question the thoroughness of the orthopaedic examination of his daughter but wanted to know why the examination did not go further when the orthopaedic clinicians failed to identify the cause of his daughter's pain. The Trust had not addressed that concern and neither did the convener. I accept that this was the first review request considered by the convener; but she applied the wrong test and thus misunderstood her role. I uphold the complaint.

Findings *(b)*

16. In deciding not to convene a review panel (paragraph 12) the convener said that the complainant's daughter's symptoms when she attended the A&E department could not have been interpreted as a sign of leukaemia; that there was no error or fault in her care or treatment; and that she would have received the same care and treatment had she attended any other unit in the country. By drawing such conclusions the convener went beyond obtaining a full picture of events, and drew her own conclusion on the answer to the complaint. In doing so, she failed to follow the duty of impartiality required by the national guidance (paragraph 6). While I note the chief executive's assurance (paragraph 14) that it was not the convener's intention to defend those complained against, I agree with the complainant's view that the convener's statements suggest she did so. I uphold the complaint.

Findings *(c)*

17. The convener obtained independent clinical advice from the second orthopaedic surgeon; but she did not tell the complainant that she had done so. That disadvantaged the complainant, leaving him with the impression that no further clinical consideration had been given to his complaint, beyond that of the Trust's original investigation. The chief executive has agreed that Trust conveners will in future inform complainants when they have taken independent clinical advice in coming to decisions on requests for review panels. Although that is not a requirement in the national guidance it is obvious good practice, which I commend. I leave this aspect of the complaint there. Turning to the second orthopaedic consultant's advice to the convener (paragraph 11), I note that he advised that the orthopaedic registrar's error of judgment was one which might be made by a proportion of orthopaedic surgeons of his grade and experience. However, he clearly thought it desirable that in cases such as the complainant's daughter's the examination should be conducted by a consultant and not one of his juniors; and he stated that he believed that if that had happened it was likely that the complainant's daughter would, among other things, have been advised to delay her trip to Australia. In substance, his advice supported key elements of the complainant's complaints. In the light of that advice, for the convener to say that the complainant's daughter would have received the same treatment wherever in the country she had attended was seriously misleading. I strongly criticise the convener for failing to take due account of the second orthopaedic surgeon's advice. If such failures were repeated they would call into question the integrity of the NHS complaints procedures and the independent role of the convener. I note with regret

that the chief executive, in his response to this office, chose to defend the convener's actions. I uphold the complaint.

Conclusion

18. The public has a right to expect that trusts will act in accordance with the requirements of the new complaints procedures on which national guidance has been issued and that conveners act, and are seen to act, objectively and impartially. Neither happened in this case. I invited the Trust to consider afresh the complainant's complaint and to consider the scope for further local resolution or an independent review, taking appropriate clinical and lay chair advice and explaining the reasons for the decision taken or, alternatively, to tell the complainant that they accept the conclusions of the second orthopaedic consultant as set out in this report.

19. I have set out my findings in paragraphs 15 to 17. The Trust have asked me to convey through my report-as I do-their apologies to the complainant for the serious shortcomings I have identified. The Trust have accepted the conclusions of the second orthopaedic surgeon.

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comments

Case No. E.1298/96-97-Trust's response to a request for an independent review and convener's decision

Complaint as put by the complainant

1. The account of the complaint provided by the complainant was that he was admitted to Whiston Hospital (the hospital), which is managed by St Helens and Knowsley Hospitals NHS Trust, on 18 December 1995 with a broken right leg. On 20 December he began to complain of pain and restricted movement in his left leg. On 22 December a senior registrar diagnosed `drop foot' but, despite treatment, there was no improvement and on 30 December, at the complainant's wife's insistence, another registrar examined his left leg and diagnosed `compartment syndrome'. In an urgent operation the complainant had muscle removed from his left leg, which may have left him permanently disabled. He complained to the Trust on 22 April 1996 about the diagnosis of his condition and the chief executive replied on 28 May. The complainant remained dissatisfied and on 30 June he wrote with further questions and requested an independent review (IR) of his complaint. The Trust's quality development manager (QDM) responded to that letter. After further correspondence about an IR, one was refused by the Trust's convener on 2 September.

2. The complaints subject to investigation were that:

a. the handling of the complaint was unsatisfactory in that the Trust did not respond to his first request for an IR;

b. the convener failed to take independent clinical advice; and

c. the convener exceeded her responsibilities by seeking to resolve the case through her own investigations, and failed to maintain impartiality.

Investigation

3. The Commissioner obtained comments and relevant documents from the Trust. The Commissioner's staff used written evidence supplied by the complainant and also took evidence from the convener and the QDM.

Complaint *(a) No response to first request for IR*

Guidance

4. The statutory directions on the NHS complaints procedure say, at article 15(3), that when a complainant requests a Trust employee to consider whether a panel should be appointed, the employee `shall inform the convener, and the request shall be treated as having been made to the convener.' Mandatory guidance on the complaints procedure, contained in paragraph 6.1 of `Complaints .... Listening .... Acting .... Improving', published by the NHS Executive in March 1996, says that such requests should be made within 28 days from the completion of local resolution and passed to the convener immediately. In paragraph 6.4 it says that the convener must obtain a statement signed by the complainant setting out their remaining grievances.

5. The guidance also recommends:

> `6.2 .... The time limit for making the request applies to the initial request and not to the making of the subsequent written statement.
>
> `6.28 The convener will .... arrange for a written acknowledgement of the .... request .... to be sent within two working days.
>
> `6.29 .... the period required for a decision .... whether to convene an Independent Review panel should not normally exceed four weeks (ie twenty working days) from the date of the complainant's initial request being received by the convener ....'

Oral and written evidence

6. The complainant wrote to the Trust on 30 June 1996 expressing dissatisfaction with previous explanations about his complaint. He asked several further questions and closed his letter: `Finally I would like an independent review of my case and would be grateful if you could inform me exactly what this involves'. The QDM telephoned the complainant on 5 July in answer to his letter. She offered him a meeting with medical staff and told the Commissioner's staff that she had explained the IR process and that the complainant then wanted to discuss his options with his wife. On 9 July he wrote again (as I have seen), refusing to meet medical staff and asking: `Could you please .... send .... relevant documents regarding an independent review ....'.

7. The QDM wrote to him on 10 July enclosing a form headed `REQUEST FOR INDEPENDENT PROFESSIONAL REVIEW'. (She told the Commissioner's staff that the Trust have since realised that the form was wrongly titled and should have referred to `independent review'.) She also said that she was to contact the consultant plastic surgeon (the consultant), who was one of two consultants responsible for the complainant's treatment, about the points he had raised. On 12 July the QDM wrote to the complainant saying that, as he was unwilling to meet the consultant, there was nothing further to add to the Trust's previous explanations. On 26 July the complainant completed the form. It was received in the Trust's quality department on 29 July and was acknowledged on the same day.

8. In her written comments to the Commissioner, the convener said that she was informed of the complainant's request for an IR on 6 August. When interviewed she said that she telephoned the complainant on 9 August to explain her role and to ask for a more detailed account of his complaint than on the form he had completed. Having received nothing from him she telephoned him again on 20 August and asked for further details. He wrote in reply, with confirmation of his specific concerns, on 22 August. She replied to his questions on 29 August, and refused his request for an IR in a letter dated 2 September.

Findings *(a)*

9. The complainant's initial request for an IR was made, along with a request for more information, in writing to the Trust on 30 June. According to mandatory guidance all requests for IR should be passed straight to the convener. It appeared that the complainant was still prepared to explore rather further the possibility of local resolution, but also wanted information about an IR. I think it was reasonable in the circumstances for the QDM first to tell the complainant very quickly about IR procedures before passing his request to the convener; and at the same time for her to try to answer the complainant's questions.

10. However, when the complainant wrote again on 9 July, there should have been no doubt that he wished to proceed to a review and the QDM should not have delayed further. It is clear from the guidance that the complainant should be asked for a statement (on a form, in this case) after the convener has been told of the request for an IR, not before as was the case here. It would be wrong to take, as the date of the request, the date the form was returned rather than the date when it was known that one was needed; and that could affect the various time limits to the complainant's disadvantage. I consider that the convener should have been contacted, not on 6 August as she was, but as soon as the complainant's letter of 9 July was received. That failure to deal properly with the request for an IR may have resulted in a delay in the decision. **I recommend** that the Trust pass requests for IR to a convener as soon as they are received and before statement forms are sought and received. I also **recommend** that they amend the title of the form to reflect the new NHS complaints procedure. I uphold this aspect of the complaint to the extent described above.

Complaint *(b) Failure to take independent clinical advice*

Guidance

11. The NHS Executive's mandatory guidance (see paragraph 4) is that:

> `6.15 Where a complaint appears to relate .... to action taken in consequence of the exercise of clinical judgement, the convener must take appropriate clinical advice ....'

12. The guidance recommends:

> `6.17 .... It is for the convener to decide .... from whom to seek appropriate clinical advice ....
>
> `6.18 In the case of trusts, ... conveners are recommended to seek this initially from the medical .... director, or the appropriate local professional head. Where [that person] .... is the subject of the complaint, or where possible conflict of interest arises, or where some other clinical opinion is appropriate, then the advice of an independent professional person should be sought.'

Oral and written evidence

13. On 29 August 1996, in the first of two letters to the complainant, the convener stated: `.... I have discussed [your questions] with [the consultant] and others ....'. Neither of her letters referred to any other clinical advice.

14. In her written response to the Commissioner, she wrote, on 18 January 1997: ` .... I followed the recommendations in the Guidance .... I sought the advice of .... [the] Medical Director of the Trust Board, who had no association with the complaint.' At interview she said that she took clinical advice at separate meetings with both the consultant and the Trust's medical director before she replied to the complainant on 29 August.

Findings *(b)*

15. The convener consulted the Trust's medical director and the consultant in reaching her decision. The medical director seems to have been an appropriate choice of adviser, within the terms of the guidance. The consultant was not a suitable person to give clinical advice as he had shared responsibility with another consultant for the treatment about which the complainant complained. (I shall comment later on the decision to discuss matters with him at that stage.) The convener informed the complainant only that she had spoken to the consultant and others. A specific reference to the medical director in her letter to the complainant would have provided greater assurance that the clinical issues at the heart of the complaint had been independently reviewed, as required by the guidance. After investigations in previous cases, the Commissioner has suggested that conveners should state explicitly, in their replies to complainants, whether independent clinical advice has been taken. I recommend that that practice is adopted by the Trust in the future. However, I do not uphold this aspect of the complaint.

Complaint *(c) Convener exceeded responsibilities and failed to maintain impartiality*

Guidance

16. The guidance from the NHS Executive (see paragraph 4) is that:

> `6.8 .... It is important that [the convener] distances him/herself from those involved in the complaint .... The convener's role is to ensure the complaint is dealt with impartially .... It is not the function of the convener .... to defend those complained against .... but rather to ascertain whether all opportunities for satisfying the complainant during Local Resolution have been explored and fully exhausted and what .... could be referred to a panel .... [The] convener will need to obtain a full picture of the events .... It is not the convener's role to .... resolve the complaint on his/her own.'

Oral and written evidence

17. On 12 July 1996, after the complainant had expressed his unwillingness to meet the consultant, the QDM wrote to him: `There is not really anything that we can add to what has already been said.'

18. The convener wrote to the complainant, on Thursday 29 August, (four days before her letter to him refusing an IR):

> ` .... I have discussed [your questions] .... as part of my investigations, with [the consultant] and others as appropriate. I would like to respond as follows taking each of your points in order.
>
> `A) The junior doctors that saw you .... are very senior with many years of experience. .... We have no doubts as to their professional abilities or adequacy of training.
>
> `....
>
> `C) Although signs of compartmental syndrome were evident on 30 December 1995 and so a diagnosis .... could be made, we cannot speculate as to when these signs were first present.'

The letter ended by saying that she would soon be able to decide about an IR and would write with her decision.

19. In her letter to the complainant of Monday 2 September, refusing him an IR, the convener wrote: `I believe that your questions have been answered fully and truthfully and that the Trust has acknowledged that a judgement about the seriousness of your condition was made by Junior Doctors [and] .... an Independent Review would not .... achieve any further explanation of your unfortunate circumstances.' That letter gave no further detail about the reasoning behind the decision.

20. The convener told the Commissioner's staff that her first letter to the complainant dealt with questions which had not been answered previously by the Trust and was written with the help of the medical director, the chief executive and the QDM. In

her written comments dated 18 January 1997, on the Commissioner's statement of complaint, she said : `My enquiries .... were to give me an understanding of the sequence of events and to ascertain whether all opportunities for satisfying the complainant .... had been explored .... '.

21. At the foot of a copy of his own letter to the chief executive, dated 16 October 1996, the complainant noted: `[the convener] was a sister in the hospital'.

22. On 17 January 1997 in his response to the Commissioner's statement of complaint, the chief executive wrote: `[The convener] has never worked as a nurse for this Trust .... [she] has not worked for the NHS for over 25 years .... '. The convener confirmed that when interviewed.

Findings *(c)*

23. The first of the convener's two letters to the complainant talks of her `investigations', and of discussions with the consultant and others. That letter reads as a defence of the Trust's actions and fails to distance the convener from those involved in this complaint. The convener told the Commissioner's staff that she wanted to reply to questions not previously answered by the Trust. If she felt that was necessary she should have referred the complaint back for further local resolution. As a result of not doing so, she compromised her role. The impression given was that the convener undertook an investigation, drew her own conclusions on behalf of the Trust and, having decided (after discussion with some of those already involved with the complaint) that she had now resolved matters, refused an IR.

24. The boundary between establishing the facts relevant to a decision and carrying out an investigation may be difficult to define, but in this case that divide was undoubtedly crossed. I have established that the convener was not a recent employee of the NHS which might have called her impartiality into question. Despite that, whatever the convener's motives, her investigations and her letter of 29 August brought into question whether she was acting impartially. The guidance was contravened in this case, and I criticise that error. I **invite** the Trust to consider afresh the decision of the convener not to grant an independent review. I uphold the complaint.

Conclusion

25. I have set out my findings in paragraphs 9-10, 15 and 23-24. The Trust have asked me to convey through my report-as I do-their apologies to the complainant for the shortcomings I have identified and have agreed to implement my recommendations in paragraphs 10 and 15 and to consider afresh the decision of the convener not to grant an independent review.

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comments

Case No. S.64/95-96-Communications with patient and relatives

Background and complaint

1. The background provided by the complainant was that in 1992 her husband underwent surgery for cancer of the gullet. Early in 1994 his symptoms recurred. In February and on 12 August he attended routine outpatient follow-up appointments at Hairmyres Hospital, East Kilbride (the hospital). On 23 August he was admitted to ward 24 of the hospital for a prostate operation. While an inpatient he was taken to Glasgow Royal Infirmary (the infirmary) on 2 September for a bone scan. On 5 September he was transferred to ward 23 of the hospital where he died on 18 September.

2. The matters investigated were that:

a. at the clinic on 12 August 1994 the complainant's husband was not told by a consultant thoracic surgeon (the thoracic surgeon) that there was a strong probability that the cancer had spread, and at no time thereafter was he told that the cancer had recurred;

b. after the complainant's husband's admission to the hospital, inadequate attention was paid to his nutritional state. In particular, the nurses did not recognise his inability to eat and persisted in trying to persuade him to eat;

c. on 2 September the complainant's husband was taken to the infirmary in an unsuitable ambulance without an appropriate escort and his intravenous fluids were discontinued for the journey. Also staff at the infirmary were not informed that he was a hospital inpatient so that they could prepare for his specific needs; and

d. after the complainant's husband's transfer to ward 23 he was nursed in a draughty area of the ward where he was continually cold.

Investigation

3. The Commissioner obtained the comments of the Trust, and relevant documents, including the complainant's husband's medical records, were examined. One of the Commissioner's investigating officers took evidence from the complainant and her sister-in-law, who is a senior nurse, and from the staff involved.

Complaint *(a) No information provided*

The complainant's and the complainant's sister-in-law's evidence

4. The complainant said that in 1992 her husband underwent a successful operation for cancer of the gullet and subsequently attended for regular check-ups with the thoracic surgeon. At the end of 1993 he experienced similar symptoms and pain which became progressively worse and by May 1994 he had lost a lot of weight. At an outpatient appointment in August the family had thought he would be admitted to hospital but after only a brief consultation the thoracic surgeon had arranged for the complainant's husband to have tests-a barium swallow and a bone scan-giving no indication of the probability that the cancer had spread. Their impression was that he arranged those only because they had pressed so hard for something to be done. The complainant said that following the consultation the thoracic surgeon in a letter to the complainant's husband's general practitioner expressed his opinion that the possibility of metastatic disease [the distant spread of malignant tumours] was high. They should have been told that so that they would have been better prepared and able to make decisions for the future; other members of the family could also have been properly informed.

5. The complainant said that her husband had been on a waiting list for a prostate operation. When the thoracic surgeon had not admitted her husband to hospital she had continually pressed the secretary of the consultant urologist (the urologist) for him to be admitted for surgery in the belief that once in hospital his serious condition could not fail to be recognised. The complainant's husband was admitted to ward 24 on 23 August. After the operation the complainant was shocked to find that there were no plans for any other treatment. She demanded to see the urologist, which she did on 2 September, when he told her there was a blockage in the stomach and that her husband would be transferred to the care of a consultant general surgeon (the general surgeon) to deal with that. The complainant said that her husband's death certificate was the first and only indication she was given that the cancer had recurred. He had been terminally ill but the information given them had not

reflected that. The complainant's sister-in-law said that it seemed to her that all the staff had known or believed that the cancer had spread but nobody told the family which meant that her brother had not been given the choice of where to die.

The staff evidence

6. The thoracic surgeon said that before he operated on the complainant's husband in 1992 he had told him that the tumour could recur and had implied that in what he had said at follow-up appointments. When he reviewed the complainant's husband on 12 August 1994, he had looked unwell and there was a possibility that the tumour might have recurred or that there might have been metastatic spread of the disease. Although he had not spelt that out he thought that would have been clear to the complainant and her husband. He arranged for a barium swallow and a bone scan and explained that, depending on the result of the barium swallow, it might be necessary to admit the complainant's husband to look down his gullet (oesophagoscopy). The complainant's husband was aware of the purpose of that procedure as it had been carried out before his operation for cancer in 1992. The thoracic surgeon ordered the tests because they were appropriate, not because the complainant and her husband had put pressure on him. His view had been that it was not necessary to admit the complainant's husband until they had the results of the barium swallow. The barium swallow was done when the complainant's husband was already in hospital and so the result would have gone to the ward. He did not see the complainant's husband during his last stay in hospital. It would have been for the urologist to convey to the complainant's husband the results of any tests while he was in his care or to seek the thoracic surgeon's advice if he had wanted it. The thoracic surgeon said that although he had not spelt out that the tumour had probably recurred or metastasized, he had implied that by agreeing that the complainant's husband's condition had deteriorated and by arranging appropriate tests. Referring to tests and procedures carried out while the complainant's husband was in hospital he wrote `since [the complainant's husband] was not admitted under my care at that time I was not in a position to inform [the complainant and her husband] about the high probability that the cancer had spread'.

7. The urologist, responsible for the complainant's husband's care in ward 24, said that his task had been to get the bladder working without the need for a catheter. The results of tests arranged before the complainant's husband's admission would have been referred to the clinician who ordered them. He knew the complainant's husband's history of oesophageal cancer a few years previously and he had not needed an ultrasound report to tell him that the complainant's husband was dying of cancer. It had been obvious as he was losing weight rapidly and vomiting. He and the nursing staff had spent a lot of time with the complainant. Although he had no specific recollection of doing so, he thought he would have explained to her that there was no certain evidence but the symptoms, together with the history, suggested a tumour. As he was always direct and honest with patients and their families he could not believe that he had not explained that to the complainant because it was so obvious. There had been no reason not to tell her.

8. The general surgeon said that the complainant's husband came under his care in ward 23 on 5 September for investigation. There was no definite evidence at that stage of cancer recurring or spreading. A liver ultrasound report of 5 September raised the possibility of malignant disease but it had not been definite. It was not his policy to tell a patient that cancer had recurred, even if that was his suspicion, until he was certain because of the effect such information had on them and their families. An endoscopy on 6 September had shown no sign of recurrence of the tumour at the original site. In a biopsy report of 8 September there was no evidence of tumour in the stomach which was encouraging. They established that there was an obstruction at the bottom end of the stomach but that had not necessarily indicated a tumour and he had planned an operation to relieve the obstruction. He would not have done that if he had had evidence that the obstruction was caused by a tumour. The complainant's husband had not needed an emergency operation and while arrangements were being made a scan report on 13 September had indicated evidence of malignancy. It had still not been definite and an operation was still under consideration but the complainant's husband's chest became much more of a problem making him unfit for surgery.

The Trust's response

9. In their formal response to the Commissioner's office the Trust said that the thoracic surgeon had chosen to defer discussions with the complainant's husband about his condition until the investigations were completed. `Thereafter clinical events initially unrelated to his cancer took [the complainant's husband] into the hands of two other consultants, neither of whom had responsibility for the transmission of such sensitive information.' The Trust said that had been most unfortunate and they had no doubt that if the complainant's husband had remained in the thoracic surgeon's care, communication would have been better. They concluded that the medical staff had not been evasive and if the complainant and her husband had asked about the spread of cancer they would have been told.

Findings *(a)*

10. The complainant said that the first and only indication she was given that her husband's cancer had recurred was from his death certificate. The thoracic surgeon believed that from what was said at the outpatient appointment on 12 August the

complainant and her husband had understood that the tumour might have recurred or metastasized, although he had not said so in so many words. He intended to wait for the outcome of the tests. The urologist said that test results were a matter for the clinician who ordered the tests but in view of the complainant's husband's condition he could not believe that he would not have explained that it was likely that the tumour had recurred. The general surgeon would not have given information without definite proof which, he said, was not there. The Trust's view was that neither the urologist nor the general surgeon had a responsibility for informing the complainant's husband; they acknowledged that that situation was `most unfortunate' and that communication would have been better had he remained in the thoracic surgeon's care. The complainant's sister-in-law said that the staff had known or believed that the cancer had spread but had said nothing. Who then was responsible between 23 August and the complainant's husband's death on 18 September for explaining his prognosis to him and his family? It seems to me that the consultant under whose care he was at the time was responsible for seeing that those needs were met, either dealing with them himself or arranging for shared care with a consultant in the relevant specialty. That the complainant's husband and his family were left without adequate information was a failure in service and I uphold this aspect of the complaint. **I recommend** that the Trust make sure that where a patient is passing through the care of a number of clinicians, the responsibility for keeping that patient and his family informed is clearly established.

Complaint *(b) Attention to nutritional state*

11. Nasogastric (NG) feeding is a method of providing a complete liquid diet by means of a fine bore tube inserted through the nose into the stomach. Supplemental parenteral nutrition is used to provide additional nutrients in solution through a peripheral venous line while the patient is encouraged to eat and drink. Total parenteral nutrition (TPN) may be used when it is impossible to provide adequate nutrition through the gastrointestinal tract. It must be administered through a central vein.

The complainant's and the complainant's sister-in-law's evidence

12. The complainant said that when her husband was admitted to the hospital he was emaciated. When she saw the urologist on 2 September she asked if her husband was able to eat. He told her that her husband could not eat because there was a blockage in his stomach. She asked him to give that information to the ward staff who appeared to think that he did not want to eat and frequently tried to persuade him to do so. The complainant's sister-in-law said that her brother had apparently been referred to a dietitian on 23 August, on admission, but he did not appear to have been seen until 26 August. A dietitian should have seen him by 24 August to prepare for his post-operative care. From 26 August to 2 September he appeared to have been receiving fortified drinks but there seemed to have been little nursing supervision of that and he was not reviewed by a dietitian. The complainant said that by the time her husband was transferred to ward 23 on 5 September he was not able to eat but nursing staff had continued to encourage him to do so which upset him. The complainant's sister-in-law felt that the staff should have considered other ways of feeding him, for instance, by TPN. They had since been told the urologist's view that even if TPN had been used earlier it would not have made a significant difference to the outcome. The complainant's sister-in-law accepted that her brother would have died but considered that his quality of life would have been improved if he had been given nutrition other than orally which he could not tolerate. He was seen by a dietitian on 3 September in ward 24 when he was given vitrimix (an intravenous food supplement) and again on 9 September in ward 23 but there was no record of a review by the dietitian between those dates.

Staff evidence

Ward 24 nursing staff

13. The sister in charge of the ward (the first sister) said that in 1994 because of a shortage of experienced staff, patients' care plans were not always completed and staff relied on information from handover reports and nursing notes. On admission the complainant's husband was able to eat but he lacked motivation and suffered from nausea. He was started on vitrimix on 3 September on the general surgeon's instructions. Patients were still encouraged to eat and drink when they were being given vitrimix. The complainant's husband was referred to a dietitian on admission.

14. A staff nurse (the first staff nurse), who admitted the complainant's husband on 23 August, said that she completed a nursing assessment which included `poor appetite (marked [weight] loss over past 10 [weeks])'. He had been very thin and looked ill and she had referred him to a dietitian. She made the referral by telephone and told the dietitian that the complainant's husband was going to theatre. [Note: I have seen a note, made on 23 August, that the dietitian would see the complainant's husband on Thursday 25 August]. The first staff nurse said that a care plan should have been completed for the complainant's husband's nutrition. Normally that would be done after a patient had been to theatre and would have included the dietitian's guidelines. If the complainant's husband had had a blockage in the stomach, which meant that he could not eat, medical staff would have informed nursing staff about that and it would have been documented. She had no recollection of being told that the complainant's husband had a blockage.

15. Other nurses interviewed gave similar evidence. None was aware that the complainant's husband had a blockage in the stomach. If they had been so informed it would have been documented and the complainant's husband would have been cared for in accordance with instructions given by medical staff. The fact that there was no care plan for the complainant's husband's nutrition would not have affected the care given to him.

Ward 23 nursing staff

16. The ward sister (the second sister) said that when transferred to the ward the complainant's husband was on intravenous vitrimix. Patients receiving vitrimix were still encouraged to eat unless medical staff instructed otherwise, the object being to build the patient up, increasing their oral intake until vitrimix was no longer necessary. The complainant's husband's diet continued to be supplemented with vitrimix. There was no record that nursing staff were told that he had a blockage which prevented him from eating. On admission to the ward the complainant's husband was assessed and care plans were drawn up including a nutrition plan.

17. An enrolled nurse said that the transfer report from ward 24 stated that the complainant's husband's appetite was poor and that he had to be encouraged with fluids, a soft diet and high calorie drinks. A staff nurse (the second staff nurse) said she completed a care plan for the complainant's husband's nutrition following his transfer to the ward because he was emaciated. The aim was to make sure he was eating. Another staff nurse (the third staff nurse) said that the complainant's husband's appetite was poor but he had been eating a little.

18. Other nurses interviewed gave similar evidence. None was aware of a blockage in the stomach and all said that if they had been told of that by medical staff it would have been documented.

19. The director of nursing and quality assurance (the director of nursing) believed that medical staff were aware of the complainant's husband's inadequate diet intake. Shortly after his admission he was fasting before his operation which would have made it difficult for nurses to assess him properly and it might have been a day or two before that could be done. In her view the complainant's husband's nutritional state was inadequately managed in ward 24. His nutrition was recognised as a problem but the deficit in his intake was not identified. She would have expected an agreed programme to be drawn up with dietetic advice. The dietitian had recorded that the complainant's husband should have supplements which were in the form of drinks. The director of nursing questioned whether he was given them as there was no record of that. There was no indication from the nursing records about what he could and could not eat. By the time the complainant's husband was transferred to ward 23 a gastro intestinal problem had been identified; a plan was drawn up; and he was given peripheral feeding in the form of vitrimix from 3 to 17 September. In her view from that stage his nutrition was adequately managed: vitrimix provided the essential proteins and he was receiving a reasonable amount of intravenous fluids. If the medical staff had thought there was a blockage preventing the complainant's husband from eating it was for them to inform the nurses and to arrange some other form of feeding.

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comments

Case No. W.34/95-96-Care of an elderly person and communication with relatives

Background and complaint

1. The background provided to the complaint was that during October 1994 the complainant's 82 year old mother, was admitted to Prince Philip Hospital, Llanelli (the first hospital), after collapsing at home. She was transferred to Mynydd Mawr Hospital (the second hospital) and then in December to Bryntirion Hospital (the third hospital) where she stayed until 20 January 1995, when she was readmitted to the first hospital after a further collapse. Her condition improved the following day but deteriorated again that evening and she died early on 22 January. The first and second hospitals are managed by Llanelli/Dinefwr NHS Trust (the first Trust) and the third hospital by Derwen Community NHS Trust (the second Trust).

2. The complaints investigated were that:

a. the complainant's mother's nursing care was inadequate in that:

b. while in the first and second hospitals

i. because of inadequate supervision and assistance by nurses, she did not consume the meals provided for her;

ii. her prescribed medication was left at her bedside, with the result that she did not take it; and that

while in the first hospital

iii. nurses neglected her hygiene needs and did not monitor her condition adequately;

c. a nurse told the complainant, incorrectly, that his mother had died;

d. instructions left by the complainant at all three hospitals, that his mother should not be revived in the event of total collapse, were ignored; and

e. the correct procedure for certifying the death of the complainant's mother was not followed, resulting in the complainant taking an invalid death certificate to the Registrar of Births and Deaths.

Investigation

3. The statement of complaint for the investigation was issued on 31 October 1995. The complainant was told that his complaint could in part concern action taken solely in the exercise of clinical judgment which, at that time, was statutorily outside the Commissioner's jurisdiction. The Commissioner obtained the comments of the first Trust and relevant papers from both Trusts were examined, including the patient's medical records. Evidence was taken from the complainant, his sisters, his wife, and staff involved from both Trusts. I have not put into this report every detail investigated but I am satisfied that no matter of significance has been overlooked.

Complaint *(a) Inadequate nursing care*

4. The complainant told the Commissioner's staff that his mother was particular in what she ate and when she was in the first and second hospitals he took in food for her such as salmon sandwiches and rice pudding. When he visited he often found that she had left the hospital food on her tray. Staff in the first hospital had not seemed to monitor what she was eating or drinking. Nurses in the second hospital admitted that they were experiencing difficulty in getting his mother to eat; she had become very stubborn toward the end of her stay there and the staff would not have been able to get her to eat if she had not wanted to do so.

5. When the complainant visited his mother at the first hospital in the afternoons her medication was on the bedside table, sometimes apparently left from two drug rounds. The nurses had said that she would not take her tablets but she had from him.

In the second hospital, where he visited on alternate days in the evenings, medication was also left on the bedside locker. He recalled that when his mother was back in the first hospital on 21 January 1995, after lunch, he had found food and medication left by her bed.

6. The complainant said that on one occasion when he arrived at the first hospital his mother had immediately asked his wife to help her change her soiled clothing. The complainant's wife, a qualified nurse, explained that she had helped to give her mother-in-law a strip wash and had noticed that her groin was very sore. She asked a nurse for some barrier cream which the nurse provided without comment. The complainant noticed that there was evidence of faecal incontinence under his mother's bed; it had remained there during the weekend.

Documentary evidence-the first hospital

7. The complainant's mother was admitted to the first hospital on 18 October 1994. The patient care record started in the accident and emergency department stated that she was doubly incontinent. The assessment form completed in the ward described her as `self caring' in respect of her personal hygiene needs, and in respect of her eating and drinking stated that she had an average appetite. The condition of her skin was assessed as good. The Waterlow score (a measurement of a person's vulnerability to pressure sores) was judged to be 10 (Note: I understand that a score of 10 put the patient in the `at risk' category.) On 24 October, the complainant's mother was documented as having loose stools and being incontinent. The care objective was to find the cause of the loose stools and the plan of care included `Clean and wash thoroughly after incontinence' and `Apply barrier cream'. Antibiotics were stopped. It was recorded on 26 October that her buttocks and groin were very red. There were unexplained gaps in the drug administration chart at times when prescribed drugs should have been given (see paragraph 9).

8. The drug administration policy in use in the first and second hospitals at the time of the events complained about required that `All drugs must be administered by an approved Nurse' and that `Immediately following the administration .... the administering Nurse must initial the Prescription Chart'. A revised policy introduced by the first Trust in August 1995 reaffirmed the administering nurse's responsibility for the `whole procedure' and said that that `must be completed for each patient before the administration of medicinal products is commenced for another patient'.

Evidence of staff at the first hospital

9. A senior staff nurse told the Commissioner's staff that she was on holiday when the complainant's mother was first admitted; she was involved in her care on only one shift and had no recollection of her. She said that catering staff gave meals to patients and any available member of staff would assist a patient if required. Sometimes families might be asked to bring in food; they were also encouraged to come in to feed patients, although they rarely did so. Uneaten food was left for about half an hour before being removed. Staff on the ward followed the hospital's policy on administering drugs and made sure that patients took their medication; she had never seen drugs left on patients' lockers. She doubted that drugs from two rounds could have been left as nurses would have seen the medication during the four-hour periods between the drug rounds, and disposed of it. If a patient refused medication, an `X' was put in the appropriate section of the administration chart, with the reason why the drug had not been given and a doctor would be informed. She would leave a patient to drink medication while dispensing drugs to other patients in a four-bedded bay, and then check that it had been taken. In those circumstances medicine pots could be left with patients.

10. The senior staff nurse said that patients known to be incontinent were offered bedpans every two hours. If they had been incontinent they would be washed and changed and, if required, barrier cream would be used. Pressure area care would be given and any discoloration, soreness or incontinence recorded, as she had done on 24 October (as I have seen). She doubted that the mark on the floor under the complainant's mother's bed (paragraph 6) was due to incontinence. Her recollection was that the carpet in the room in which she was nursed had a burn which might have been mistaken for incontinence. Faecal incontinence stains were easily removed by cleaning materials and the ward was cleaned regularly. (Note: the Commissioner's officers saw the burn and agreed it could have been mistaken for faecal incontinence.)

11. A relief sister who covered the ward in the absence of the senior staff nurse in the first week of the complainant's mother's stay also could not remember her. She said that it was a very busy ward and in practice nurses often heard from catering staff or relatives if patients were not eating; nurses would then record the problem and review it after 24 hours; if it continued, supplements to the diet could be given or a referral made to a dietician. She gave similar evidence to that of the senior staff nurse about the procedure when patients refused medication. She said that she was often interrupted or distracted during a drug round but she always went back to check that her last patient had taken the medication she had given out. Only then would she sign the chart. If a patient was incontinent that was highlighted as a problem, and she was surprised that the complainant's mother's incontinence had not been identified and a care plan drawn up when she was admitted to the ward. A

relative might find a patient had been incontinent as that could occur between the regular checks by nursing staff. A staff nurse gave similar evidence about ward procedures to that of the senior staff nurse and the relief sister. She could not recall nursing the complainant's mother in October 1994.

12. The senior nurse manager for medicine, who was responsible for the ward concerned and other wards, said that when the complainant's mother was admitted to the ward, she was assessed as self caring. She would therefore have been encouraged to do as much as possible for herself, including feeding herself. If she was not eating catering staff should have told the nurses. Since the time of these events hotel services (catering) staff had received training on the nutritional needs of patients and the importance of informing the nursing staff about what patients had eaten. There was now a nutrition form on each bed which showed dieticians, who visited daily, if the patient had any dietary problems. In her enquiries into this complaint she had found that nurses were signing that drugs had been taken before making sure that the patient had done so. It had been correct to encourage self caring patients, such as the complainant's mother, to be responsible for taking their own medication but it was the nurses' duty to make sure that the medication was taken and only then should the administration chart have been signed. The complainant's mother was identified on admission as being doubly incontinent but there was no document to show that her hygiene needs were then met. Patients with incontinence were checked every two hours and the senior nurse manager was confident that that plan of care had been implemented, despite the lack of records.

Documentary evidence-the second hospital

13. The complainant's mother was transferred to the second hospital on 27 October and her patient care record from the first hospital continued to be used. An unsigned and undated assessment form, completed probably on 27 October, stated that she had had a loss of appetite since being in hospital. A fresh assessment on 16 November noted that she had a poor appetite; on 19 November it was recorded that she was refusing to eat and drink. The plan of care at that time was to encourage snacks and fluids of her choice, commence a nutrition chart, and weigh her weekly. Thereafter, her reluctance and later refusal to eat were documented on several occasions, and there is a note of a conversation with the complainant on 22 November about her preference for sandwiches. On three occasions no entry was made in the drug administration chart and on nine occasions reasons were given for the non-administration of drugs. It was also recorded that she refused all medication on 16 November and twice spat out her medication on 18 November.

Evidence of staff at the second hospital

14. A staff nurse told the Commissioner's staff that the complainant's mother refused to eat whatever she was offered. She had tried many things to encourage her but without success. She had suggested that the complainant should try to get his mother to eat. She recalled the complainant's mother saying that she would eat a tomato sandwich which she had then refused. Nurses had sat with her and tried to coax her to eat. She had also encouraged her to take her medication. If she refused, the drug administration chart was marked accordingly with the reason for the refusal. The staff nurse said that she had never seen drugs left untaken and that the complainant's mother had usually sat in the day-room or at the end of the ward, not by her bed, and would be given her medication where she was.

15. Another staff nurse, who completed the assessment of the complainant's mother on 16 November, said that she was self caring when admitted but that her condition deteriorated and she would not eat or take her medication. If patients refused to eat, even the food that they liked, no doctor, dietician or nurse could make them do so. The complainant's mother had become difficult when asked to take her tablets and held them in her mouth rather than swallowing them. The staff nurse denied that tablets were left on bedside tables. She said that all patients were encouraged to sit away from their bed during the day.

16. The ward sister said that patients not eating were helped and if the problem continued a food chart was started. If there was no improvement the patient was given food supplements or referred to a dietitian. Efforts were always made to establish what patients liked to eat and relatives were encouraged to bring their favourite foods. The sister said that she had never seen medication left by a patient's bed or about the ward and her staff had assured her that it was not. At the time she had been satisfied with the standard of record-keeping but since this complaint staff had received further training on the importance of comprehensive and clear records.

17. The first Trust's director of nursing said that there was little record of what the complainant's mother had eaten at the first hospital but it was clear that at the second hospital nurses had supervised and encouraged her to eat. The nurses in both hospitals had not been able to say that they had not left patients before making sure that they had taken their medication. That was not acceptable. In a report the director said that staff had been questioned at length on this issue. They had commented that when they were known to have supervised the complainant's mother taking her medicine, her tablets were sometimes later found either in the bed or on the floor discarded. She regularly considered how detailed the nursing notes should be about patients' nursing needs. She felt that all care, including specific elements for `self caring' patients, should be documented and

that it was important that records were updated as patients' needs changed.

18. The consultant physician (the consultant) responsible for the complainant's mother's care at the first and second hospitals said that the nursing staff had kept him informed about her eating. A patient's wishes had to be respected and force-feeding would not have been acceptable. He had never seen medication left about the ward. The fact that the complainant's mother, despite incontinence and poor mobility, had not suffered sores in pressure areas suggested a good standard of nursing.

19. The chief executive of the first Trust told the Commissioner in the Trust's formal response to the investigation that they were satisfied that the complainant's mother was given appropriate care and attention at mealtimes; that in line with their policy staff should have made sure that she took the medication prescribed but her medication was frequently discarded either in her bed or on the floor - on occasions she put tablets in her mouth to disguise the fact that she had not swallowed them; and that the hygiene given was up to the standard expected. She explained that it was not their practice to document routine ward events but exceptions to routine.

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comments

Case No. W.44/96-Nursing care and adequacy of nurse staff

Background and complaint

1. The background provided by the complainant was that her husband, who had cancer, was admitted to Ward 5 at East Glamorgan General Hospital on 8 April 1995. He was transferred to Ward 3 on 15 April, from where he was discharged home on 4 May. The complainant's husband died on 17 May. On 31 May the complainant wrote to East Glamorgan NHS Trust (the Trust), which manage the hospital, about the care and treatment her husband received. An exchange of correspondence followed but the complainant remained dissatisfied.

2. The matters investigated were that when the complainant's husband was a patient in Ward 3:

a. he received inadequate nourishment. In particular, he missed meals because he was too ill to complete diet sheets;

b. full vomit and urine containers were left at his bedside and had to be removed by the complainant;

c. medication should not have been left on his bedside locker; and

d. the level of staffing was inadequate in that the complainant had to search for nurses when her husband needed attention.

Investigation

3. I obtained the comments of the Trust and examined relevant papers, including the complainant's husband's clinical and nursing records. My staff took evidence from the complainant and the Trust staff involved.

The complainant's evidence

4. The complainant told my investigator that in the weeks before her husband was admitted to hospital he had lost a lot of weight. Throughout his stay in hospital, he became progressively weaker. She visited him every day but, in Ward 3, she never saw him with a diet sheet or meal; at meal-times the trolley went straight past him and he was not left anything to eat. When the complainant chased after the staff to ask why he had been missed out, she was told that he must not have completed a diet sheet. Some of those whom she approached offered to get her husband food, but others would not as there was no diet sheet. The complainant knew that her husband was not able to eat a full meal, but he said he would like something light such as yoghurt or ice-cream. She thought that it was important for him to receive adequate food but was worried that he was being overlooked.

5. The complainant said that, every time she visited her husband, she found at least one container of urine or vomit left on his bedside locker. She felt unable to leave them where they were as some of her family found the sight and smell of the contents distressing. She took the containers to the sluice, marking them carefully with her husband's name and bed number. She told staff they were there so that the contents could be measured for his fluid balance chart.

6. The complainant was also concerned about finding tablets on her husband's bedside locker on most occasions when she visited him; she remembered finding morphine elixir there as well. Her husband had threatened suicide if his cancer was found to have returned, and she was also worried that children visiting the ward might pick up the tablets believing them to be sweets. She made a complaint about this at the time but could not now recall for certain which nurses she had approached. One replied by telling her that the tablets were not dangerous, and a staff nurse said that the complainant's husband had not wanted his medication earlier so it was left with him to take when he was ready. The complainant believed it would have been possible for him to save up the tablets and take an overdose.

7. The complainant said that, in her opinion, there was an adequate number of staff in the ward. The problem was that they were never around when she needed help and she had to search the ward for them. Whenever she tried to find staff, they were not in the main ward area but were all in a room at the end. (Note: the ward comprises a number of four- and six-bedded bays, and two single rooms. The complainant's husband was in a bay near the ward entrance and opposite the ward office and staff room.) The complainant said that, although there was a call bell above her husband's bed, she would not have used it as she

was capable of finding staff herself and did not want to bother them unnecessarily. The complainant was not satisfied by the Trust's reply to her various complaints; she thought they were just making excuses.

Drug administration policy

8. The code of practice for drug administration, issued in June 1993 by the former Mid Glamorgan Health Authority, states that `.... Drugs are to be given at the time stated, in the dosage prescribed, by the correct route, and the nurse must as a general rule ensure that the patient has taken the medication. However it is acknowledged that in certain circumstances this may not always be possible eg .... patient controlled analgesia etc'. The prescription sheets themselves carry instructions to nursing staff which include: `.... Enter `X' in box in the event of non administration and specify reason, with date and time in the section provided on the reverse of this sheet ....'.

Documentary evidence

9. I examined the complainant's husband's nursing and medical records. An entry on the day of his admission (to Ward 5), records that he had a poor appetite and had vomited that morning; it notes that his weight was then 12 stone, having fallen by one stone, five pounds during the previous three weeks. An entry in his clinical notes records his weight on 24 April as 11 stone, 12 pounds. I saw 23 entries in the nursing records about the complainant's husband's intake of food and fluids e.g. `small diet and fluids tolerated', eight entries noting that he had vomited though only one entry records the amount, and four entries that there had been no nausea or vomiting. I also saw a summary fluid balance chart covering the period 17 April 1995 to 4 May 1995. There was an entry for each day, except that there was one undated entry where those for 21 and 22 April should be. (Note: my investigator was told by a staff nurse that in the past the individual daily charts, updated every hour, were destroyed after the day's total had been transferred to the summary chart; that that practice was no longer followed-both daily and summary charts were now kept in the patient's records.) A care plan dated 23 April stated that the complainant's husband's fluid balance was to be strictly monitored. His prescription records contain five entries which detail when he did not receive, or refused, his medication. Corresponding with those entries are crosses on the regular prescription sheet, but there are additional crosses and blank spaces representing 13 drug rounds where the reason for non-administration was not recorded.

Staff evidence

10. Among those staff working in Ward 3 while the complainant's husband was a patient there, and whom my investigator interviewed, separately, about the complainant's concerns, were one student nurse and six staff nurses. All of them had at some point made entries in the nursing records. Four of the staff nurses gave broadly similar evidence so for ease of presentation I set out first the relevant matters common to the evidence of each, and then set out any significant areas of difference. Each of them could remember the complainant's husband, some from a previous admission to the ward in November 1994, and described him as a quiet patient who was obviously very poorly. He was able to walk a little and they thought that he was capable of asking if he needed anything. They described the complainant as a friendly, pleasant woman with whom they felt they had had a good relationship. None of them remembered the complainant ever complaining to them about her husband's care.

11. They told my investigator that diet sheets were issued by the kitchen staff during the morning and collected a few hours later. Either the kitchen or ward staff would help any patient who could not fill in the sheet. The ward staff distributed meals from the trolley. At the end of the round, the ward staff made a list of any extra or replacement meals needed and telephoned the kitchen to arrange for them to be delivered. This procedure was very easy to follow and as there were often not enough meals on the trolley, especially on days when patients were admitted or discharged, at least once on each shift they had to obtain additional meals. Two of the staff nurses said that the complainant's husband did not eat much; he suffered from nausea and would not have wanted to eat a lot. If they were concerned about his appetite, they would have encouraged him with other foods or build-up drinks. Two nurses commented that plates were often cleared away by the domestic staff, so the nurses were not always able to tell how much a patient had consumed. None remembered the complainant approaching them about her husband's meals and they did not remember being particularly concerned about her husband's appetite; if they were, they would have recorded that in the notes and referred him to either the medical staff or the dietician. There was no difficulty in obtaining additional or replacement dishes, and light meals such as soup and yoghurt were readily available. One staff nurse said that, given the complainant's husband's condition when he was admitted, information obtained then about his appetite and weight loss should have been used to assess his care needs with the aim of making sure that he received adequate nourishment, especially fluids.

12. Each of the four staff nurses said that patients normally asked a member of staff to remove urine bottles and containers as soon as they had used them. The containers were checked regularly by the staff during the course of their duties in the ward. If

they noticed a container that had been used, they removed it as soon as they saw it. One of them commented that a backlog might occur if the sluice was broken, but that happened very rarely; another said that, although staff cleared containers as quickly as possible, one or two might occasionally accumulate. They all regarded a used container as something which should not be left lying around, and each referred to the importance of measuring the contents for fluid balance charts. They told my investigator that at various times they had seen the complainant carrying the containers and offered to take them from her; she had refused their help and told them not to worry, saying that she knew that they were busy and that she did not mind moving them herself. They knew that the complainant left containers at the sluice for measuring, and attended to them as soon as they could. Removal of containers was a nursing task, but relatives who wanted to help out were not discouraged from doing so. One of the staff nurses said that family involvement in giving care was not a matter which would be recorded in the patient's notes.

13. The four staff nurses each said that drug rounds took place at set times throughout the day (at about 5.45 am, 11.00 am (which was a joint round for doses timed for 10.00 am and 12.00 noon), 1.15 pm, 5.15 pm and 9.30 pm) and were usually carried out by the most senior nurse in the ward at the time. Drugs were issued to the patient and the prescription sheet signed by the nurse. If the drug was not given, or the patient refused it, the form was marked with a cross and the reason entered on the back. When shown the complainant's husband's prescription sheet with some spaces left blank, they acknowledged that that should not have happened. One staff nurse said that unless a medication was a dangerous drug, it could sometimes be left for the patient to take later; a decision on that depended on her assessment of the individual patient. Another said that Oromorph (the morphine elixir prescribed for the complainant's husband) could not be left as the interval between doses needed to be calculated. A third said that a nurse, using her discretion, might leave medication with the patient where, for example, it needed to be taken at meal-time. The remaining staff nurse commented that, where a drug was left for a patient to take later, there was no formal check-up but a nurse seeing it still there would remind the patient to take it. All the nurses said that if they saw a drug had not been taken they would mark the chart accordingly. None of the nurses interviewed could remember dispensing drugs to the complainant's husband although two of them, who were able to recall him, said that they would not have been concerned about leaving medication with him. One of them believed that, because of his nausea, the complainant's husband often wanted to take his drugs later. Two of the nurses pointed out that Oromorph was prescribed `as required' and would have been dispensed for pain relief when he asked for it. They thought it likely that he would have taken it immediately.

14. The four staff nurses told the investigator that, even during meal and coffee breaks, there would always be staff in the main ward areas, but because of the ward layout they might not necessarily be in view. They all said that they tried to keep a discreet distance from patients who had visitors, so that visits were not disturbed unnecessarily. That said, they would intervene if they needed to do so. The call bell could be used to attract the attention of a member of staff, but one of the nurses said she believed that relatives liked an opportunity to ask questions away from the patient.

15. A fifth staff nurse also remembered the complainant declining help, but she could not recall the complainant's husband. A sixth staff nurse, and the student nurse, could not remember either the complainant or her husband. All three gave evidence, in respect of procedures, which was similar to that of the four staff nurses set out in paragraphs 10 to 14.

16. The senior staff nurse, whose responsibilities included supervising and monitoring ward staff, said that the complainant's husband was very poorly and his condition deteriorated gradually during his stay in the ward. At that stage in his illness, the main purpose of his care was to see to his immediate needs and to make him as comfortable as possible. He had had a very poor appetite. He did not refuse food and always tried to eat something, but once he had had enough he could not be forced to have any more. She did not consider it likely that the complainant's husband could have been overlooked but, even if he had, he probably would not have told staff as it was easier for him to go without. She remembered that he liked toast, soup and ice-cream and on at least one occasion she had made toast for him herself. She saw that the complainant could not understand why her husband was unable to eat very much.

17. The senior staff nurse's main concern was not the complainant's husband's appetite but his hydration level, and it was she who had drawn up the care plan for that on 23 April (paragraph 9). His needs in that respect should in her opinion have been assessed and recorded at the time of admission. She recalled that on one occasion she was removing a container, but the complainant took it from her, telling her not to bother as she would do it herself. Ideally, the nursing records should have noted the complainants wish to provide care for her husband. If there had been concern about her husband's fluid balance, staff would have investigated and, if necessary, he could have been catheterised. She had dispensed medication to the complainant's husband but explained that she would not have left medication with him unless the complainant was present to make sure that he took it. In her opinion, if he had been left medication, he would not have taken it on his own. He needed support to help him drink the Oromorph. As the ward allowed fairly open visiting, staff had to continue with their work regardless of whether a patient had visitors although they tried not to intrude. There were always staff in the ward, and she was satisfied with the staffing level and with the procedure for obtaining extra staff if needed.

18. The ward sister remembered the complainant as being a pleasant and helpful person, and her husband as quite alert but ill with jaundice and nausea. There had been no hint of any concerns while he was in the ward. He had not wanted to eat much and often asked for his meal to be taken away. On one occasion, when she was trying to encourage him to eat, he said that he did not want to do so because the nausea made it difficult for him to manage a full meal. She was present when one of the nurses offered to take a container from the complainant, but the complainant declined the offer. She acknowledged that nurses should observe medication being taken, but added that at times that rule seemed `awfully regimented'. She expected only one nurse at a time, from each team, to be absent on a rest break. Such breaks tended to be at visiting times when the nurses were less busy, and those remaining on duty would keep at a distance, as far as possible, in order to give patients and their relatives some privacy. If pressures on the nurses became too great there was a procedure for requesting help from the nurse bank (a pool of nurses available to be called in to cover shortages). The ward sister was satisfied with the care provided by the nursing staff.

19. The consultant surgeon responsible for the complainant's husband's care (the consultant) said that, at the time of his admission in April 1995, the complainant's husband was deeply jaundiced and in pain; he did not want to eat because of his nausea and vomiting. At that stage in his illness, the medical and nursing care he was given was simply to make him more comfortable. He would not have been concerned if the complainant's husband had missed drugs to the extent implied by the gaps on the drug records; they were small doses prescribed to give immediate pain relief and if he did not want them he would not have been forced to take them. The complainant's husband would not have been able to do himself any harm by trying to take several together, nor was there any problem in leaving Oromorph for him to have when he wanted it. The consultant said that Ward 3 was kept clean and tidy and he was very satisfied with the level of care provided by the nursing staff.

20. The Trust's senior nurse advisor (the nurse advisor), who is responsible for professional nursing standards, said that it was the responsibility of the nurses to arrange a meal for any patient who had been missed. She understood that the complainant's concern was that her husband was not offered anything to eat, and that she had chased after the trolley down the ward. The nurse advisor had tried to explain to her that she had approached staff before they were able to check if every patient had something, but the complainant would not accept that the staff would have come back to her husband. The removal of used containers was a nursing responsibility and the nursing advisor did not expect them to be left at the patient's bedside. She accepted what the ward staff had said about the complainant refusing their help and was sorry that the complainant now perceived that she had been obliged to remove the containers herself. She was satisfied with the standard of care given to the complainant's husband, but acknowledged that the quality of record keeping could have been better in some respects; in particular, the care which the complainant offered to provide for her husband should have been recorded.

21. The chief executive told my investigator that the Trust had not identified any shortcomings during their investigation, and she was satisfied with the procedures in place. She did not regard the staffing level in the ward as unsafe but was concerned about staff visibility during visiting hours. Staff in other wards made a point of speaking to relatives during visiting hours. That did not happen in Ward 3. She had asked the senior nurse advisor to take the matter up with staff.

Findings *(a) inadequate nourishment*

22. The complainant was concerned that her husband had missed meals because he was too ill to complete his diet sheets. There is no evidence to suggest that that was the case, and I have been told that there are procedures in place to make sure that meals are obtained for those patients who at first are missed. The entries in the nursing records show that staff in Ward 3 noted with reasonable frequency, if not in great detail, the complainant's husband's nutritional intake and I am persuaded that they encouraged him to eat. What is not quite so satisfactory is that it took some eight days for anyone to consider drawing up a care plan aimed at dealing systematically with the nutritional needs of a patient who was known to have a condition which leads to poor appetite and fluid intake, which may then cause weight loss and dehydration. I agree with the comments of the senior staff nurse (paragraph 17) about that, and I suggest that the Trust remind staff of the importance of including nutritional requirements in the care plans for patients, especially when they are terminally ill. I have found no evidence that this shortcoming resulted in any want of attention to the complainant's husband's intake of nourishment, so I do not uphold the complaint.

Findings *(b) full containers left by bedside*

23. There will clearly be occasions when, for a short period, a full container will remain uncollected, but I am persuaded that in normal circumstances the nurses would have removed used containers promptly from the complainant's husband's bedside. The evidence leaves me in no doubt that the complainant often volunteered to remove containers herself, in order to relieve the nurses of this task. I do not believe that this arose from any laxity on the part of the nurses, but it is unfortunate that the nursing records make no mention of the care provided by the complainant. Other cases I have investigated have highlighted similar problems elsewhere and I suggest that staff be encouraged to document in the nursing records the part which relatives

play in providing care. That said, I do not uphold this aspect of the complaint.

Findings *(c) medication left on the bedside locker*

24. I am troubled that there is such a divergence of view, among the nurses, about whether the complainant's husband would have been capable of taking medication himself; and that there are differences of opinion on the question of whether it mattered if Oromorph was left with him. I would have expected to find a common approach to such an aspect of care and treatment. Record-keeping is an aspect open to my scrutiny and comment, and I criticise the deficiencies in the records detailing the administration of the complainant's husband's medication. I find it very probable that, if medication was left with him, proper monitoring was not carried out to make sure that the drugs were taken. I recommend that the Trust review their code of practice for drug administration to make sure that there is a consistency in nursing practice about the ways in which patients' drugs are administered. To the extent indicated, I uphold this aspect of the complaint.

Findings *(d) inadequate staffing level*

25. I have found no evidence to suggest that the general level of staffing in Ward 3 was inadequate. The complainant has made clear that her concerns were not about staff numbers, but arose from difficulties which, she has said, she frequently experienced in finding a nurse. The chief executive considers that staff in Ward 3 did not have as high a profile during visiting hours as those in other wards and, as that seems to address the essence of the complainant's concerns, I am content to leave this matter there. The real question at issue is the deployment, rather than the actual number, of nurses so I do not uphold the complaint.

Conclusion

26. I have set out my findings in paragraphs 22 to 25. The Trust have agreed to implement my recommendation in paragraph 24, and also the steps I have suggested in paragraphs 22 and 23. They have asked me to convey through my report-as I do-their apologies to the complainant for the shortcomings which I have identified.

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comments

Complaint *(b) Delay before seeing the body*

21. The complainant told the Commissioner's staff that after being told of her father's death, she arrived at the hospital with her friend at about 9.40 am. When she had spoken on the telephone to the student nurse, the student nurse had said that her father's body was still in the ward; when the complainant arrived in the ward and asked if she could see the body the student nurse said that it had been removed to the mortuary. The student nurse contacted the mortuary technician who told her that, because of other commitments in another of the Trust's hospitals, he would not be able to show the body to the complainant until around midday. An appointment was made and the complainant went to collect her father's belongings and spoke to hospital staff about his treatment. At midday she was still with the operational services manager (see Appendix - 22 July 1994); at her request he telephoned the ward to say she would be delayed. When she arrived in the ward at 12.15 pm she was upset to discover from the student nurse that the mortuary technician had left the hospital and would not return until the next day. She refused the student nurse's suggestion that she return then and insisted on seeing her father's body as soon as possible. The student nurse then telephoned the mortuary technician who agreed to return to the mortuary. He arrived at around 1 pm and the complainant was then able to view her father's body. The complainant's friend said that when she and the complainant went to the ward at around 9.30 am, the student nurse told them that the complainant's father's body was still in the ward but that it was not convenient for them to view it then.

Viewing procedures

22. The hospital has no written guidance for nurses about the arrangements for allowing relatives to view the body of a deceased patient in the ward. The Trust's risk manager whose responsibilities include advising on the handling of complaints told the Commissioner's staff that nurses generally understood that, if a body was in the ward and in a suitable state for viewing, the nurse in charge could decide to allow relatives to view it there.

23. At the time of the patient's death the only guidance to hospital staff about arrangements for allowing relatives to view a body in the mortuary was contained in a memorandum by the pathology business manager on mortuary procedures. It stated: `There are now three mortuary staff based at [the hospital] and we hope to be able to provide a smooth and efficient service from this base. .... A member of the mortuary staff will be in attendance for viewings by relatives. To arrange this, the Patient Affairs Officer should telephone the mortuary.' Under a heading `Viewing Arrangements Outside Working Hours' it stated: `.... the porters must be contacted by the nursing staff to allow access to the chapel of rest. .... all relatives are accompanied by a member of the nursing staff. .... it is the responsibility of the porters to return the body to the body store ....' According to the senior staff nurse there was a copy of the memorandum in the A and E ward procedures manual.

Staff evidence

24. The student nurse said that at the time of the patient's death she had not been aware of the hospital procedures for allowing relatives to view the body of a deceased patient. She could not remember whether the patient's body was in the ward or the mortuary when the complainant and her friend arrived. On the advice of the senior staff nurse she had telephoned the mortuary technician to arrange a viewing in the mortuary. He had told her that he was working elsewhere but would be back at the hospital by midday. The student nurse had a faint recollection that he was not available when the complainant came back to the ward at midday, and remembered the complainant asking her to call him again. The student nurse took the complainant to the mortuary to see the body.

25. The senior staff nurse said that when he came on duty at 8 am the patient's body was still in the ward. There were difficulties in obtaining porters to take the body to the mortuary and he thought that it had remained in the ward until around 10 am. He did not remember any discussion about arrangements for viewing the body. If the student nurse had asked him for advice on what to do he would have shown her the memorandum on mortuary procedures. Had he known while the body was still in the ward that the complainant wished to view it without delay he would have arranged for her to view it there.

26. The mortuary technician said that arranging for relatives to view bodies was a high priority for mortuary staff. He did not remember the patient but his diary for 22 July confirmed that on that day he was covering another of the Trust's premises as well as the hospital. On such occasions he normally worked at the other premises between 8 am and 11 am, so an appointment for midday at the hospital mortuary made sense. If, as appeared to have been the case, he had been at the other premises when

the complainant arrived, there was no reason why the nursing staff could not have taken her to the mortuary to view the body; each ward had a key, as did the porters.

27. The consultant told the Commissioner's staff that a more experienced nurse would probably have been able to arrange for the complainant to view her father's body sooner than the student nurse managed.

28. In March 1995 the Trust's mortuary staff issued a revised instruction on procedures for viewing bodies. The revised procedures stated that when staff were working in the mortuary, staff should contact the mortuary technician who will prepare the body in the chapel of rest and be in attendance during the viewing. At other times the ward sister should arrange for a porter to place the body in the chapel of rest where senior nursing staff will prepare it and be in attendance during the viewing.

Findings *(b)*

29. It appears possible that when the complainant and her friend arrived in the ward the patient's body was still there. If it was, it would have been possible for the complainant to see the body in the ward. Once the body was in the mortuary, a nurse could have arranged a viewing there without having to wait for the mortuary technician. The student nurse appears to have been unaware of either option; the senior staff nurse was aware of both but did not explain them to the student nurse. The consultant has suggested that if someone more experienced than the student nurse had been given the task he or she might have been able to arrange for the complainant to view the body sooner than was managed. There was clearly an avoidable delay before the complainant was shown her father's body. I again criticise the senior staff nurse for leaving the task to an inexperienced student nurse. The instructions available to ward staff on how to arrange a viewing were incomplete and the student nurse was not familiar with them. I recommend that the Trust review guidance and training for arranging for relatives to view bodies, in order to make sure that the task is carried out without delay by staff with appropriate knowledge and experience. I uphold the complaint.

Complaint *(c) Handling of complaint*

30. The sequence of events and exchanges is summarised in an appendix. When the complainant wrote to the Commissioner with her complaint in November 1994 she said that she had `.... constantly chased up the people concerned with no avail'. She continued: `Since my father died .... I have suffered greatly .... I do not see why I should beg for such a reply.'

Trust procedures

31. The Trust's complaints procedure at the time of the complainant's complaint to them stated that the hospital manager had overall responsibility for dealing with complaints and monitoring progress. The administration department of which she was a member was responsible for making sure that the investigating officer replied to complaints within 20 working days or an interim letter was sent. It was also responsible for making sure that complaints monitoring forms were filled in.

Staff evidence

32. The hospital manager confirmed to the Commissioner's staff that she had signed the letter of 25 July to the complainant. On being shown the letter she acknowledged that it contained many mistakes and said that she was shocked by them. She said she had passed the complaint to the medical division's clinical service manager for medicine (the clinical service manager) for action. At the time the A and E department which is part of the medical division was allowed to deal with its own complaints because of the particular interest taken by the consultant. He would normally produce a reply for the general manager to sign. The hospital manager would maintain a file for the complaint but had no further involvement and did not monitor progress although she would receive a copy of the final reply. The hospital manager admitted that she had not realised that a reply had not been sent to the complainant. Monitoring procedures had now been introduced and holding letters were sent when appropriate.

33. The clinical service manager confirmed that the complaint had been sent to him and he had passed it on to the consultant for further action. He would then have had no further involvement as the consultant had been permitted to carry out his own investigation. The clinical service manager had concerns about that practice because it meant that he was unable to control the investigation or the reply. The clinical service administrator who worked for the clinical service manager said that the complaint would have been passed on to the senior nurse because of its content. In the early part of 1995, although the clinical service manager and administrator were both aware that a reply was needed, neither felt that they had sufficient authority to press the consultant, or that senior managers would support them if they did. After the A and E department ceased to be responsible for replying to complaints (see paragraph 36) the time taken to reply was properly monitored. As a result it had become much easier to control the progress of investigations.

34. The senior nurse said that when the consultant asked her to investigate the complaint, she had spoken to the staff concerned about the failure to telephone the complainant. She knew that the complainant had also complained about the viewing of the body but the consultant had not asked her to investigate that. She understood that after she had given him her report he had spoken to the complainant and that the matter had been resolved.

35. The consultant said that he had always taken the view that a complainant would prefer a reply from him rather than from a hospital manager and it was this belief which had led him to deal directly with complaints. At the time of the complainant's complaint other work pressures meant that replies to complaints were being delayed and he had agreed with the general manager that, while the A and E department would continue to establish the facts, replies would be signed and sent by the general manager. That agreement was not recorded in writing although the consultant believed that the acknowledgment letter of 25 July referred to the practice. The consultant said that when the complaint was received in the A and E department it was not recorded and he did not see it. It would have been passed to the senior nurse as it involved nursing matters. His understanding was that, once she had completed her investigation, she would pass the results to the clinical service manager to whom she reported for a reply to be prepared.

36. The consultant said that his discussion with the complainant on 31 August had lasted about an hour. She had been upset and angry. He had made a long note of their conversation but, for reasons which were not now clear to him, he had not given it to the clinical service manager: with hindsight, he believed that he should have done. The consultant said that he realised that the telephone call was not the end of the matter and that a written reply was required. It had not been necessary for him to see the senior nurse's report but she knew he liked to be kept in the picture. He had assumed that the senior nurse would give the report to the clinical service manager and that he would then prepare the reply to the complainant. He could offer no reason why no further work was done on the complaint. He said he could only assume that the clinical service manager had thought that he was dealing with the matter while he himself believed that the clinical service manager was. Between late November 1994 and January 1995 he had been on sick leave. The consultant accepted that he had failed to respond to the promptings of the clinical service administrator in February 1995 and later, when it became apparent that no reply had been sent. The A and E department had been under severe pressure at the time and complaints had been given a very low priority. Since May 1995 complaints about the A and E department had been dealt with by the clinical service manager like those against other parts of the medical division.

37. The clinical service administrator confirmed that she had made the annotation on the Trust's copy of their letter to the complainant on 5 September (see Appendix) after speaking to the consultant's secretary.

38. In a letter to this office in reply to the statement of complaint for the Commissioner's investigation, the chief executive wrote that `the complaint was not handled satisfactorily and it is clear .... that [the complainant] did not receive a full reply'.

Findings *(c)*

39. This investigation has revealed a disgraceful lack of sensitivity to a bereaved relative by University College Hospital. After the complainant complained to the Trust on 22 July 1994, the hospital manager sent her a prompt letter of acknowledgment but it contained a number of errors and the final sentence degenerated into nonsense. I strongly criticise the hospital manager for sending such a poor letter. The impression it gave of carelessness and incompetence was borne out by later events: for example, the first staff nurse was not interviewed until the Commissioner began his investigation. The hospital manager promised a full reply within 20 working days but the complainant never received one despite repeated telephone calls and, later, promptings from this office (see Appendix - 31 January and following). Bearing in mind the nature of the complaint, that was a serious failure. The reasons were threefold. The consultant was unable to deal with complaints against the A and E department, as he had agreed to, because of pressure of work; he and the clinical service manager had different understandings about who would do what, and no-one monitored progress either in the medical division or centrally. The repeated failure to take action after the promptings by the Commissioner's staff in January, February and March 1995 was further evidence of a breakdown of effective management.

40. In reports on investigations into four other complaints about the Trust's handling of complaints during 1993 and 1994 (E.1353/94-95 issued in February 1996, E.359/94-95 issued in March 1996, E.883/94-95 issued in August 1996 and E.1352/94-95 issued in October 1996) the Commissioner drew attention to recurring shortcomings in the Trust's performance and made recommendations for improvements. My findings on this investigation reinforce the criticisms in the previous reports. I recommend that the Trust take immediate steps to assure itself that its complaint-handling procedures are properly understood by all concerned and are being carried out effectively. I uphold the complaint.

Conclusion

41. I have set out my findings in paragraphs 19-20, 29 and 39-40. The Trust have asked me to convey to the complainant-as I

do through this report-their apologies for the shortcomings I have identified. They have agreed to implement my recommendations in paragraphs 20, 29 and 40.

APPENDIX TO E.965/94-95

Sequence of events and exchanges

1994

22 July When she visited the hospital the complainant made a complaint to the operational services manager about the hospital's failure to inform her of her father's deteriorating condition in time for her to see him before he died. The operational services manager made a note of the complaint and passed it to the hospital manager.

25 July The hospital manager wrote to the complainant acknowledging the complaint. In the letter heading the street name in the complainant's address was mis-spelt. Although the complainant was addressed in the heading, the letter started as `Dear Mrs [-]'. It continued: `Thank you for your verbal complaint which was received today on the 22nd July.' (The letter was dated 25 July.) The hospital manager wrote that she had asked the clinical service manager to investigate the complaint on behalf of the Trust's general manager. She continued: `She [the general manager] will let you have a full reply to your concerns within 20 (working) days of this letter and will keep the general manager informed.' She ended: `Thank you for having taken the trouble to write to us, and please accept our sincere condolences and apologies that may have been caused to date.'

27 July The complaint was faxed to the clinical service manager who was the designated investigating officer. He passed it to the A and E department for investigation.

During August The senior nurse in the A and E department made a note of an investigation which she had carried out into the complaint. She wrote at the end: `This is a broad account of events and I will fill in the missing pieces when I have spoken to staff who are on leave.' She sent the note to the consultant. The complainant made several attempts to speak to the clinical service manager by telephone about her complaint but was unable to reach him. She asked if there was someone else who could speak to her. (Note: The clinical service manager commented at interview that while he was available throughout the month on one of the Trust's main numbers, his name might not have been recognised by staff on the other switchboard.)

31 August The consultant telephoned the complainant and spoke to her for about an hour. In a note of their conversation he recorded that she had been angry and upset. He had apologised profusely but she had `not really accepted' his apology. He had then said: `If I can find out any more details I will ensure that they are sent to her in the official reply that will be sent.'

2 September The consultant signed the copy of the senior nurse's note of her investigation which she had sent to him. He wrote: `Thanks so much.'

5 September The clinical service administrator wrote on a copy of the hospital manager's letter of 25 July to the complainant: `[The consultant] spoke to [the complainant] personally on `phone last week for 1 hour-is investigating case.'

End of November The A and E consultant went on sick leave until January.

1995

Between 31 January and 10 February After the complainant had written to the Commissioner to complain about the Trust's failure to reply to her complaint, a member of the Commissioner's staff made several telephone calls to the Trust to enquire about the matter.

13 February The clinical service administrator telephoned the Commissioner's office to say that the Trust had delayed replying to the complainant's complaint because the consultant had been away from the hospital on sick leave. She said that the complainant could expect a reply within two weeks.

14 February The clinical service administrator wrote to the consultant to remind him that the complaint had not been answered and to ask him for advice as to how to reply.

1 March After a telephone call from the complainant a member of the Commissioner's staff telephoned the clinical service administrator to say that the complainant was still waiting for a reply. The clinical service administrator said that the papers were still with the consultant and that she would remind him.

3 March In a summary of outstanding complaints the clinical service administrator noted that the consultant had not replied to her letter of 14 February; she had asked his secretary to remind him of the complaint and tell him that the complainant had been in contact with this office.

1 May The complainant telephoned the Commissioner's staff to say that she still had not received an answer to her complaint from the Trust.

19 May The clinical service administrator wrote in a file note that the complaint had been brought up at a business management group meeting with the consultant but he had still not responded.

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comments

Findings *(b)*

25. The national guidance about the provision of incontinence supplies to persons in residential care homes made it clear that if a health authority provided free supplies to certain categories of person living in their homes, they should do the same for those categories in residential care homes. In a letter commenting on the complainant's complaint, the Parliamentary Under Secretary of State for Health confirmed (paragraph 4) that while the level of general provision was a matter for the health authority, once that was decided, supplies should be made available to persons in residential care homes according to the same criteria as those for persons living in their own homes.

26. When the Health Authority were faced with the requirement to carry out their responsibilities for providing incontinence supplies, they believed that they could not afford a full service to persons in residential care homes, but were reluctant to reduce the service to persons in their own homes because of the disruption which that would cause. Until April 1995 they therefore operated a partial service for certain categories of persons in residential care homes. They considered-rightly, in my view-that the national guidance allowed them discretion to decide on services according to resources. They also, however, judged that the requirement for consistency between services to persons at home and to those in residential homes was secondary to considerations of resources. That judgment is directly contradicted by the evidence of the Department of Health (paragraph 18) and the letter from the Parliamentary Under Secretary of State for Health (paragraph 4). The Health Authority's action in introducing a partial service was in clear contravention of the national guidance.

27. The Health Authority decided to reimburse those residents who were covered by the partial service for the costs they had incurred because of the delay in introducing that service after the national guidance came into effect. They declined to reimburse those who, like the residents on whose behalf the complainant complained, had to meet their own costs until April 1995. I do not find valid their justification (paragraph 22) for not reimbursing the complainant's residents and others in the same category: in my view, those persons had suffered hardship and injustice because of the authority's partial service, which was in contravention of the national guidance. I recommend that the Health Authority review the case for reimbursing the complainant and those residents on whose behalf she complained. I uphold the complaint.

Conclusion

28. I have set out my findings in paragraphs 14, 15 and 25-27. East Norfolk Health Authority have asked me to convey-as I do through my report-their apologies to the complainant for the shortcomings I have found, and have agreed to implement my recommendation in paragraph 27.

APPENDIX TO E.1190/94-95

Summary of events and correspondence

1993

4 January The Health Authority received HSG(92)50 reminding them of their responsibility for providing incontinence supplies to persons in residential care homes on the same basis as to persons in their own homes.

15 March The Health Authority's locality manager who became the Trust's locality manager in 1994 made an estimate that a full incontinence service for persons in residential care homes would cost £630,000. She told the assistant director of planning her findings.

23 March The assistant director of planning produced a paper about requirements for additional incontinence services, saying that a full service would probably cost £630,000. He concluded that an urgent decision was needed on the level of service to be provided in the coming financial year.

8 April The director of planning decided that the criteria for providing incontinence services should be reviewed and staff should work out a level of provision within available resources.

12 May The director of planning wrote to the advisory committee (paragraph 10) asking for their help in drawing up criteria

and stating that £250,000 was available for the year.

7 June The advisory committee set up a working party to draw up new criteria.

End of June Norfolk Social Services told the complainant that the Health Authority had become responsible for providing incontinence supplies to persons in residential care homes from 1 April.

1 July The working party met and drew up a plan of action which included a meeting on 26 August.

3 July The complainant wrote to the chief executive asking when her residents would be able to obtain the free incontinence supplies to which she understood they were entitled. The chief executive's secretary sent the letter to the deputy director of planning asking her to draft a reply.

18 August The head of corporate business acknowledged the complainant's letter and said that a full reply would be sent `as soon as possible'.

23 August The contracts manager was told by a member of the working party that their meeting arranged for 26 August had been cancelled.

14 September The complainant wrote to the chief executive expressing regret that he had not yet replied to her letter of 3 July. She said she wished to apply for free incontinence supplies for a person who was now living in her own home and receiving supplies without charge but would shortly enter her residential care home.

29 September Because the working party had not yet proposed any criteria, the advisory committee proposed to the Health Authority's purchasing team that a partial service should be provided, confined to residents who were doubly incontinent and suffering from senile dementia, but meeting all the costs of supplies to persons living in their own homes.

5 October The purchasing team agreed that the available funds of £250,000 should be used for the partial service.

21 October The Parliamentary Under Secretary of State for Health wrote to the Member following an enquiry he made on behalf of the complainant (see paragraph 4).

26 October The chief executive sent a standard letter to all owners of residential care homes in the area. He quoted the national guidance on provision of incontinence supplies to persons in residential care homes. He stated that there had been a delay in making the new arrangements because it would not be possible to provide a full service and a working party was drawing up criteria for a partial service which was likely to cover only persons who were doubly incontinent or demented. He continued: `While I am able to confirm that the Authority is taking steps as rapidly as possible to meet its obligations, it should be noted that the service can only be provided within the resources available. The Health Authority will consider the costs incurred by residential homes in having to provide this service since 1 April 1993, to ascertain what level of reimbursement might be made.'

16 November The locality manager of the Trust wrote to all proprietors of residential and other homes to inform them that Norwich Health Authority had agreed that residents who were doubly incontinent and those who were diagnosed as suffering from dementia and were intractably incontinent were to be assessed for free provision of incontinence supplies. This was described as an `interim agreement'.

25 November The complainant wrote to the Member about the proposed partial service: `I cannot accept that people who were previously receiving incontinence supplies [free] when they lived in the community should be penalised when they move into a private residential home.' She said she had one such resident.

29 November The Member sent the complainant's letter to the head of corporate business for her comments. The complainant wrote to the chief executive questioning the proposed partial service on the grounds that the national guidance said that supplies for persons in residential care homes should be provided on the same basis as those for persons in their own homes. She said that her new resident who had previously received supplies free was now expected to pay for them out of her personal allowance of £12.65 a week. The home's fees did not cover such supplies and the complainant argued that the resident's needs should be met by the Health Authority.

1994

January The Health Authority began to assess persons in residential homes for eligibility for the partial service.

3 February The complainant wrote to the chief executive complaining that she had not yet received a reply to her letters and

suggesting that the Health Authority's silence on the matter `indicates that you are aware of the deficiencies of your service and do not wish to commit yourself in writing'.

8 February The complainant sent a copy of her letter of 3 February to the Member.

15 February The Member sent the letter to the Health Authority asking for their comments.

March The Health Authority began to provide incontinence supplies to persons in residential care homes who met the criteria for the partial service.

5 April The complainant's solicitor wrote to the chief executive asking for his views on the position of the new resident under the new arrangement.

12 April Norfolk Social Services wrote to the complainant that residential care homes should not charge residents whose fees were paid for by Social Services for incontinence supplies. The costs should be claimed from the Health Authority.

5 May The complainant's solicitor wrote to the chief executive that she was still waiting for a reply to the enquiries which she had been making since November 1993.

25 May The Trust's locality manager told the contracts manager that the assessments of persons in the residential care homes for the partial service suggested that the extra cost of providing a full service would be around £125,000.

4 July The contracts manager made a note of a telephone enquiry from the complainant's solicitor. The solicitor had suggested that it was unfair for persons to be deprived of free supplies because they had moved into residential care homes. The contracts manager had explained that the Health Authority were not prepared to extend the partial service until the advisory committee's working party (see 23 August 1993) produced proposals for clinical criteria for a final arrangement. He agreed to discuss the matter with colleagues before replying to her further.

5 July The contracts manager wrote to the complainant's solicitor suggesting that until the working party reported, the best course of action would be to request a reassessment of the complainant's resident against the criteria for the partial service and, if the complainant remained dissatisfied after that, a complaint could be made to either the chief executive or the director of quality. (Note: The working party never reported to the Health Authority on criteria for the final arrangement.)

2 August The Health Authority decided to reimburse those residents who were demented and doubly incontinent for the supplies for which they had paid between 1 April 1993 and 1 March 1994. £150,000 was set aside for the purpose.

17 August The complainant's resident was reassessed and found to be ineligible for free supplies according to the criteria for the partial service. The complainant wrote to the director of quality that she wished to make a formal complaint about the chief executive's failure to reply to her letters of 29 November 1993 and 3 February 1994 and her solicitor's letters of 5 April and 5 May. She added that the partial service was `unfairly discriminating' against her residents because they were not receiving supplies on the same basis as persons living in their own homes. The complainant also wrote to the Department of Health.

24 August The Department of Health sent the complainant's letter to the chief executive asking him to reply.

September The Health Authority's Health Investment Plan for the financial year beginning on 1 April 1995 was circulated for discussion. It stated that in 1995-96 the provision of incontinence supplies to persons in residential care homes would be extended to match the full service to people living in their own homes.

2 September The director of quality acknowledged the complainant's letter of 17 August.

23 September The head of corporate business acknowledged the Department of Health's letter of 24 August and wrote that the chief executive would reply fully as soon as possible. She sent the correspondence to the contracts manager and asked him to prepare a draft by 30 September.

30 September The complainant wrote again to the Department of Health.

19 October The complainant's solicitor wrote to the contracts manager asking whether the working group had yet reported on the criteria for the provision of incontinence services. The solicitor also wrote again to the director of quality.

1 November The director of quality acknowledged the solicitor's letter saying that he was investigating the matter with the Trust and that he would reply as soon as he had all the relevant information.

4 November The Trust wrote to the director of quality with information about the complainant's complaint.

10 November The Department of Health sent the complainant's letter to them of 30 September to the chief executive. The secretary to the head of corporate business drew the letter to the attention of the contracts manager.

17 November The chief executive wrote to the complainant that he was replying to her recent correspondence which had been passed to him by the Department of Health. He recognised that she was not satisfied with the partial service, but wrote that the Health Authority were meeting their obligation to provide services according to their resources and priorities. He acknowledged that there was a difference between the service to persons in residential care homes and that for persons in their own homes but wrote that the Health Authority were working to achieve a consistent policy.

1995

25 January At a public meeting of the Health Authority it was decided to allocate an additional £125,000 to their contract with the Trust in order to provide a full service of incontinence supplies for persons living in residential care homes.

1 April All persons in residential care homes suffering from incontinence had their incontinence supplies funded by the Health Authority.

24 August The complainant wrote to the chief executive requesting reimbursement for those residents who had had to pay for their incontinence supplies while the partial service was in force.

11 September The personal assistant to the chief executive acknowledged the complainant's request.

10 October The chief executive wrote to the complainant that in providing the partial service the Health Authority had been `acting within [their] policies and meeting [their] obligations to provide services in the light of resources and priorities at that time'. He continued: `The important fact now is that [a] consistent policy for all groups of people has now been agreed. Unfortunately [the Health Authority] would not wish to reimburse any residents for whom incontinence products were bought after their admission to [the complainant's residential home].' He did not explain why.

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comments

Documents

15. The nurse who filled in the patient information sheet when the patient was admitted to the heart care unit wrote under the heading `Current Medication' `Eye drops' but gave no further details. Under `Past medical history' she wrote `Hypertension [-] TB as a child' but gave no details of his recent eye operation. In her notes on his admission she wrote `Poor Historian'. There is no record in the nursing notes of any conversation with the patient's son. After the fall at 1 am on 18 March the senior house officer who examined the patient wrote in the clinical notes `.... No neuro[logical] deficit. Denies any other injury. Neuro[logical] obs[ervations] for 2 [hours] 1/2 [hourly], if stable 2 [hourly].' The first sister wrote in the nursing notes `Seen by doctor. Neuro[logical] obs[ervations] recorded hourly.' During the morning of 18 March the patient was transferred to ward NE3. A house officer who examined him later that day did not record any problems with his vision. There are no notes of any further examinations by doctors until 21 March. There is no reference to any problems with his vision in the entries in the nursing notes for 18-20 March. On 21 March a staff nurse in ward NE3 (the second staff nurse) made an untimed entry in the nursing notes: `[Complained of] having only half visual field in [right] eye following fall 2 days ago. [Doctor] informed and came to see. .... ? detached retina.' The house officer who examined him wrote in the medical notes: `Past [treatment] - bilat[eral] cataract op[eration]s + insertion of lenses. Ever since 18/3/94, when he fell out of bed, [patient complained of] loss of lower field of vision. Getting worse. `Like a curtain (from below)." The house officer diagnosed a possible detached retina and a senior house officer confirmed the diagnosis after speaking to the on-call ophthalmic senior house officer at the second hospital who commented: `Cataract surgery predisposes to [retinal detachment].' The patient was then transferred to the second hospital for treatment.

16. On 29 April 1994 the administration manager asked a consultant ophthalmic surgeon (the first consultant) in the first hospital for comments on the complainant's complaint that four days had elapsed between the fall and the discovery of the retinal detachment. He replied: `There is no doubt in my mind that he should have received a full ophthalmic examination by an ophthalmologist sooner than he did.' On 4 July 1994 the complainant wrote to the Trust that a solicitor had advised her `that the treatment her father had received appeared to have fallen below the general accepted standard of care'. She sought an ex gratia payment for her father in recognition of the fact that he had lost the sight of his right eye as a result of what happened during his stay in the first hospital. The Trust's directorate manager for medical specialties sought advice on the matter from a consultant ophthalmic surgeon (the second consultant) in another hospital. He replied: `I do not think this patient has a claim against the physicians .... I am confident that the detachment is a complication of surgery, the fall at most was a trigger that may have brought on the inevitable a little sooner than if it had not taken place. .... It is my practice to warn patients to report any change in the vision in the eye; prompt review and an active search of the retina gives the best chance of a successful repair.' In answer to a question whether the patient should have been examined immediately, he wrote: `With no leading symptoms I do not think a full examination was specifically indicated.' In reply to a question whether immediate diagnosis would have improved the prognosis he wrote: `I would need more details but probably not.'

Staff evidence

17. The first sister said that while the complainant's father was in the heart care unit she was not aware that he had recently undergone an eye operation. If a patient's relatives handed over medicine the normal procedure was to make a note in the nursing record, place the medicine in the medicine trolley and draw it to the attention of doctors at the first opportunity. Although there was a note in the nursing record about the patient's eyedrops it included no information about the reason for the treatment or the dosage to be given. The neurological observations which she had carried out after the fall were a precautionary measure for a patient who had suffered a head injury and would have involved looking at the patient's eyes and checking other reflexes.

18. The lead nurse said that any information which had been given to staff about the patient's eye operation should have been recorded in the nursing notes. The neurological observation carried out after the patient's fall would have detected any change in pupil reaction but if nurses had been aware that he had recently had an eye operation they would probably have sought expert ophthalmic advice on whether there were any other symptoms which they should have been looking for. The lead nurse said that since, but not as a direct result of, this complaint the forms for nursing records used in the hospital had been revised. The new forms (which I have seen) include spaces in which nurses should record any information they obtain about medication prior to admission, previous medical and surgical details and discussions with relatives. The lead nurse said that the complainant's complaint had brought home to staff in the heart care unit the importance of recording information provided by patients' relatives and the lead nurse was confident that staff were filling in the new forms correctly. As far as she was

aware, there were no written instructions on the use of the forms but she did not consider that any were needed because it was quite clear what should be recorded on them.

19. The nurse who admitted the patient to ward NE3 on 18 March (the third staff nurse) and was responsible for his care during his first three days there said that if she had learnt of his eye operation and gathered that the doctor who had examined him after his fall had not been aware of it, she would have asked a doctor to examine him again without delay.

20. The Trust's customer relations manager said that the importance of adequate record-keeping was emphasised both in the initial training of nurses and the continuing in-service training of qualified staff. The quality of nursing records was also now examined as part of the annual audit of each ward carried out by the Trust's head nurses.

Findings *(b)*

21. It is accepted that when the patient was admitted to the first hospital his son told nurses about his eye operation and explained that he was using eye drops. The Trust have said that the information was passed on orally and that is confirmed by the son's account (paragraph 14) of what he gathered when he visited his father on 17 March. However, the information did not reach the first sister who cared for the patient after his fall, and staff in ward NE3 where he was moved the next day were not aware until 21 March that he had recently had an eye operation. The lead nurse has said that if the nurses who treated the patient immediately after his fall had known about the operation they would probably have sought ophthalmic advice; the third staff nurse has said that if she had known that the doctor who examined him after the fall had not known about the operation she would have asked another doctor to examine him; the first consultant has said that the patient should have received a full ophthalmic examination sooner than he did and the second consultant has commented that prompt review and an active search of the retina give the best chance of a successful repair. I strongly criticise the nurses' failure to record and pass on the information about the patient's eye operation. I note that improved forms and arrangements for record-keeping have since been introduced. I recommend that the Trust keep those arrangements under review to make sure that all information relevant to patients' care and treatment is recorded and passed on when appropriate. I uphold the complaint.

Complaint *(c) Response to complaint*

22. As noted in paragraph 4, this complaint was considered in the Commissioner's special investigation into complaint-handling by the Trust. The Commissioner found that the Trust were dilatory throughout their dealings with the complainant and that their first reply did not deal fully with her concerns; he upheld the complaint. In the light of his findings on that and the other complaints considered in his special investigation the Commissioner made a number of recommendations for improvements in complaint-handling which the Trust agreed to implement.

Conclusion

23. I have set out my findings in paragraphs 11, 21 and 22. The Trust have asked me to convey to the complainant-as I do through my report-their apologies for the shortcomings I have identified and have agreed to implement my recommendation in paragraph 21.

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comments

Evidence of Trust staff and Board members

25. The chairman of the Trust said that he had never had to deal with an IPR report before. He decided to ask the chairman of the Board's audit sub-committee to consider the report, with a Panel consisting of a mix of executive and non-executive members. The terms of reference of the audit sub-committee included looking at matters of deep concern to the Trust. A clinician was needed on the Panel; but the obvious choice, the medical director, was involved in the complaint and therefore inappropriate. Instead, two clinical directors joined the Panel. He recognised that having the chief executive on the Panel might be a problem because of his involvement in the complaint, but considered that, providing the chief executive was excluded from any part of the process dealing with his own actions, it would be more effective to have the chief executive on the Panel as he would have to implement any recommendations. He would not have included the chief executive if there had been any allegation against him so serious as to raise the possibility of his dismissal. He considered but rejected the idea of having an independent member of the Panel-the IPR had already provided an independent medical view and it was now for the Trust to act. With hindsight, having an independent member of the Panel might have improved public perception but he did not think it would have changed the Panel's report. After discussion the chairman of the Trust had drafted the terms of reference of the Panel which were discussed by the Board at the first opportunity. He had met the complainants on 9 November and considered that they had had a useful discussion.

26. The chairman of the Trust told my staff that the purpose of the Panel was to identify what needed to be done (using the IPR as a starting point) and to decide whether disciplinary action was necessary. Some issues had not been covered fully by the IPR -for instance it had criticised the handling of the complaint but without interviewing administrative staff involved-and the Panel needed to look at each point in detail, particularly if disciplinary action might follow. It was because of that possibility that the director of human resources had attended. When the Panel's report was presented to the Board there was a free discussion and a consensus was reached to accept the report as drafted. It was appropriate for the chief executive and the medical director to have been at that Board meeting, so that the whole Board could be associated with the decisions. He did not consider that they should have been excluded from the discussion; but that they should have withdrawn (as they did) when decisions were being made about the report. As the report cleared them their withdrawal from the discussion would have made no difference. The chairman of the Trust said that he regretted very much that the quality of care given to the complainants' daughter was not up to standard and that the Trust had not been able to save her life. The Trust were determined to learn the necessary lessons and he was as confident as he could be that they had done so.

27. The chief executive said that he first saw the IPR report when the chairman of the Trust sent for him to discuss how to respond. The facts that the RHA had already drawn conclusions on the IPR report before sending it to the Trust and that they had already sent a copy to the complainants made it more difficult to decide how to handle it. He was normally responsible for explaining to the complainant what was to be done as a result of an IPR report, although he had never before dealt with one of such seriousness. He and the chairman of the Trust discussed who might be on a Panel to look at the report and drafted the terms of reference. The Panel was set up because of the seriousness of the matter, the time delay in getting the IPR report and the RHA's letter, and was in compliance with the Trust's serious incident policy. The Panel considered the need for disciplinary action. The investigation therefore had to be thorough. It was not the Trust's fault that some matters needed to be considered in greater detail than the IPR had done. The Panel's chairman had a legal background. The chief executive considered that, if he himself had not been a member of the Panel, it would have been more difficult for him to understand in detail the rationale for decisions, including about disciplinary matters, which he would have to implement, possibly against resistance. He had to explain procedures to the Panel as well as give evidence about his actions but he was not involved in discussions of his involvement in handling the complaint. The Panel's report was not an attempt to undermine the IPR report. The Panel acted on the recommendations of the IPR report and did not reject any. The only difference of opinion was about the motivations of the clinicians in their original investigation of the complaint: the IPR assessors had not interviewed the Trust staff about that.

28. When the Panel's report was complete he realised that the complainants would not be happy and he telephoned to offer to meet them but they refused. The young woman's father was angry that there was to be no disciplinary action as a public demonstration of concern. The chief executive explained to him that such action would not have been public and said that it was not appropriate. When the Panel's report was presented to the Board there were detailed discussions and many questions were asked. The Board had been keen to make sure that they could not be perceived as attempting to `whitewash' the IPR report. After the questions the chief executive withdrew from the meeting so the Board could discuss whether they were

satisfied with the Panel's report. The Board had made sure that they would remain quorate without the chief executive and the medical director being present.

29. The chairman of the Panel said that his responsibility was to make sure that all the points in the IPR were dealt with, that all points of view were fairly recorded and the Panel produced a competent report for the Board. They did not re-investigate the complaint-they looked at the recommendations and responded to them. In some respects they felt the IPR was not right and said so. The Panel's report was better as a result of the critical review of the IPR. It had been essential that the chief executive was a member of the Panel: the report would have been much less valuable without that. He did not consider that the chief executive had had a conflict of interest. The chairman of the Panel had drafted the report and the Panel members had commented. He considered that criticisms about the IPR made to the Panel should be recorded so that the report was rounded. He included them in the preliminary comment of the Panel's report: he thought it was appropriate for the reader to see them first. If they had been put at the end they might have been seen as prejudicing what had gone before. He knew that the complainants had wanted disciplinary action; and he thought the Panel's decision that that would be inappropriate devalued the rest of the report in their eyes. He was satisfied that the Panel report was fair and thorough. When it was presented to the Board he gave an oral report and the chief executive commented. The chairman of the Panel then answered questions from the Board and a consensus was reached to accept the Panel's report.

30. A clinical director on the Panel (the first clinical director) said that its purpose was to look at the IPR report recommendations and bring in its own recommendations to make sure that things improved. It also dealt with concerns raised by the complainants when they attended the Panel. There were inconsistencies in the record of events and the notes. The Panel therefore needed to interview staff to understand exactly what had happened in order to make effective plans to avoid similar problems. He was concerned at first about the composition of the Panel; and he discussed at length with the chairman of the Trust the involvement of the chief executive and the legal manager. His concern stemmed from their roles in the handling of the original complaint. However, it would have been harder for the Panel to operate without the chief executive; and the Panel agreed that it was better for him to be a member but to leave the room when his actions were discussed. The legal manager acted as secretary to the Panel and was able to give some background information about the complaint handling. Nursing advice was given by the nurse manager interviewed. (Note: The Trust did not have a director of nursing in post at that time.)

31. The second clinical director on the Panel (the second clinical director) said that the purpose of the Panel was to make sure the same things did not happen again. The IPR report had to be looked at in detail before it could be implemented locally. In some ways the Panel re-investigated the issues because they wanted to make sure they understood matters thoroughly and make detailed changes. He could see that it might look as though they were trying to undermine the IPR report; but that was not their intention. They had taken the IPR report very seriously.

32. A non-executive director who was a member of the Panel (the first non-executive director) said that its purpose was to consider the comments made in the IPR report to see whether they were factually correct and, if so, whether the recommendations were appropriate; and to examine what the Trust had done to implement them. The Panel also had to consider what action, if any, should be taken about the conduct of the staff involved. It was never the intention of the Panel to undermine the IPR report but they had to make sure they had a balanced view of events rather than depending solely on the IPR report. He agreed that the legal manager and the chief executive could add more by being there most of the time and excluded when their conduct was discussed. He did not attend the Board meeting which discussed the Panel report.

33. A non-executive director who was not a member of the Panel (the second non-executive director) said that the chairman of the Trust had considered asking her to be a Panel member but since she knew the complainants slightly she had not considered that appropriate. The purpose of the Panel was to find out what had happened, what the failings were, who failed, why things failed, and what needed to be done to put things right and stop the same failures happening again. That included the possibility of disciplinary action. The composition of the Panel was correct for that purpose. Four out of the five members of the Panel were not involved in the complaint; and the chief executive was on the Panel because he would have to implement the recommendations. The presence of the chief executive emphasised the Panel's seriousness. It had to re-investigate the complaint because the hospital had not done that properly originally, and it covered some topics additional to those in the IPR report. When the Panel's report was presented to the Board she had decided that it was not inappropriate for her to attend, because she was not a close friend of the complainants. At the meeting she tried to examine the issues critically from their point of view and made the Panel justify their recommendations. The chief executive and the medical director withdrew from the meeting when the Board discussed the points which referred to them personally. Once the Board had decided to accept the report they returned to the room to discuss the action to be taken.

34. The medical director said that he attended the Panel as a witness, commented on the final draft of the Panel report (although he did not amend it) and was asked to implement some of the recommendations. He was concerned about the membership of the Panel because, like him, the chief executive and the legal manager had been involved in the original

investigation of the complaint (which had been criticised in the IPR report). He told my staff that he considered that the presence at the Panel of those people had been inappropriate. In his written evidence to the Panel he said:

> `It is .... totally inappropriate that the Chief Executive or the [legal] Manager play any part in these proceeding[s] other than as witnesses.'

(Note: It was recorded in the minute of the Panel meeting on 9 November 1994 that he had no objection to the composition of the Panel.) He explained to my staff that he had withdrawn his objection at the meeting, because by then the composition of the Panel was fixed and he had to continue working with its members. He did not consider that the composition of the Panel had affected the final report. Whenever the Panel's report was discussed by the Board he withdrew from the meeting. He was never present when his involvement was discussed.

35. The legal manager said that he was responsible for the organisation and recording of Panel meetings. He was a witness about his initial brief involvement in handling the complaint. He would have volunteered information on other issues. He was not involved in writing the Panel's report or drafting the recommendations. He did not think there was any conflict between his different roles.

36. The corporate business manager said that she took minutes of the Board meetings. During the meeting which discussed the Panel's report the chief executive and the medical director withdrew: she could remember a discussion about whether the meeting would remain quorate. She did not record their withdrawal because she tried to keep Board minutes as short as possible. She now noted such events.

Evidence of former RHA staff

37. The former regional consultant in public health medicine said that normally when he received an IPR report he wrote to the Trust recommending what they should tell the complainant and what action should be taken. He had realised that the IPR into the complaint was unlike any of the many other cases in which he had been involved and required a different approach because of its complexity and scope. The then regional director for public health agreed to refer the case to the RHA Board. At that point a new regional director for public health was appointed and his involvement ended.

38. The regional director of public health, who was appointed in October 1994, said that the Trust's response to the IPR by setting up their own internal inquiry was unusual. The Panel's report seemed to be an inquiry into the IPR and, if so, he was concerned about the composition of the Panel. Evidence was taken only from within the Trust: there was no external or expert advice. The involvement of the chief executive and the legal manager in the Panel was inappropriate if the complaint was to be re-investigated. If the purpose of the Panel was to consider disciplinary action, which he felt was necessary, then the Panel was not the appropriate way to proceed.

39. The former RHA chair said that it was unusual for the RHA Board to become involved with an IPR, but exceptional action was necessary because this complaint was so serious. At that time Trusts had only recently been set up, which changed the relationship between the RHA and the providers of health services. She had needed to set out clearly to the Trust the RHA's role in this complaint. She was disappointed that the Panel's report seemed to be defensive and had not made it sufficiently clear that they recognised the seriousness of the complaint. She considered that the Trust should have looked at how they could implement the IPR-if they had wanted to clarify its recommendations they should have asked the reviewers instead of attempting to defend themselves.

Findings

40. The Trust had received an IPR report which was highly critical of the complainants' daughter's care and treatment and which, unusually, went beyond clinical matters to comment critically on the way the complaint had first been handled. Nothing I have seen during this investigation causes me to question the seriousness with which the Trust took the IPR report or their intention to deal with it in a way appropriate to its gravity. A large amount of time of Board members and senior staff was given to the matter; many changes were made to the Trust's procedures; and the implementation of those changes was followed through. However, good intentions are not always enough. Poor administration can sometimes flow from the best of intentions and it was particularly important in this case not only that justice was done, but that it was seen to be done.

41. I agree with the chief executive (paragraph 27) that the Trust's decision on how to handle the IPR report was made all the more difficult by the fact that the RHA had already sent the report to the complainants (despite national guidance that Trust chief executives should communicate the outcome of IPRs to complainants) (paragraph 7)-and it appears, discussed the report at a RHA meeting-before sending it to the Trust. I consider that it was entirely appropriate for the Trust to ask a group of senior staff and Board members to consider the IPR report and to produce a detailed action plan for the Board's approval.

However, the Panel which the Trust set up did more than that: to a large extent it re-investigated the complaint, interviewing staff and drawing its own conclusions. It was called the complaint investigation panel. It was set up under the serious incident policy, the purpose of which was to investigate serious incidents within the hospital. As this incident had already been investigated by the IPR, I question the appropriateness of the use of the serious incident policy. Was such a substantial element of re-investigation appropriate? Ordinarily I would expect a Trust to accept and implement an IPR report without re-investigation. However, the IPR assessors had commented on the handling of the complaint without interviewing all those involved and I do not question the need for further investigation of that. Nor do I question the need for further detailed work on changes to be implemented. In this case I can see why some detailed work was needed to develop action plans or to pursue additional points. However, I cannot see that it was appropriate to undertake re-investigation of all aspects of the complaint: other difficulties apart, it was bound to appear as if the Trust were acting as a court of appeal on their own case. The re-investigation produced some different conclusions (see Appendix B), but mainly differences in the interpretation of the actions and motives of staff: in the handling of the complaint, whether there had been a lack of empathy towards patients who had overdosed, and about the evidence given to the coroner.

42. The Panel's terms of reference included making recommendations on disciplinary action. Although the RHA had asked the Trust to consider action against staff and it is not for me to question the Trust's actions on personnel matters, the inclusion of that had the disadvantage of making it less likely that evidence to the Panel would be given frankly. Moreover, I cannot see that the possibility of disciplinary action resulting in the chief executive's dismissal, could necessarily be excluded as the chairman of the Trust suggested (paragraph 25)-the chief executive's actions in handling the complaint had not then been investigated.

43. If the Panel was to do more than agree details of changes to be made, but was to re-investigate, then its membership needed particularly careful consideration. The chief executive's membership of the panel was considered by most of those involved to be essential to its success. I accept that he would have had much to add to discussions and that his involvement might facilitate changes. However, he had played an important part in the original handling of the complaint, which was criticised by the IPR and was a significant point being investigated by the Panel. Whether or not he participated in discussions about his involvement, and whether or not his presence when others gave evidence affected the outcome of that part of the Panel's work, I cannot see that it was appropriate for him to be a Panel member, when he was also a witness to be questioned about his own actions. The Trust do not seem to have paid adequate regard to how that would be perceived by others, particularly the complainants. The legal manager, while he was not a member of the Panel, was present at all the Panel meetings; and again it is impossible to say what effect (if any) that might have had on the Panel's conclusions when he too was also a witness about his involvement in the handling of the complaint. Although he had been director of nursing (as the complainants were aware), that was not at the time of their daughter's death and he did not attend the Panel to give nursing advice. His presence, as well as that of the chief executive, could only undermine the credibility of the Panel. In the circumstances I consider that it was inappropriate for the chief executive and the legal manager to take the roles they did in the Panel's work.

44. That involvement shows insensitivity by the Trust to the appearance of what they were doing. I can understand why the complainants came to fear that the Trust were trying to reinterpret the IPR report in order to deflect blame from those involved. The inclusion of the preliminary comment (Appendix A) was unhelpful in that respect. Whether or not the criticisms it contained were justified, its inclusion at the beginning of the Panel's report must have raised concerns with the complainants about the Trust's attitude to their complaint. Any concerns would have been better put to the assessors through the RHA, and any significant inaccuracies in the IPR report would have been better corrected in the text of the Panel's report. The Trust should have considered more carefully the form their response took as well as the substance. In summary, the Trust were at fault in failing to give separate consideration to the different aspects of what was needed to follow up the findings and recommendations of the IPR: the matters on which it was necessary to establish facts not already investigated adequately by the IPR; the making of recommendations regarding future action; possible disciplinary action; and the way in which consideration of these aspects was linked in both substance and appearance.

45. Demonstrating proper impartiality also posed problems when the Panel report went to the Board. The situation was complicated by the fact that one Board member was a personal friend of the complainants, one knew them slightly, and two (the chief executive and the medical director) were involved in the complaint. I see no reason to criticise the actions of any of those. The personal friend did not attend the relevant Board meeting; the two staff involved in the complaint withdrew at the appropriate moment; and the acquaintance of the complainants looked at the report critically. I am concerned that the chairman of the Trust considered that the withdrawal of the chief executive and the medical director would not have been essential. While withdrawal may not have been imposed by standing orders, not to require it would have been very poor practice, as being contrary to natural justice. I am also concerned that the withdrawal of the chief executive and medical director was not recorded in the minutes of the Board meeting. I note that this practice has now changed. I recommend that the chairman of the Trust makes sure that a record is kept of such points in the minutes of future Board meetings. I uphold the

complaint to the extent described above.

Conclusion

46. I have set out my findings in paragraphs 40 to 45. Salisbury Health Care NHS Trust have implemented my recommendation in paragraph 45 and have asked me to convey to the complainants through my report-as I do-their apologies for the shortcomings found.

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comments

Staff evidence

10. The consultant said that he was aware that the hospital operated a complaints procedure but he had had no personal involvement with it before the complaint. He had received a copy of the complaint and also the reminder letters from the surgical general manager. He had been aware that the MP was involved. He had not provided the surgical general manager with his report earlier because the complainant's medical notes had never been available when he had an opportunity to look at them. He needed to see them to enable him to prepare his report on the complaint thoroughly in case the complainant took legal action. He told the investigator that treating his patients would always take priority over writing a report. The consultant said he did not know why his report on the complainant's complaint was dated 29 October but was not sent to the surgical general manager until 20 December. He said he probably redrafted the report two or three times. He had a full operating schedule and had no time to review the case until the week before Christmas when his operating list was considerably reduced. When he was later asked to refer the complainant's complaint to the RMO he had asked the surgical general manager for advice. He was told that only he (the consultant) could refer the complaint and he had decided not to do so. He had seen the complainant shopping and walking around with apparent ease which did not tally with her complaint that her operations had left her with restricted mobility. He thought that he had already done everything he possibly could for the complainant.

11. The business manager told the investigator that part of his duties involved co-ordinating replies to complaints. On receipt of the complainant's complaint in June 1992 he had passed it to the surgical general manager for action. He could not remember why he had not sent him a reminder until 21 August. He said there had been a weakness in the complaints handling system at the first health authority which had meant that holding letters were not sent to the complainant. That had now been rectified by the Trust and holding letters were sent routinely if replies to complaints were delayed. The business manager said he had drafted the chairman's reply to the MP saying that the investigation was at an advanced stage; he did that because he thought at the time that a reply would be sent shortly.

12. The business manager said that when the complainant asked for an IPR neither he nor the surgical general manager knew how to proceed as it was the first IPR in which the hospital had been involved. The business manager contacted the RMO's office and was told, as far as he understood, that the complaint had to be referred to the RMO by the consultant concerned. The business manager said that he should have brought the problem of the consultant's delay in doing so to the attention of the chief executive. After he wrote to the adviser to explain the consultant's objections to an IPR he did not realise that the adviser had wrongly assumed from that, that the Trust had also objected. He failed to notice the reference to that in the adviser's letter of 1 July 1994.

13. The surgical general manager told the investigator that the complainant's complaint had probably not been sent to the consultant until 22 June 1992, because he (the surgical general manager) had been on leave. There was now a cover arrangement for leave and complaints would not have to wait for his return. He said that he should have sent the consultant a written reminder before 7 September, but he had spoken to the consultant and his secretary many times about the report. It was not until the chief executive became involved in December 1992 that the consultant replied. He had not previously thought of asking for the chief executive's help. The surgical general manager said that he had not been aware of any occasion when the complainant's medical records had been missing, except just before the meeting in April 1993 when they had been traced to the consultant's secretary. It would now be impossible to find out where the records had been at any given time in 1992.

14. The surgical general manager said that the complainant was not satisfied with his letter of 12 February 1993, so a meeting was arranged, and held on 14 April. It had taken some time to find a mutually convenient date. The complainant then asked for an IPR, and after seeking advice from the business manager the surgical general manager asked the consultant to refer the complaint to the RMO. The consultant refused to do so. The surgical general manager then gave him two or three weeks to reconsider but he still refused. The surgical general manager was under the impression at that time that only the consultant could refer the case to the RMO. He had suggested that the consultant should speak to the adviser but he was not sure whether the consultant had done so. In January 1994 the consultant was still reluctant to refer the complaint and so in desperation, on 10 January, the surgical general manager himself referred it to the RMO. He said the entire delay was due to the consultant's reluctance to refer the complaint to the RHA.

15. The surgical general manager said he could not explain why he had failed to reply to or to take action on the adviser's letter of 27 January asking about the delay and for another set of records; it was a slip-up on his part. He had also incorrectly told the chief executive that the papers on the complainant's case had been referred to the RMO immediately after the meeting

with the complainant in April 1993. What he should have said was that he sought advice on procedure from the RMO's office immediately after that meeting. The Trust had never refused to refer the case. They would have referred it themselves had they realised it was in their power to do so. There had been a misunderstanding about that with the RHA. He said the handling of the complainant's complaint by all those involved had been `a catalogue of disasters'. Such delays would not now be permitted. The Trust were particularly careful to meet deadlines.

16. The consultant's secretary said that when the complainant's complaint arrived in the consultant's office in June 1992 she obtained the medical records and showed them to the consultant. She passed on to the consultant the written and oral requests from the surgical general manager and the business manager for his report. Each time a written reminder arrived she would attach it to the front of the medical records and pass them to the consultant. The medical records were often missing; sometimes they were returned to her from other departments, sometimes she would have to go and fetch them. She had tried hard to get the consultant to reply to the complaint. She thought he had not done so because he was so busy.

17. The district general manager offered his personal apologies to the complainant and said that he was ultimately responsible for the handling of her complaint during the period leading up to the creation of the Trust in April 1993. He said that 1992 and 1993 had been very busy years as preparations were made for the creation of the Trust and the merging of the two health authorities. He was not sure whether any complaints monitoring reports had been produced during this period. (Note: documents provided by the second health authority showed a gap in monitoring between June 1992 and mid 1994). He admitted the complaint had been poorly handled and said that that had happened because of the turmoil of the organisational changes.

18. The chief executive told the investigator that he had been aware that the surgical general manager had been chasing the consultant for a reply during the second half of 1992. In December 1992 he had spoken to the consultant's secretary, which had prompted the production of the consultant's report. In his view there had been no excuse for the consultant's delay in producing that report. He knew that the complainant had requested an IPR in April 1993, but he had not been involved in the complaint again until April 1994, when the adviser contacted him to say he had had no reply to his letter of 27 January. When asked about the delays the surgical general manager told him that he had referred the complaint to the RMO in April 1993, immediately following the meeting with the complainant. It was not until the chief executive was interviewed by the Commissioner's investigator that he learnt that that had only happened in January 1994. His letter to the surgical general manager of 3 May 1994 reflected that he had not known of that delay although he recognised that he should have done. He was now satisfied that complaints were dealt with promptly. Procedures and timescales had been tightened up and he had regular monitoring meetings with the business manager in which he challenged any delays.

19. In his formal response to the Commissioner the chief executive wrote:

> `.... the delay was regrettable and the Trust has since done much work on improving the management of complaints through the development of monitoring reports and review meetings, both at Trust Board level and with the Community Health Council ....'

20. The adviser told the investigator that he was responsible for assisting the RMO to process complaints put forward for IPR. He said that he had been under the impression that only consultants could refer requests for IPRs but he now realised that that was not the case. He would have told the Trust, if asked, that it had to be done by the consultant. After receiving the surgical general manager's referral letter of 10 January 1994 he wrote on 27 January asking for, among other things, better copies of the complainant's records. He expected to receive a reply in two to four weeks. By April he had still not heard from the Trust so after an abortive phone call to the surgical general manager's office he sent a reminder on 13 April to the chief executive. On 14 April he wrote to the consultant asking if the IPR request had been put forward with his knowledge. He did not receive a reply to that letter but on 18 April the business manager spoke to the adviser's secretary, and the adviser had gained the impression from that that the Trust, as well as the consultant, did not want an IPR. As the adviser did not know how to proceed he wrote to the second RMO for advice. The second RMO was away at a conference and did not reply until 22 June. The medical records arrived on 8 July. When he later found out that the Trust did not support the consultant's stance about the IPR the adviser apologised, but he did not consider himself entirely to blame for the misunderstanding. He said that the Trust should have been quicker in producing the medical records and in replying to his letters.

21. The second RMO said that the adviser was experienced, and able to deal with most problems himself. They met regularly but the distance between the adviser's office in Harrogate and his own office in Newcastle caused some unavoidable delays. It had been the practice of the former Yorkshire Regional Health Authority in which the adviser had worked to stick more closely to the wording of the DHSS guidance (paragraph 6) regarding who could refer IPRs. While the second RMO adopted a very flexible approach he knew that the adviser would either expect the relevant consultant to make the referral, or if the Trust made it, seek the consultants agreement. With regard to the adviser writing to the Trust in January and not pressing for a

reply until April, he said that that kind of delay was not uncommon at the time. The adviser had been very busy and only worked part-time. Delays of that sort would not now be acceptable.

22. The second RMO said the adviser had asked him for advice after finding that the consultant was refusing to co-operate. He discussed the case with the adviser on 18 May. On his return from a conference he reviewed the case thoroughly and wrote to the adviser on 22 June saying that in his view an IPR was appropriate. The consultant's feelings on seeing the complainant shopping were valid, but were not a good enough reason to decide against an IPR. The second RMO had drafted the letter sent by the regional director to the chief executive on 7 October which had finally resolved the difficulties. He said it had been a frequent problem that consultants refused to co-operate with IPRs. He or the adviser would try, usually successfully, to persuade and reassure them. The Trust were not alone in having to struggle with a difficult consultant, and such situations were not easy to handle. Once the deadlock was broken the Trust had acted quickly.

Findings *(a)*

23. The complainant made a written complaint about her treatment at the hospital in June 1992 and received no substantive reply until February 1993, a delay of eight months. The consultant failed to provide his report for six months and, despite his busy operating schedule and claims about missing records, must bear much of the blame for that delay. The surgical general manager and business manager should not have let the matter drift for so long; they should have asked the chief executive to intervene with the consultant at an earlier stage. It was also unsatisfactory that the complainant was not sent holding letters explaining the delay and highly unsatisfactory that a letter drafted by the business manager for the chairman to send to the MP stated that investigations were at an advanced stage when clearly they were not.

24. Once the complainant asked for her case to be referred for an IPR it was a further nine months before that was done. The business manager and surgical general manager have explained that they had no experience of IPRs and that advice received from the RMO's office had led them to believe that only the consultant concerned could make the referral. They might well have gained that impression from the RMO's office, but that said, the surgical general manager, once he knew that the consultant had declined to refer the complaint himself should have sought further advice or involved the chief executive. Again the matter was allowed to drift and records show that complaints were not being monitored at the time. I note that the Trust's complaints procedure has now been improved and that the chief executive takes a more personal role in the management and monitoring of complaints. I uphold this aspect of the complaint against the second health authority as successor body to the first health authority, and also against the Trust.

Findings *(b)*

25. After the complainant's case was referred to the RMO in January 1994 there was yet a further delay of ten months before the JCC were approached by the RHA to appoint assessors for the IPR. On receiving the referral the adviser asked the surgical general manager for legible copies of the records and for a reply on other matters relating to the complaint. The adviser reminded the chief executive in April about that, but the records were not sent to him until 8 July and he never received a reply to his letter. The surgical general manager has not been able to explain why he failed to deal with the adviser's letter; he has called it a slip-up on his part. That was careless and unsatisfactory. Once the chief executive knew of the problem he asked the surgical general manager to explain the delays. It was not until the Commissioner's investigation that the chief executive became aware that the answer given to him at that time by the surgical general manager, that he had referred the case for IPR to the RMO immediately after the meeting with the complainant, did not represent the facts. I am concerned about the accuracy of that response but that is a matter for the chief executive.

26. There was then confusion over whether or not the Trust supported the consultant's stance on opposing the IPR. The adviser gained the impression that they were in support, but he was wrong. Although, as he has admitted, he should not have come to that conclusion, he set out his understanding of the position in his letter of 1 July to the business manager which went entirely unchallenged until 7 October when the regional director wrote personally to the chief executive. The business manager should have been alert to the content of the adviser's letter. That was poor administration. Once the misunderstanding about the willingness of the Trust and the consultant to co-operate was resolved by the chief executive, the RHA acted quickly to arrange the IPR. To the extent of the shortcomings I have identified I uphold this aspect of the complaint against the RHA and the Trust.

27. From the time the complainant complained to the hospital it was three years before her IPR was held. Notwithstanding the organisational changes that were taking place at the time it was a disgrace that she had to wait so long for her complaint to be resolved. The surgical general manager has said that the handling of her complaint was a catalogue of disasters. I agree and strongly criticise the first health authority and the Trust for that.

Conclusion

28. I have set out my findings in paragraphs 23 to 27. Pontefract Hospitals NHS Trust, Wakefield Health Authority and the regional director for the Northern and Yorkshire office of the NHS Executive have asked me to convey to the complainant through my report as I do-their apologies for the shortcomings I have identified.

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comments

The complainant's evidence

20. The complainant said that on 27 February 1995, according to a patient in the next bed, her father had fallen to the floor by his bed but that had not been documented. A nurse said that he had sat on the floor deliberately. Her father's eyes had become `blood red', and the doctor who saw him the next day said that he would look into the problem. She heard no more about it and the condition appeared to improve within a few days. During a meeting with the Trust on 25 May 1995 the family learned that the complainant's father's eye condition and treatment had not been recorded in the medical and nursing notes. There had also been an incident involving a psychiatric patient the night before he died, which had caused him great distress, but that too had not been recorded.

Evidence of the Trust

21. The chief executive's response to the Commissioner's statement of complaint included:

> `It is accepted that there were a number of omissions from the nursing records, including the incident referred to on 28th February, where the behaviour of a patient during the night had distressed [the complainant's father]. The omission of reference to [the complainant's father's] eye problem is accepted as a specific failure in the standard of medical record keeping.
>
> `Remedial action
>
> The particular concerns highlighted in respect of [the ward] staff have been addressed in the detailed action plan ....
>
> `The general issue of the standards of clinical record keeping have been addressed by the establishment of a Medical Records Committee. This will set standards, and review, all types of clinical record keeping ....'

22. In a letter to the complainant dated 23 August 1995 the chief executive said that the nursing notes showed that her father had been found, apparently having rolled out of bed, but nursing staff had failed to complete an incident form. He said `this is unacceptable practice' and assured her that the issue had been discussed with ward staff. He expressed regret at the failure to record her father's eye condition and treatment in the medical notes and noted that there was no record in the nursing notes that his eyes had been bathed.

23. The staff nurse gave evidence that problems with record keeping had applied across the ward. There had since been some improvement. New folders had been introduced making it easier to see where something was missing. Staff had been trained in the standards expected. Since she had been appointed ward sister she had carried out random checks of the documents maintained by the primary nurses who cared for patients. The forms used had been standardised across the directorate which helped bank nurses to be familiar with documentation used. However some problems remained: there was scope for further improvement.

24. The ward manager gave evidence that he had checked the complainant's father's notes after his death and found them lacking. The nurses on duty at the time the complainant's father was a patient had explained to him that the ward had been busy at the time, and attending to the physical care of patients had been a priority. The ward manager thought that there had not been a wider problem with the standard of nursing records which he had monitored through spot checks.

25. The director said that poor record keeping was a general problem in the ward, and there was scope for improvement elsewhere in the Trust. Procedures had been put in place to develop and audit record keeping standards. The director said that she expected all trained nurses to meet the standards set by the UKCC.

26. The consultant accepted that there were omissions from the complainant's father's medical records and that his eye condition should have been recorded. However, while he accepted that the omissions were important to the family, he did not consider them relevant to the complainant's father's medical care. He thought that the standard of medical record keeping had since improved. Auditing of standards was carried out through monthly random checks of records selected by the audit office and reviewed by consultants from different teams.

Findings *(b)*

27. The chief executive has accepted that the complainant's father's nursing and medical records were not as complete as they might have been. I agree with that conclusion. I am concerned at the suggestion that poor record keeping by nurses is a problem elsewhere in the Trust. I recommend that the Trust review their systems for auditing nursing and medical records, to make sure that the significant actions, interventions and decisions of staff are recorded. I uphold the complaint.

Complaint *(c) Failure in communication*

28. I have seen a copy of the Trust's `Procedure for the Investigation of Untoward Incidents' issued on 10 July 1996-after the events complained about. It includes in paragraph 2.1: `.... it is the responsibility of the police to inform the relatives of a deceased person of their death. It will be the responsibility of hospital staff to inform the police what further information should be given to the relatives, in order to avoid any unnecessary distress or misinformation. This information could include the circumstances of the death'. The form of words was agreed by the Trust with a chief inspector of the Essex Constabulary.

Evidence of the complainant and her mother

29. The complainant's mother told the Commissioner's investigators that bank nurses did not know the patients. The nurses' attitude to questions raised by the family was `you shouldn't be asking'. The complainant also found that nurses' reaction to requests for care for her father, such as a request for a replacement drip bag, were unpleasant. The complainant's mother described how she learned about her husband's death. She was visited by two policemen who said that her husband had died. She and her daughter, the complainant, then went to the hospital. Ward staff said that her husband's body was in the morgue and they were waiting for the mortician. She waited an hour and a half to see his body, but was not told why, or how her husband had died. When she asked why she was being questioned about her husband's scars and operations she was simply told that was `normal procedure'. The next morning a man from the Coroner's office telephoned and asked if she was aware of the circumstances of her husband's death. Since she was not, he came to her house to explain that her husband had died following a fall from a balcony. In a letter to the Commissioner the complainant said that the family had thought that her father had died of natural causes. Discovering from the Coroner that that was not the case had caused immense shock and distress.

Evidence of the Trust

30. The chief executive's response to the statement of complaint included:

> `It is accepted that there were certain failures of communication with [the complainant's father's] family before his death, concerning [his] treatment and clinical condition.
>
> `Although the particular complaint of evasiveness proved difficult to investigate, it was accepted that the approach of staff may have appeared evasive.
>
> `It is accepted that there was a difference in understanding between the nursing staff and police officers as to who would inform the family of the circumstances of [the] death. The nursing staff believed that police officers would do this, and when they subsequently met the family, assumed that this had happened ....'
>
> and,
>
> `Remedial Action
>
> The Trust's Head of Nursing met with a representative of the local police to discuss and agree the procedure for notification of relatives in the event of death in unusual circumstances. The current untoward incident policy is being revised to incorporate the agreed changes, and is due to go to the Trust Board for endorsement in April 1996.
>
> `The action plan for [the ward] paid particular attention to the communication problems experienced by the family, and set standards for improvement.
>
> `The Trust has adopted the theme of `improving communication' as one of its corporate objectives for 1996/97. This will be addressed and monitored via the performance management system.
>
> `Conclusion
>
> The Trust accepts many of the concerns voiced by [the complainant] and other family members. We have apologised to the family for these, and the distress caused to them. We have spent considerable time addressing the issues raised, in order to try to meet the family's needs, but also in order to learn from the shortcomings in [the complainant's

father's] care. We have used the experience of this family to improve the standard of care within [the ward] but also to address wider issues of communication and record keeping within the Trust.'

31. I have seen a copy of the letter from the chief executive to the complainant dated 10 November 1995 in which he says:

> `.... I would .... like to assure you that we have taken the issue concerning the attitude of the nursing staff very seriously. We have had major discussions with all the nursing staff currently on [the ward] to ensure that lessons are learnt from the experience of you and your family....'

32. At interview the chief executive said that complaints training was being given to senior staff in the Trust, including ward managers, directorate managers and consultants and a programme of customer care training was being developed for ward staff. The corporate objective to improve the standard of communication should lead to a training strategy which would build on the nurses' professional review system and personal development plans. He explained that the revised untoward incident policy had been agreed by the Trust Board. It should then have been cascaded to all staff. During a second interview with the chief executive in September 1996, he told the Commissioner's investigators that the policy had been circulated to all wards.

33. The staff nurse told the Commissioner's investigators that communication with relatives and patients had improved. The primary nurse system of allocating a nurse to care for a patient had been strengthened. Staff were being encouraged to be communicative, and relatives were invited to attend ward rounds if they had questions. Shift handovers had been improved so that full information was given about patients' problems.

34. When she was interviewed in August 1996 the staff nurse had only recently seen the revised untoward incident policy. She thought it wrong that only senior managers knew about it. The ward manager, who left the Trust at the end of August 1996, said that he had not seen the revised policy. The director said that she expected all senior nurses to be aware of the policy, and copies to be available in wards.

35. When interviewed the consultant said that he was aware of the Trust's corporate objective to improve communication and had changed the way that he worked in the light of that. The consultant said that he was pleased that the untoward incident policy had been agreed with the police force, so that everyone knew where they stood. The policy had been circulated to all wards, although it was possible that staff might not recall or have studied it because of the amount of information circulated. He hoped that staff would refer to the policy if an incident were to occur in future. He thought that the police should have told the family how the complainant's father died, and that their failure had let the Trust down.

Findings *(c)*

36. The chief executive has accepted that there were inadequacies in the communication between the nurses and the family before the complainant's father's death. I note the measures taken since that time to improve communication. Turning to the communication of how the complainant's father died, I appreciate that the circumstances of his death presented the hospital with an unusual situation, but I do not believe that that in any way excuses the complete breakdown in communication which occurred. I consider it wholly unacceptable that the complainant's mother did not learn about the circumstances of her husband's death until the following day. I note that the new untoward incident policy lays responsibility for passing information to the police with Trust staff, and to the police for passing that information on to the next of kin. I do not criticise that arrangement, although I am concerned that a misunderstanding may arise between Trust staff and the police, or the police and the next of kin, which will result in the next of kin not knowing what happened. **I recommend** that the Trust consider whether the policy could be strengthened to address that possibility, perhaps by making the member of Trust staff who supports the next of kin on their arrival at the hospital responsible for checking that the family are aware of the circumstances of the patient's death. I am concerned that some ward staff did not know of the existence of the policy when they were interviewed. **I recommend** that the Trust make sure all qualified medical and nursing staff are aware of the policy. I uphold the complaint.

Conclusion

37. I have set out my findings at paragraphs 16, 27 and 36. The Health Authority have asked me to convey through my report-as I do-their apologies to the complainant for the shortcomings I have identified and the Trust have agreed to implement my recommendations in paragraphs 16, 27 and 36.

comments

Evidence of the second Trust

19. In his comments to the Commissioner the chief executive of the second Trust wrote:

> `[The first Trust] carry out the monitoring of waiting times for this clinic and .... arrange .... appointments under the instructions of [the consultant]. .... the urgent .... nature of many types of renal disease requires patients to be seen immediately and the clinics are overbooked rather than allow any waiting list to develop.
>
> `Clearly, [the complainant's] complaints were justified .... negotiation .... has now resulted in increased provision for this service .... I am satisfied that every effort was made to [reach] a satisfactory conclusion at the earliest opportunity. .... we were not aware of [the] complaint until February 1996 by which time the arrangements for the additional clinic were nearing completion.'

He enclosed copy correspondence including a letter dated 18 January 1995 from the contracts manager to the Authority's predecessor about the over-subscription of the clinic and the excessive waiting times. He said that proposals to expand the service were developed over the following months.

20. In a second letter to the Commissioner dated 11 December 1996, the chief executive of the second Trust said:

> `.... Patients attending a renal clinic have special characteristics and requirements [these are] quite different from those attending other general medical clinics:-
>
> -Urgency ....
>
> -Chronicity ....
>
> -Complexity and high economic investment ....
>
> `The philosophy of renal outpatient clinics .... has been to respect the urgency of the patient's clinical condition and waiting time within clinic has been sacrificed to ensure patients are seen without delays on a clinic waiting list.'

21. The consultant said that the clinic attendance had grown from five to ten patients in 1987 to 30 to 40 in 1995. He considered it important for patients to be seen at regular intervals, even if that meant a long wait at the clinic. He thought that the first Trust were responsible for the administration of the clinic but that waiting times were his responsibility. He had coped with the problems by progressively overbooking the clinic and it was rare for it to be completed before 3.00pm. He did not like patients having to wait but to have given them realistic appointment times would have legitimised an unacceptable situation. The problem was inadequate funding for the region as a whole. Two monthly sessions at Salisbury might not be enough; what was needed was an additional consultant for the regional service.

22. He said that delays in resolving the problem were caused by a combination of protracted negotiations, differences of opinion about whose service it was, funding difficulties and a lack of experience of contracting. He did not find out that the complainant had complained until May 1996. If he had known sooner he would have spoken to the complainant and explained the reasons for the delays and the efforts being made to alleviate them.

23. The contracts manager said that, before the introduction of the NHS internal market, the renal service in the region was provided by the second Trust, funded by the regional health authority. Now individual health authorities contracted with them for renal services for their residents. The second Trust were the service provider and were responsible for the waiting times at the clinic and the first Trust were responsible for accommodation, equipment and nursing and administrative support-though there was no formal contract between the two Trusts. Information about waiting times should have been sent to the second Trust for reporting to the Authority.

24. She first discussed the waiting times at the clinic with the first Trust in July 1995, and they agreed to make a joint bid to the Authority for funding for an additional clinic. In about September the second Trust prepared a draft bid and sent it to the first Trust for comment. Nothing happened for a couple of months. There were staff changes at both Trusts. In December she wrote to the first Trust enquiring about progress and suggesting a meeting to resolve any outstanding issues. (Note: That letter refers to the chairman of the first Trust having discussed the situation with the consultant and having offered to pay for the

expansion of the service.) After a colleague received a letter from the first Trust's business manager apparently referring to the cost to the first Trust of an extra clinic session she wrote to the business manager saying that the second Trust could not fund the cost of the consultant's services. In early 1996, following further discussions between the Trusts, she made a formal bid to the Authority for funding for the extra clinic session. She did not know about the complaint until about February 1996. She discussed it with the Authority and was told that funding would be made available for the extra clinic from the start of the new financial year. After receiving oral assurances (Note: I have seen that they were confirmed by letter on 14 May.) from the Authority that the funding would be provided, arrangements were made to start the new clinic on 3 June. There had been a problem in finding accommodation for the new clinic session which took a short time to resolve.

25. The contracts manager said that at the time of the complaint, and to some extent still, there was a lack of understanding about who owned and was accountable for which parts of the service. That confusion had delayed the resolution of the problem. She considered that accountability for the former regional services (such as the renal clinics) still needed to be clarified.

The evidence of the Authority

26. In comments to the Commissioner the chief executive of the Authority wrote that the renal outpatients clinic at the first Trust came within the contract with the second Trust. Neither Trust had been reporting detailed information about the waiting times at the renal clinic, because each thought the other was responsible. Now monitoring of the clinic's waiting times was being carried out by the first Trust. The Authority had agreed on 9 February 1996 to fund the extra clinic session. The problem of lengthening outpatient waiting times was not brought to their attention until this investigation started.

Findings

27. The complainant and his wife experienced excessive waits, well outside the Patient's Charter standard, in the renal outpatients clinic at the first Trust. Such lengthy waits, far from being exceptional, had become the norm as more and more patients attended the clinic. It commonly ran until 3.00pm although the last scheduled appointment was at 12.10pm. Both Trusts had recognised the problem even before the complainant complained, yet it remained unresolved nine months later. Why was that?

28. Proposals for an extra clinic session each month were being developed by the second Trust in the first part of 1995 and a proposal written in August was sent to the first Trust. There seems to have been no effective action for some time by the first Trust in response to that or the complaints, despite the chairman's letter in September referring to urgent steps being taken. The first Trust's chief executive accepts that they had not pursued progress adequately then. The situation was complicated by the confusion about responsibility for all or some aspects of the clinic: the business manager at the first Trust was unaware of the second Trust's proposal and assumed that his Trust were responsible for solving the problem. The first Trust took sole responsibility for dealing with the complaints about the clinic and did not inform the second Trust. When the proposal for an extra clinic session was pursued further by both Trusts problems emerged over funding, again apparently based on some confusion between the Trusts. At one point the first Trust offered to provide some temporary funding, but then decided to await the outcome of negotiations. While I understand that those were necessary before extra clinic sessions could be arranged, the difficulties described above meant that the negotiations were unnecessarily prolonged, for which the first Trust must take their share of responsibility. The second Trust and the Authority were not the subject of this complaint. Some confusion remains about arrangements for monitoring and reporting to the Authority on the waiting times at the clinic. **I recommend** that the first Trust should approach the second Trust and the Authority with a view to producing an agreed document outlining the responsibilities of each Trust for the clinic and the arrangements for monitoring its performance. I further **recommend** that the first Trust review the arrangements for any similar clinics provided in or by other Trusts to make sure that there is no similar confusion or uncertainty about responsibilities.

29. I can understand why the complainant found the first Trust's response to his complaints unacceptable, when after urgent action had been promised he experienced an even longer wait at the next appointment and when the chairman's subsequent letter (paragraph 10) suggested that there was no solution possible without extra resources. What was required in the short term was for patients to be given appointment times which reflected when, in reality, they were likely to be seen. I understand the consultant's fears about legitimising an unsatisfactory situation but it is quite unacceptable that patients continued to be misled about when they could expect to be seen. I agree with the chairman that the complaint should have been discussed with the second Trust. The first Trust took responsibility for handling the complaint but failed to pursue adequately the need for a realistic clinic schedule until a longer term solution could be found. **I recommend** that the first Trust review their complaints procedures to make sure that guidance is given on arrangements for complaints involving other Trusts. I uphold the complaint.

Conclusion

30. I have set out my findings in paragraphs 27-29. Salisbury Health Care NHS Trust have agreed to implement my recommendations in paragraphs 28 and 29 and have asked me to convey to the complainant through my report - as I do - their apologies for the shortcomings found.

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comments

Staff evidence

30. The bank nurse (paragraph 13) told the investigators that she had not been in charge of the patient's care. However, she had occasionally helped in his care. She said that she was not interviewed by Trust staff about the complaint.

31. The ward manager said that the complaint was referred to her shortly after it was received at the hospital. The nursing rotas were available at the time. She remembered speaking to the ward staff, some of whom wrote statements. (Note: the Trust have not been able to locate these statements). She had no recollection of being asked to identify the nurse who cared for the patient. She thought that the nursing rotas went missing in June 1995 when the ward's services moved to another location. When the investigator gave her the description provided by the complainant of the nurse on duty when the patient died, the ward manager said that she thought it was the senior staff nurse. She said that in addition to the nursing rotas there was a ward allocations book which recorded for each shift which nurses were allocated to which patients. (Note: the Trust have said that this book cannot be found.)

32. The senior staff nurse said that she had not been asked about the complaint before the Commissioner's investigation. Of the other nurses interviewed by the investigators, two could remember being spoken to about the complaint; one of those said that she had provided a written statement to the effect that she had not been involved in the patient's care.

33. The A and E manager confirmed that she was responsible for investigating the complaint until she left the hospital in April 1995. The complaint was then taken over by the director. The A and E manager recalled speaking to the nursing staff but they were reluctant to make formal statements about the complaint unless they could check the facts against the nursing records which were then missing. She had no recollection of trying to identify the nurse who cared for the patient. The divisional general manager for clinical services (the divisional manager) said that it would have been the director's responsibility to follow up the action after the meeting in September 1995.

34. The director said that she had been responsible for trying to trace the nurse who cared for the patient. She recalled consulting the ward manager. The director confirmed that she had been under the impression that the nurse concerned was the bank nurse who last gave drugs to the patient on 9 December 1994 (paragraph 13). The director said the reason why the action after the 18 September 1995 meeting was not followed up was because at the time the drug book also could not be found. (Note: after the Commissioner's investigation began, a copy of the relevant page of the drug book was found in the Trust's complaints file.)

35. The chief executive said that `someone should have looked harder [for the duty rotas] and interviewed staff involved more assiduously'.

Findings *(c)*

36. The complainant has complained that the Trust's investigation of the complaint was inadequate because the nurse who cared for her husband was not identified and no explanation was given for that. She has complained that a meeting was not arranged with the nurse identified from the drug prescription book. I strongly criticise the Trust staff for not clarifying the complainant's central concerns at the outset. By the time the meeting in July 1995 took place the nursing rotas were missing. However the ward manager's allocation book could have provided information. A muddle was allowed to develop which was exacerbated by poor co-ordination and a general lack of determination to resolve the complaint. Issues became confused; and during the Trust's investigation the director wrongly assumed that the nurse in charge of the patient's care was the bank nurse. There were meetings but they clearly lacked focus and were not effectively followed up. The director must bear primary responsibility for the handling of the complaint from April 1995. I uphold this complaint.

Complaint *(d) Dilatory handling of the complaint*

37. The complainant told the investigators that she was dissatisfied with the length of time it took the Trust to deal with her complaint. She was also concerned about the five month delay before the Trust informed her about the loss of her husband's records.

The Trust's formal response

38. In his formal response the chief executive said `.... It is accepted that the Trust was initially dilatory in dealing with the complaint, due to the non availability of the medical records, and that in retrospect, it would have been more satisfactory to have held a meeting and explored other avenues to progress the complaint much earlier. Indeed, this is now the approach which would be adopted in a case where medical records could not be located for any reason ....'.

National guidance and local procedures

39. Department of Health and Social Security circular HC(88)37 issued in June 1988 stated: `.... The aim should be to process the complaint speedily and thoroughly at all stages. The complainant must be kept informed of progress and where appropriate interim replies or holding letters must be sent'. The Patient's Charter (issued in 1992 and revised in 1995), gave patients the right `.... to have any complaint about NHS services .... investigated and to receive a full and prompt written reply from the chief executive or general manager. (Note: guidance on the implementation of the new NHS complaints procedure issued in March 1996 - after the events surrounding the complainant's complaint - stated `.... The chief executive of the NHS in England has agreed that, from 1 April 1996, all written complaints will receive a response from the Chief Executive or General Manager of the Trust concerned. The reply might take the form of a full personally signed response or a shorter letter covering a full report from another member of staff, which the chief executive has reviewed and is content with ....'.)

40. The Trust's complaints procedure at the time stated `.... Complaints will be acknowledged within two working days, and normally completed with meetings, correspondence, investigation and final response within 20 working days. If for any reason the time limit overruns, the complainant will be notified in writing with the reason within the 20 working days .... If the time limits .... are broken, then the Divisional Manager will record the reasons, keep the complainant informed of progress .... At any stage of the investigation the complainant should be invited by the investigating officer to meet him/her to discuss their complaint in detail. The Trust's revised complaints procedure from April 1996, which was introduced consequent to the new NHS complaints procedure, included `.... Responses will generally be drafted for signature by the relevant Divisional Manager, although sometimes the complainant will request a response from the Chief Executive or he will wish to send a personal reply ....'.

Staff evidence

41. The customer care manager said that a new computer system for monitoring complaints was introduced in January 1995. Weekly reports were sent to the two divisional managers showing which complaints were outstanding. A quarterly report summarising all complaints was also sent to care group directors, the two divisional general managers and to the Trust Board complaints group. A senior customer care officer (the first CCO), who left in May 1995, was mainly responsible for monitoring complaints. The customer care manager said that in April 1995 she sent a message to the A and E manager and the director asking for a response to the complaints even though the records could not be found.

42. The A and E manager said that although she had been away for some time at the end of December 1994 and in January 1995 that should not have delayed the investigation of the complaint. She explained that a reply to the complainant was not drafted earlier because the A and E manager believed that the medical records would be found. The director said that in the early part of 1995 there were a number of factors which could have contributed to the delay. They included the reorganisations the hospital was undergoing; changes in the management of complaints; a new computer system; and the fact that two capable staff who handled complaints left in 1994 and their replacements were still inexperienced. In addition, the delay in holding the meeting in July 1995 might have been because the staff involved wanted to see the medical notes. After the second meeting in September 1995 she sent the CHC officer a note of the meeting. When the CHC officer replied in January 1996 he reiterated many of the questions which had already been considered. Many of those questions could only have been fully answered with reference to the missing records.

43. The chief executive said that the complainant's complaint had been handled too slowly. He first became involved in the summer of 1995 when action was already being taken. The chief executive said that he dealt personally with some complaints. However in the main he delegated the signing of letters to complainants to his two divisional managers. He would need more staff in his own office if he were personally to sign all letters. The chief executive confirmed that complaints management had been transferred to his business manager in August 1995 (paragraph 24) so that that person could be directly responsible to him for complaints. That had strengthened the chief executive's involvement and accountability in the process. He added that the Trust's new complaints monitoring procedures were better and there had been improvements in performance.

Findings *(d)*

44. The Trust have accepted that initially they were dilatory in dealing with the complaint because the patient's medical records were not available; and that in retrospect they should have held a meeting and considered other ways of resolving the complaint at an earlier stage. The Trust records show that on 28 April 1995 the first CCO told the citizen's advice bureau that

the records were missing (Appendix A). However, I find it unsatisfactory that it was not until 26 June 1995-after the complainant had formally applied to see the records-that the Trust wrote confirming that they could not be located. After the meeting on 18 September 1995 staff failed to take effective action to resolve the complaint. In view of my comments in paragraph 36 I consider the tone of the director's letter of 25 January 1996 to the CHC officer (Appendix A) to be unacceptable. The chief executive's general practice (and the Trust written policy) in relation to the signing of replies to complaints is contrary to the Patient's Charter and to the revised national guidance on complaints handling. I uphold this complaint.

Conclusion

45. I have set out my findings in paragraphs 18, 27, 36 and 44. I am disturbed not only about several aspects of the Trust's handling of the complaint but also about failures to safeguard records. That has hampered the Commissioner's investigation and is indicative of lax procedures at the time. The Trust have agreed to implement my recommendation in paragraph 27 and have asked me to convey-as I do-their apologies for the shortcomings which I have found.

APPENDIX A TO E.1242/96-97

Chronology of main events and correspondence

30 December 1994
The complainant wrote to the department of neurology at the hospital complaining about aspects of her husband's care and treatment (paragraph 6 of this report).

5 January 1995
The complainant copied her letter of complaint to the hospital's patient liaison manager.

9 January
The first CCO wrote to the complainant stating that she had asked the relevant department to investigate the matter and a divisional manager would respond direct. The first CCO asked the A and E manager and an official concerned with the critical care groups to investigate the complaint.

28 February
The complainant telephoned the first CCO about her outstanding complaint.

2 March
Another customer care officer (the second CCO) wrote to the complainant stating `Further to our telephone conversation on 28 February 1995, can I firstly apologise for not informing you in the first instance of what stage your complaint is being processed ....'.

3 March
The A and E manager wrote to the second CCO saying she was unable to progress with the investigation because she could not locate the patient's hospital notes. She said the ward staff would like to see the notes before commenting.

23 March
The complainant wrote to the Trust complaining about the delay.

28 March
The first CCO replied. She did not mention that the records were missing but said that the responsible manager needed to make sure that a thorough investigation was carried out. On the same day the first CCO wrote to the medical records manager about the lost medical records.

3 April
The first CCO wrote to the A and E manager stating `If by the time you return from leave, the records still have not materialized, then you may want to consider formally advising those concerned ....'.

28 April
According to the Trust's records an official from a Citizens Advice Bureau (CAB) telephoned the Trust; and the first CCO told the CAB that the records could not be found and that was why there was a delay in responding.

1 May

The director wrote to the first CCO with copies to the customer care manager and the business manager referring to the complainant's letter of 30 December and to an earlier letter of complaint from the complainant's son.

9 May
The project director, neurosciences, wrote to the professor of neurology stating `Please find enclosed a copy of some correspondence recently forwarded to me from the Customer Care Department. I would be very grateful for your clarification of what had happened in this case ....'.

31 May
The second CCO wrote to the divisional manager enclosing copies of the complaint. He said that the CHC officer had telephoned that day demanding to speak to him (the divisional manager).

1 June
The complainant signed an application form, requesting her husband's records from 7 to 9 December.

5 June
Another customer care officer (the third CCO) wrote to the complainant inviting her to a meeting on 3 July.

26 June
The second CCO wrote to the complainant stating `.... Thank you for your telephone call this morning concerning your recent access to your late husband's patient records .... We are unfortunately .... unable to locate the specific records that you require ....'.

29 June
The CHC officer wrote to the divisional manager stating that `.... I am extremely anxious that the notes are located and are available before the meeting'.

3 July
The meeting took place. According to the Trust records it was attended by the complainant, her son, a family friend, the CHC officer, the divisional manager and the director. A note of the meeting stated `.... ACTION .... Following a fresh investigation, [the complainant]/her son will be provided with a detailed response to the complaints outlined in their previous correspondence .... This to be provided within one month of the date of the meeting ....'.

20 July
The director wrote to the complainant stating `.... In the absence of the notes I have attempted to gather together information from all relevant professional staff in order to try and establish a more detailed picture of events and address your specific concerns ....'. The director then provided responses to certain concerns which had been raised. She added `.... I appreciate that in some areas I have not been able to respond to you in as much depth as I would have hoped given the absence of the medical and nursing notes. I do, however, hope that this will at least form a basis for further discussions ....'.

2 August
The second CCO wrote to the complainant confirming that another meeting was being arranged.

7 August
The senior registrar in dermatology wrote to the director providing information on the patient's condition and treatment. On the same day the second CCO also wrote to the complainant stating that the earliest date for the meeting would probably be in September. On that day the CHC officer also wrote to the divisional manager, suggesting that the police be asked to investigate the loss of records.

16 August
The divisional manager wrote to the CHC officer explaining that some records had been found, including the drug administration book, but not the notes about the patient's admission in December. He said that he could not see how involving the police would help the complainant.

30 August
The second CCO wrote to the CHC officer proposing dates for the meeting.

6 September
The CHC officer wrote to the divisional manager confirming the meeting on 18 September 1995. He listed the questions on which the complainant wished to focus. They included `the time of death and the events which followed [the patient's] death' and `the reason for the state of [the patient's] body when family and friends arrived and why the body was not laid out

properly ....'. In a separate letter to the divisional manager the CHC officer said `.... [the complainant] believes that the notes have been destroyed in order to hide evidence of malpractice by nursing staff ....'. He therefore asked the divisional manager to raise the matter with the police.

13 September
The divisional manager wrote to the CHC officer confirming the details of the meeting. In a separate letter to the CHC officer he also wrote suggesting that the CHC officer contact the police direct if he considered that necessary.

18 September
The second meeting took place. According to the Trust's records it was attended by the complainant, the CHC officer, a family friend, the director, the house officer, the senior registrar in dermatology, a medical registrar, a staff nurse and the second CCO. The Trust's note of the meeting recorded `.... [The complainant] wanted to know who the nurse was who gave her the news of her husband's death .... Notes of 7-9th December still missing .... the patient's condition was very serious and all efforts were made to ensure appropriate treatment .... Nursing Procedures of laying out the body explained by Staff Nurse ....'.

25 September
The director wrote to the CHC officer enclosing the note of the meeting. She said that `.... Every attempt is being made to identify who the nurse was [the complainant] mentioned on duty when her husband died. I will as agreed contact [the complainant] again if further information becomes available'.

26 September
The CHC officer wrote to the police asking them to investigate the disappearance of the notes.

17 October
The complainant wrote to the CHC officer commenting on the Trust's note of the meeting and listing many points about which she was concerned. For example, she said `.... In our opinion the state of [my husband's] body was not because of his illness but the time he had been left .... we feel he had been neglected and had been dead for some time ....'.

21 November
The police wrote to the CHC officer saying they could find no evidence to substantiate the `allegation of theft'.

18 January 1996
The CHC officer wrote to the director with a list of comments on the note of the meeting on 18 September. One of those was `Who were the nurses and doctors on duty when the patient died?'.

25 January
The director wrote to the CHC officer stating `.... I .... fail to understand, given your presence at the meeting, the rationale behind a printed list of questions which were either explained at the meeting or indeed were discussed and a decision made collectively that the full details that the complainant wished to know were not available'.

5 February
The CHC officer replied stating `.... [The complainant] is at the centre of our concern .... I hope that a more sympathetic and helpful approach will now be adopted ....'.

22 February
The divisional manager wrote to the CHC officer saying that he felt the Trust had done all it could to deal with the complainant's concerns.

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comments

Evidence of the Trust's staff

18. The CNM said that relatives could always visit outside normal times by arrangement with a senior nurse. There were notices on the ward doors and information leaflets in each room within the ward explaining that arrangement. She had been unable to discover why the patient's relatives felt uncomfortable about visiting outside normal hours: they had not complained at the time. Alternative visiting arrangements were common; and a relatives' sitting room and bedroom were available. Since this complaint the ward had adopted an `open' policy for visits between 2.00 pm and 8.00 pm.

19. The enrolled nurse said that she could not recall the patient's relatives asking to visit outside normal hours; but had they done so there would have been no objection. She did not know why they felt uncomfortable about asking, as the only inconvenient time would have been during doctors' rounds. The staff nurse and the ward manager separately gave similar evidence.

20. The deputy chief executive said that visiting times had always been flexible and he had received no other complaints about visiting arrangements.

21. In her formal response to the statement of complaint the chief executive wrote `.... nursing staff were encouraged to apply [the visiting times] flexibly .... Had [the complainant] or her brother indicated they wished to visit outside these hours this would not have been a problem. We have no records of [the patient's] relatives being denied extended visiting time.'

Findings *(a)(ii)*

22. There is no record of any communication with the patient's relatives about visiting arrangements; and the ward staff have no recollection of them asking to visit outside normal hours. The staff said that such arrangements were common and that information explaining the position was displayed in the ward. I am not persuaded that, had the patient's relatives pursued the matter, they would have been denied information about flexible visiting arrangements. I do not find this complaint made out.

Complaint *(b) Mortuary arrangements*

Evidence of the relatives

23. The complainant's brother said that he and other relatives agreed that it would be more appropriate to view the patient's body in the chapel of rest at the undertakers than at the hospital. On 9 February 1995 the manager of the undertakers telephoned him to say that he had collected the patient's body from the hospital. He explained to the complainant's brother that it appeared that the body had been stored at the hospital unrefrigerated and that, because of her deteriorated condition, he was not able to prepare the patient's body properly for viewing. He strongly advised the complainant's brother and his family not to view the patient's body; and the complainant's brother therefore had no option but to agree to the coffin being sealed immediately. All the family were extremely distressed, particularly as they were not with the patient when she died. The complainant said that if, as the Trust had suggested, her mother's body was too large to be stored in the normal way, alternative arrangements should have been made, and her family should have been told about the problem. The thought of her mother's body deteriorating in the mortuary had caused her a great deal of anguish.

Evidence of staff employed by the undertakers

24. The undertaker's employee who collected the patient's body from the hospital said that it had been placed in the corner of the body storage area in the hospital mortuary and had been covered with a sheet. The body had been too large to place in the undertaker's refrigerated cabinets, and he therefore laid it out on a trolley. He remembered the patient's body well and said that her deterioration had rendered her unsuitable to be viewed by her family. The manager of the undertakers said that he saw the body on its arrival at his premises. The body had deteriorated. While there was little that the hospital could have done to prevent the deterioration, he thought that the staff there could have advised the patient's relatives to view the body earlier.

National guidance

25. In 1991 the Health and Safety Commission issued a revised Code of Practice entitled `Safe working and the prevention of infection in the mortuary and post-mortem room'. The Code stated that one of the functions of a mortuary was `to prevent

tissue decomposition while burial or cremation arrangements are under way'. It also stated that `.... bodies will normally be stored in cabinets at a reduced temperature (approx 4 .C) ....'

Documentation

26. The Trust's written procedure for receipt of bodies into the mortuary stated that the mortuary register must be completed correctly with the body's details and that `the body must be placed in a fridge onto a metal tray ....' There was no instruction about how large bodies should be accommodated. The mortuary register showed that [the patient's] body was received on 5 February at 11.14 pm and released to the undertakers on 8 February at 2.25 pm.

Evidence of Trust staff

27. In her formal reply to the statement of complaint the chief executive wrote:

> `[The patient's] body was received in the mortuary on 5th February, 1995 and was released on 8th February, 1995 to [the undertakers]. The body weighed 136.9 kg (21.5 stone) with a maximum width of 29 inches. The refrigerator storage was of insufficient dimension to facilitate a body of these dimensions. [The patient's] body was, therefore, laid out in the mortuary body storage room and this area was screened off. The handling procedures and further care within the mortuary of the body of the deceased were of the usual highest standards. The ambient temperature of this area is approximately 5-7 .C during February which is only 1-3 .C above the refrigerated component.
>
> `The death certificate was signed on 7th February, 1995 and the body released to [the undertakers] on 8th February, 1995. A request was not made by the family to see the body whilst in the Hospital mortuary. If such a request had been made the family would have been facilitated to do so by the mortuary staff.
>
> `When the body was released to [the undertakers] there was no evidence of any deterioration in the condition noted at this time. If such an occurrence had taken place, [the undertakers] would have been notified by the mortuary regarding the changes.
>
> `[A consultant pathologist (the second consultant)], confirms that she is satisfied with the handling and storage procedures at the mortuary and that these procedures were adhered to in this case. The body was not refrigerated on the basis of overall body weight and dimensions. Nevertheless, the conditions of storage were of sufficient high standard for the Consultant Pathology staff and mortuary technician staff to be assured that no undue deterioration of the body had occurred.'

28. A mortuary technician said that he was on duty when the patient's body arrived and it was obvious that she would not fit in the refrigerated container. The body was therefore covered by a sheet and left in the far corner of the room. He dowsed the body with disinfectant and changed the sheet each day. He could not recall the exact condition of the body when it was released to the undertakers but he thought that the skin had begun to blister.

29. The second consultant, who held joint responsibility for the mortuary said that no record was kept of the condition of bodies received in the mortuary unless anything untoward was noted, in which case a note was made in the record book. After being prepared, bodies were placed into refrigerated cabinets which were of a standard size. Although the cabinets could be adapted for height, there was a maximum width restriction. The patient's body was too wide to be placed in the refrigerated cabinet. She was therefore covered and laid out in the general storage area, which was not refrigerated but was unheated. The second consultant said that mortuary staff always told her about any problems, and would almost certainly have alerted her to the fact that the patient's body had not been placed in refrigerated storage. (Note: The Commissioner's investigator visited the mortuary and saw that the maximum width of the refrigerated cabinets was 27 inches.)

30. The second consultant could not recall the condition of the patient's body when it was released to the undertakers, but thought that no undue deterioration had taken place. Had that not been the case, the matter would have been brought to her attention, and a note would have been made in the record book. (I have seen that there is no note to that effect.) In February the temperature in the general storage area was only a few degrees higher than in the refrigerated facilities, so the rate of deterioration of the patient's body would have been only slightly greater. Her body weight and diabetes would not have affected the deterioration. The second consultant said that the undertakers had not told her that they were concerned about the condition of the patient's body. After this complaint she contacted other mortuaries in the area and none of them had cold storage facilities to accommodate bodies of the patient's size. She had discussed the matter with the speciality manager for pathology services and with the chief technician; but they had not thought it practicable to provide facilities for the very few cases where bodies could not be stored normally.

31. The speciality manager for general surgery (the speciality manager) said that she had written to the chief executive to establish whether anything could be done to prevent future difficulties with the storage of large bodies. She discussed the matter with the chief executive and the general manager of pathology services but it was decided that it would not be viable to extend the existing facilities.

32. The chief executive and the deputy chief executive separately expressed concern that the undertakers had disclosed information to the patient's relatives when they were not in possession of the full facts.

Findings *(b)*

33. The Trust's staff have explained that the patient's body was too large to place in the refrigerated cabinet. There is no documentation to show the condition of the patient's body; but the second consultant did not think there would have been any undue deterioration. The undertakers' staff gave a different account. On balance I am persuaded that the condition of the patient's body did deteriorate in the hospital mortuary and that the position was not properly monitored and documented by the hospital staff. It is unacceptable that this should have happened, and I can understand the distress felt by the patient's relatives. **I recommend** that the Trust remind staff of the need carefully to monitor the state of bodies in the mortuary and to liaise with relatives or undertakers if there are difficulties about storage arrangements. In such circumstances effective communication is important in ensuring that the body is released without undue delay. I uphold this complaint.

Complaint *(c) Trust's investigation of complaint about a breach of confidentiality*

Evidence of the relatives

34. The complainant said that a family friend who happened to be a patient in the same ward as her mother told her that a nursing auxiliary had chatted to him about the patient after her death. The nursing auxiliary had mentioned several personal details and had also discussed the circumstances of the patient's death. The complainant considered it completely unacceptable that the nursing auxiliary should have spoken so casually about such personal matters. Unfortunately, her friend did not know the auxiliary's name; but even so, the Trust's two-sentence reply to that part of her complaint suggested that very little had been done to investigate the matter. (Note: In his letter of 19 May 1995 on behalf of the chief executive the deputy chief executive wrote `I am very concerned to learn that a member of the nursing staff gossiped about [the patient] to another patient. All of the staff have been reminded about the importance of confidentiality and that breaches of this kind are unacceptable .... If I can be of any further help, or if you would like to meet [the first consultant] .... please do not hesitate to contact me ....'.) The complainant said that she had not taken up the offer of a meeting because the family was so disgusted and angry with the superficial reply that they wished to take their concerns elsewhere.

The Patient's Charter and the Trust's complaints procedure

35. The Patient's Charter (1992) established the right `To have any complaint about NHS services .... investigated and to receive a full and prompt written reply from the chief executive ....'. The Charter also gives the right `to have access to .... health records and to know that those working for the NHS are under a legal duty to keep their contents confidential ....'. The Trust's complaints policy in force at the time included the aim `To ensure that all complainants are given a full, accurate and speedy response to their concerns'.

Evidence of the Trust's staff

36. The speciality manager said that she was responsible for investigating complaints about the surgical department and for drafting replies. She asked the CNM to investigate the allegation. The CNM reported to her orally and said that all the nursing auxiliaries had denied talking about the patient. She did not make a written record of the conversation. The complainant had not named the nursing auxiliary concerned which hampered the investigation. She now accepted that the complainant could have been asked for more information about the nursing auxiliary, and that she could have been given more details about the Trust's investigation.

37. The CNM said that she interviewed all of the nursing auxiliaries in the ward about the complaint. They categorically denied talking to another patient about the patient and were fully aware of the Trust's policy on confidentiality. She also spoke to the senior nursing staff; but none of them had heard a nursing auxiliary discussing the patient. She did not keep a record of the interviews or take any written statements. She discussed with the speciality manager the results of her enquiries but was not asked to seek further information. She had taken the complaint very seriously and, had any proof of a breach of confidence emerged, disciplinary action would have been taken. She had reminded ward staff and senior sisters about the importance of adhering to the Trust's policy on confidentiality. All new nursing staff were issued with handbooks which included information about confidentiality; and new nursing auxiliaries were reminded about the need for confidentiality by means of check-lists (as

I have seen).

38. The staff nurse and the enrolled nurse both said that they had not heard a nursing auxiliary gossiping about the patient and could not recall being consulted about the complaint. The ward manager said that the CNM had discussed the matter with him.

39. The management co-ordinator said that she acted as a facilitator for complaints handling and monitored the progress of investigations. She was in the process of running a series of courses for all staff on the provisions of the new NHS complaints procedure (which came into force on 1 April 1996), and the courses included the issue of confidentiality. The Trust issued its own new complaints procedure in April 1996.

40. The deputy chief executive (who was acting as chief executive at the time of this complaint) said that when he signed the reply to the complainant he thought that all of her concerns had been addressed. In retrospect, however, he thought that she should have been given a fuller explanation of the steps which the Trust had taken to investigate her complaint about a breach of confidentiality. He also accepted that the complainant could have been asked whether she could provide more information to help identify the nursing auxiliary concerned.

41. In her formal reply the chief executive wrote: `.... Each of the auxiliaries were counselled regarding the importance of maintaining confidentiality and the unacceptabilty of breaches of this kind .... This matter was taken very seriously by the Trust although the investigations were hampered by a lack of an individual's name. I acknowledge that further details of the action taken by the Trust regarding this matter could have been included in the response to [the complainant] ....'

42. The chief executive said that the Trust took confidentiality very seriously and a new draft policy was currently being considered by the Trust's management executive (as I have seen). The revised complaints policy was operating well; and she made a point of checking through all the relevant papers before signing replies to complainants.

Findings *(c)*

43. The deputy chief executive has accepted that the Trust could have asked the complainant whether she could provide more information to identify the nursing auxiliary concerned. Although, in his letter of 19 May, the deputy chief executive offered a meeting, his reply lacked detail. I am also critical of the lack of records relating to the interviews with the nursing auxiliaries and the discussions between the speciality manager and the CNM. **I recommend** that the Trust should now reinvestigate this complaint with more thoroughness and remind staff dealing with complaints of the importance of recording all significant discussions and of providing full replies to complainants. I uphold this complaint.

Conclusion

44. I have set out my findings in paragraphs 16, 22, 33 and 43. The Trust have agreed to act on my recommendations in paragraphs 16, 33 and 43 and have asked me to convey to the complainant and her family-as I do-their apologies for the shortcomings which I have identified.

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comments

Staff evidence

24. The consultant pathologist said that the report on the specimen was issued on 17 February. It would then have been available on the computer system and would have been sent to the relevant consultant.

25. The consultant surgeon said that when results arrived from the laboratory they should be seen by a consultant or registrar and initialled. He said that the word `file' on the test report found in the other patient's file was in his handwriting. However, he thought that he had written that in September 1995, not February, and had then intended the report to go in the complaint's file. The complainant's father's histology test was routine and that was probably why it was not checked. It would have been unusual to get a test result back before the patient left hospital, though urgent tests would be checked immediately. The complainant's father was given a routine appointment for six weeks after the operation and the test result should have been reviewed then.

26. The senior surgical registrar said that test reports were usually sent to the surgical office. The report was reviewed by one of the surgical team and if the patient was still in hospital action was taken as necessary. If the patient had left the hospital the discharge letter to the GP should include an acknowledgment that the test result had been checked. If the report was not available when that letter was written the test result should be sought. (Note: the Commissioner's investigator was unable to interview the registrar who wrote to the GP in March as he has left the country.) A doctor reviewing the report in the other patient's name would have had no reason to suspect that it referred to anyone else. The other patient had had a double valve replacement and to find a thrombus in such a case was not unusual (and would require no action as such patients were routinely given anti-coagulants) whereas it was unusual in a myxoma case.

27. The surgical registrar who saw the complainant's father on 18 April said he was recovering well. The discharge letter to the GP had given a diagnosis of myxoma. It was the responsibility of the person who wrote that to check that the result had been received. If it had not been, and the surgical registrar had written that letter, he would have said so. The other registrar who had written the letter had been very new and might not have known all the normal procedures. The surgical registrar was not suspicious when he found no trace of the result because the complainant's father had a `classic case' of myxoma. At first he thought it was possible that the surgeons had been so sure of the diagnosis that no specimen had been sent but he checked the operation note and saw that one had been sent. He telephoned the laboratory and was told there was no result for the complainant's father. He did not investigate further as he was not worried about the complainant's father's condition. However, in the absence of a test result he decided to send him for another scan then, rather than wait the usual six months. (Note: his note of the consultation made no reference to the missing test result.)

28. The consultant cardiologist said that if the surgeons sent a specimen to the laboratory it was their responsibility to follow up the results. He said that he would expect to receive a discharge letter from the surgeons saying what the tests showed and what their conclusions were. If the test results were not mentioned he would assume that they had confirmed the original diagnosis. He would have expected to see the test result only if he had requested it himself.

Findings *(b)*

29. After the initial mislabelling of the specimen, the Trust's arrangements for reviewing test results proved inadequate to remedy the situation. I criticise the Trust for that. Several opportunities to identify the problem were missed. The report (in the other patient's name) was produced before the complainant's father left hospital and should have been reviewed by a doctor. It has not been possible to identify who, if anyone, did that review in February: the consultant surgeon said that he saw the report and wrote `file' on it only in September. While simply finding a thrombus might not have merited particular action in the case of the other patient (since he would already have been receiving anti-coagulants) the fact, apparent from the report, that the result changed the diagnosis should have prompted the need for more detailed consideration. That would have then shown that some error had been made. Checks for test results could usefully have been made while the complainant's father's care was being reviewed during his hospital stay and then when the discharge summary was written. A further opportunity to check was not adequately pursued when he attended outpatients on 18 April. The surgical registrar noticed the absence of a result, found that the laboratory had no record of receiving a specimen but did not pursue matters further. In the absence of the test result he sent the complainant's father for an echocardiogram rather earlier than usual: but that was still not until late June by which time a thrombus had recurred and further surgery was needed. Only in July was the missing test result traced. Even apparently routine tests can produce surprises, as here, and it is essential that there are adequate systems to make sure that test

results are obtained expeditiously, reviewed appropriately and acted upon. Those systems failed-with serious consequences for the complainant's father. I cannot say for certain whether the second operation would have been necessary if the test result had been checked earlier, but his treatment certainly would have been different in that he would have received anti-coagulants. **I recommend** that the Trust review arrangements for reviewing test results and audit compliance with them. I uphold the complaint.

Complaint *(c) Failure to inform the clinicians of the error*

30. The complainant said that, at a meeting on 12 December 1995 about his complaint, he was told that the error had been discovered in the laboratory. He understood that staff there had re-labelled and re-filed the result but did not tell the clinicians. The clinicians only found out when they checked because of unexpected results in a routine test. He was concerned that the failure to inform the clinicians might have affected his father's treatment.

31. In comments at the beginning of this investigation the Trust said:

> `The problem of the missing histology report was identified in July and a new report issued. The various medical staff involved in [the complainant's father's] care knew of the new report but were not necessarily aware of the reasons why it had been missing. The Trust accepts that the fragmentation of [his] care was a contributory factor.'

32. A note of the meeting held on 12 December to discuss the complaint says:

> `[The consultant surgeon] explained that the histology had been discovered in July and been re-issued under the correct name. [He] said that he had no idea of the mix-up until the complaint had come in and he had begun to investigate and he believed that fragmentation of care had led to the mix-up not coming to light sooner. He believed that the cardiologists had probably picked up on the error and asked that the histology be re-checked.'

33. In an internal memo to the service manager the consultant said:

> `I do not know exactly who first discovered that there had been a mislabelling of the histology specimen. I suspect when the echocardiogram showed a new mass, several people found out at relatively the same time particularly the cardiologists, myself and perhaps my junior staff as well as the pathology department. I cannot remember the exact sequence of events last summer though I have a recollection that when I mentioned it to my junior staff, other doctors, particularly the cardiologists and the pathologists had independently at approximately the same time become aware of it.'

34. A note made on a copy of the test result held in the laboratory said `Specimen wrongly labelled-number deleted from [the other patient's] file. 12/7/95.'

Staff evidence

35. The consultant cardiologist said that when the complainant's father was re-admitted on 7 July under his care he asked the cardiology registrar to review the histology test result from the operation in February.

36. The cardiology registrar said that he and the consultant were concerned because the mass showing on the echocardiogram in July looked like a thrombus not a myxoma-it would also have been unusual for a myxoma to grow so quickly. They decided to look at the test result from the previous operation. When he could not find one in the complainant's father's records he telephoned the laboratory. They had no record of a test result for him but traced one for a possible myxoma in February-the report in the other patient's name. The cardiology registrar discovered that the other patient had had his operation on the same day as the complainant's father. It was unlikely that two myxomas, which are rare, would have been treated on the same day. He looked at the test result in the other patient's name and saw that it was not relevant to him as he had had a valve replacement. He therefore put the complainant's father's name on a copy of the report and put it in his medical records. He did not look at the other patient's medical records and he did not know who should have removed the report from his file. (Several staff told the Commissioner's investigator that they were not sure who should have removed the original test result from the other patient's medical records.)

37. The pathology business manager said that when the problem was discovered in July one of her staff amended all the laboratory records.

38. The consultant pathologist said that after she wrote the test report in February she heard nothing more until the business manager asked her to review the slides. She did so and made the same diagnosis.

39. The consultant surgeon said that in July the cardiology registrar telephoned to tell him that an echocardiogram had shown that the complainant's father had a thrombus not a myxoma. The consultant surgeon suggested that he checked the previous histology report.

Findings *(c)*

40. The complainant left the meeting on 12 December with the impression that the mistake had first been discovered in the laboratory and that his father's doctors had not been informed immediately. I can understand why he might have gained that impression from the consultant surgeon's comments: though in fact it is clear that the mistake was discovered after enquiries by the cardiologists in July. Both teams of doctors treating his father were quickly made aware of the change in diagnosis, though some clinicians may not have become aware of all the reasons for that until his complaint. While the information given to the complainant initially may have been confusing I am satisfied that, once the mistake was discovered, there was no delay in giving doctors treating his father essential information about the changed diagnosis. The cardiology registrar put the amended report into the complainant's father's medical notes and the laboratory corrected their own records. However, I am concerned that the report was found in the other patient's records by the Commissioner's staff in 1996. I cannot say whether that adversely affected that patient's treatment, but it is clearly unacceptable for that erroneous report to have been there until found by the Commissioner's staff-whether it had been there since February 1995 or only since September as the consultant surgeon's evidence (paragraph 25) would suggest. No one had taken responsibility for co-ordinating all the efforts to correct the mistake. I criticise the Trust for that. However, I do not uphold the complaint as put.

Complaint *(d) Failure to tell the complainant's father about the mistake*

41. The complainant said that neither his father nor his family were informed about the mis-labelling of the specimen until after he complained to the Trust in September. They were not told even when his father was referred for the second operation. By that time the clinicians knew about the mistake. No explanation was given as to why they were not informed and no investigation was conducted until after he complained.

42. In comments to the Commissioner at the beginning of the investigation the Trust said:

> was not until [the complainant] made a complaint in September that the full story of the missing histology report was revealed. The Trust regrets that the patient was not formally advised of the missing pathology report and the impact that had on his care.'

Staff evidence

43. The cardiology registrar said that he told the consultant cardiologist about the mistake in the labelling of the complainant's father's histology specimen in July. He did not think that it was his responsibility to tell him about it. That decision ought to have been made at a higher level-by the consultant cardiologist and the consultant surgeon.

44. The consultant cardiologist said that he did not discuss the mis-labelling of the histology specimen with the complainant's father because he was not aware of all the circumstances. The cardiology registrar was the main channel of communication with the complainant's father and his family and he assumed that the cardiology registrar would have discussed the problem with them. Alternatively he would have thought the surgeons would have spoken to the family.

45. The consultant surgeon said that he found out in July that there had been a mistake with the labelling of the histology specimen. The complainant's father was not under his care then and he would not therefore have considered it his responsibility to tell him or his family.

Findings *(d)*

46. The complainant's father's family clearly had been made aware of the test result before the complainant complained in September (paragraph 5), but for different reasons none of the doctors involved had taken responsibility for telling the complainant's father or his family why that result was so delayed-ie about the labelling error. Clearly the clinicians' priority had to be to treat him, but when the mistake had had such a potentially serious effect on his treatment he was entitled to a full explanation of what had happened. That explanation should have been offered, even before any complaint was made. Providing it was the responsibility of the consultant surgeon-under whose care he was at the time of the error. Although not the subject of this complaint I am also concerned that action to try to reduce the risk of recurrence (ie the revision of the policy) was not taken until prompted by the complaint. An investigation into the mistake and any necessary review of procedures should have been initiated by the clinical staff in July when the error was discovered and a member of staff (clinical or managerial) should have been nominated to co-ordinate action. I recommend that the Trust remind staff of their

responsibilities when such incidents occur. I uphold the complaint.

Conclusion

47. I have set out my findings in paragraphs 19, 29, 40 and 46. The Trust have agreed to implement my recommendations in paragraphs 19, 29 and 46 and have asked me to convey to the complainant through this report-as I do-their apologies for the shortcomings I have identified.

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comments

Staff evidence

18. The consultant said that doctors were aware of the Trust's protocol on patient observations; and all observations were done on admission. Their frequency would be specified if relevant to the illness, otherwise nursing staff did them once or twice daily. Apart from the time of her admission and after her fall on 11 January the patient had no medical condition warranting daily observations.

19. A senior house officer who examined the patient after she fell on 11 January (the second SHO) said that he asked a nurse to carry out two-hourly observations and report any change to him. Although not written in the notes it was implied that the two-hourly observations would be carried out until the patient was reviewed by her regular team the next morning. It was the nursing staff's responsibility to make sure the observations were done.

20. The first SHO said that he did not know if two-hourly observations had been done. Such observations had not been necessary. If they had been he would have made a note of that. The patient would have had to be seriously ill to need two-hourly observations. He was not aware of the hospital's protocol on patient observations. A house officer (the house officer) was also not aware whether the hospital had a policy on the observation of patients.

21. The senior charge nurse said that he would have expected staff both to record occasions when they were unable to do the observations and to tell the doctors on the ward rounds. The second SHO had asked the night staff to do the two-hourly observations on 11 January and it was for those nurses to decide whether or not to continue with the observations and also to decide whether to complete a head injuries observation chart. The morning staff would not have asked to see the chart if the night staff had said there was no change in the patient's condition after her fall. Entries should be made on the evaluation sheets every day and he could not explain why entries had not been made on some days. The documentation did not show that the patient received all the care she needed. The Trust were striving to improve the documentation of observations to make staff more aware of the need to record any problems.

22. All of the nursing staff interviewed by the investigator, apart from the student nurse, were aware of the Trust's protocol on patient observations. An enrolled nurse on night duty (the second enrolled nurse) said that she relied on the handover from previous staff as well as the care plan: a lot of information about patients was passed on orally, although it should also have been recorded in the notes. She said that she could not remember the night of 11 January. She had completed an accident report form after the patient's fall and would have started a head injuries observation chart. She did not know what had happened to the chart. If the second SHO had requested two-hourly observations she would have recorded them on the head injuries observation chart.

23. The clinical nurse manager said that the Trust did not have a written policy on documentation but relied on that issued by the UKCC. The senior charge nurse was responsible for checking that there was adequate documentation in the ward and, as the patient's named nurse, he should have checked for problems and planned her care. Care plans were to be prepared once a problem had been identified and updated as the patient's condition changed. An entry should be made on the evaluation sheet every day. She would have expected to see more entries documenting the patient's problems and the care given. The Trust's protocol on patient observations was not complied with during the first 48 hours of the patient's time in the ward. Any decision not to follow the policy should have been documented. After the patient's fall nurses should have completed a head injuries observation chart. The two-hourly observations should have been done until the nurses were satisfied that the patient was stable; and the decision to stop should have been documented. The Trust were halfway through an audit of patient records, which was started partly in response to this complaint. At the end of it they hoped to set standards for record keeping.

Findings *(b)*

24. The senior charge nurse was responsible for the standard of documentation in the ward and, as the patient's named nurse, for planning her care. There were many shortfalls in the patient's documentation: for example, the care plan was not updated; there were no entries on the evaluation sheet for some of the days she was in hospital; and the head injuries observation chart was missing. Although it is clear from the records that care was given to the patient, the Trust have accepted that the quality of the documentation was poor. I have noted the action being taken by the Trust to improve documentation. **I recommend** that they issue clear written instructions to nurses about their responsibilities for the recording of care given to patients and that the position is closely monitored. I also **recommend** that the Trust remind ward managers and consultants to make sure their staff

are aware of and implement the protocol on patient observations. I uphold the complaint to the extent that the care which the patient received including her observations was not fully and properly recorded. Because of the inadequate documentation I am unable to make a finding on the frequency of the nursing observations and the type of care which the patient received.

25. I turn now to the complaint that the second SHO's instruction on 11 January was not carried out. I am left in doubt about precisely what happened after the second SHO saw the patient. In the absence of a specific instruction from the second SHO about the duration of the two hourly observations, any decision by nursing staff to discontinue them would reasonably be a matter of clinical judgment. At the time of this incident such a decision was outside the Commissioner's statutory jurisdiction. However, the nurses' decision should have been documented. On the evidence available I am unable to make a finding on this aspect of the complaint.

Complaint *(c) No consultation with the family before instructions that the patient should not be resuscitated*

Evidence of the complainant

26. The complainant said that he found out about the decision not to resuscitate his mother when he received copies of her medical records in November 1995. (Note: an entry dated 16 January 1995 in the patient's clinical records made by the house officer stated `In view of rapid deterioration and general condition, in event of cardiac arrest [not for resuscitation]'. A further entry made on 25 January by the house officer when she spoke to the complainant included `.... I explained that it was very unlikely for her to improve and the prognosis was extremely bad .... I told him that we would keep her comfortable and pain free'.) The complainant said that he and his brother met the consultant on 18 January but the consultant did not discuss the decision with them. The house officer also did not tell him about the decision. The complainant added that the decision not to resuscitate had been noted in the nursing records (Note: there is such an entry dated 16 January 1995 on the nursing assessment sheet).

Guidance

27. The Trust's `not for resuscitation' policy, which was given to SHOs and house officers when they attended their induction courses, stated:

a. All patients are for resuscitation unless a clear decision has been made to the contrary.

b. A decision not to resuscitate should involve the consultant, junior medical staff, and ward nursing staff. Responsibility lies with the consultant to ensure a common policy is followed.

c. Relatives are not normally involved in the decision making but should, where possible and appropriate, be informed of the decision, why it has been made, and their comments noted.

d. .... Those involved in the decision making and the views of any relatives informed should be noted.

e. The nursing staff must be informed of the decision and ``not for [resuscitation]'' must be clearly written in the nursing process.

f. Any ``not for resuscitation'' decision should be reviewed on each consultant ward round .... Any policy change should be clearly written in the patient's notes and nursing process.

g. In general, any decision not to resuscitate will involve the consultant caring for the patient. However, there will be occasions when the most senior of the on-call junior staff can make the decision .... Housemen should not make ``do not resuscitate'' decisions ....'.

28. In the Commissioner's Annual Report for the year 1990-1991 the then Commissioner reported on a case in which there was confusion among staff about whether a decision not to resuscitate a patient should be discussed with relatives. He found that it was the responsibility of the consultant to make sure that a common policy, whether written or otherwise, was followed by his staff. In December 1991 the chief medical officer of the Department of Health wrote to all consultants in England drawing attention to the Commissioner's findings.

Evidence of the staff

29. The house officer said that she knew she had to consult the first SHO and, if available, the consultant before making a decision not to resuscitate but was not aware that the hospital had a policy on `not for resuscitation' decisions. She could not remember whether the first SHO had been present when she examined the patient on 16 January; but, if he was not, she would

have discussed the decision with him. It was not normal practice for a house officer to record that she had discussed the decision with senior doctors. She could not recall whether she had mentioned the matter to the complainant on 25 January as that was not specifically recorded but she would normally explain to relatives why the decision had been made.

30. The first SHO said that he was aware of the Trust's `not for resuscitation' policy. The decision not to resuscitate the patient would have been taken either by him or the consultant. It would have been reviewed daily. As there was nothing in the patient's notes to rescind the decision, she was presumably not for resuscitation, although he could not be certain about that. The staff would always continue to treat patients who were not for resuscitation. After the decision was made, he had made a note in the records (as I have seen) of the need to speak to the family. However, such a discussion did not happen - if it had he would have recorded it.

31. The consultant said that the house officer had not consulted him before she made the decision not to resuscitate on 16 January. She should have recorded whether she had discussed it with the first SHO and the relatives. When he saw the patient on 18 January he prescribed treatment for her and his entry to that effect in the clinical records reversed the decision not to resuscitate made on 16 January. (Note: the consultant's note of 18 January described the patient's condition and treatment. There was no reference to cancelling the `not for resuscitation' decision taken on 16 January.) He could not say why the decision not to resuscitate had not been removed from the nursing records. Continuing to treat the patient showed that she was for resuscitation if she had a cardiac arrest. In the event, the patient died of bronchopneumonia so that there was no need to consider resuscitation.

Findings *(c)*

32. The Trust's `not for resuscitation' policy stated that relatives were not normally involved in the decision making but should, where possible and appropriate, be informed of the decision, why it had been made and have their

comments noted. The decision not to resuscitate the patient was taken in the exercise of clinical judgment, which at the time of the events complained of was outside the Commissioner's jurisdiction. I am not persuaded that the medical staff told the family of that decision. In other cases the then Commissioner criticised failures to communicate such a sensitive decision to relatives, and this case merits similar criticism. I am also concerned that other aspects of the Trust's policy were not followed. On balance I consider that the house officer did consult the first SHO and that the latter probably made the decision not to resuscitate the patient. That was not noted in the records. Also, although the consultant said that by prescribing active treatment for the patient on 18 January he had rescinded the decision not to resuscitate, that `policy change' (paragraph 28 item d) of this report) was not clearly written in the clinical and nursing records. I have noted the consultant's evidence that in the event there was no need to consider resuscitation in this case. However, he was responsible for making sure that a clear decision about resuscitation was both made and fully recorded and that all medical and nursing staff had a proper understanding of the position. **I recommend** that the Trust remind all medical staff of the requirements of their `not for resuscitation' policy; and in particular that they remind consultants that it is their responsibility to make sure that all junior staff are aware of that policy and follow it. I uphold this complaint in that the patient's relatives appear not to have been informed of the decision.

Conclusion

33. I have set out my findings in paragraphs 12, 24, 25 and 32. The Trust have agreed to implement my recommendations in paragraphs 12, 24 and 33 and have asked me to convey to the complainant through this report-as I do-their apologies for the shortcomings I have identified.

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comments

Evidence of the consultant

16. The consultant told my investigator that he, like many other doctors from within the hospital and elsewhere, had referred samples from patients to the doctor at the B12 unit when he suspected that the patients' neurological problems indicated a B12 deficiency. The doctor was a world authority on vitamin B12 and had been testing samples for many years. The doctor tested patients' samples, carried out further investigations where necessary and recommended treatment to manage the patients' conditions.

17. The consultant said that on 19 December 1995 (the day of the complainant's son's planned test) the doctor told him that he had asked the chief executive to confirm that the costs to the B12 unit of carrying out that test would be paid by the Trust. The consultant did not know why that had been necessary: had funding not already been agreed by the Health Authority the Trust would not have given the complainant's son an admission date. During the afternoon, while the complainant's son was waiting for the test, the doctor had shown the consultant a letter from the chief executive (to the doctor) dated 19 December 1995, which said that the doctor would not be reimbursed for his costs in carrying out the test. The consultant decided to cancel the test, since the doctor would have had to meet the cost himself. The consultant said that he had been told by the doctor that the chief executive had refused to meet the cost, even though the chief executive had been told by the doctor that the Health Authority were prepared to pay for the complainant's son's test. He was later told by the chief executive that the chief executive's secretary had tried to contact the consultant to obtain the consultant's approval for the test. Although he had been available he had received no message. He failed to understand why the chief executive needed his approval since he had arranged the test and the admission.

18. The consultant knew of no other case where a procedure had been cancelled at such short notice. Until then referrals to the B12 unit had been a routine matter. He considered that the complainant's son's treatment had been stopped arbitrarily, and that it had been indefensible to make funding an issue just before the test. He had told the chief executive of his concern that the complainant's son's clinical care had been so ill managed. On 21 December 1995 the chief executive and the medical director had written to colleagues within the Trust. The letter said that the doctor had asked that the services of the B12 unit should become part of the Trust. The Trust had set certain conditions which had not been met and accordingly asked colleagues not to refer patients to the B12 unit. The conditions were: first, that all patients admitted for B12 diagnosis testing or treatment must be admitted under the care of a consultant; second, all treatment must be based on written treatment protocols which are made widely available to all relevant staff; and third, that the research on which such treatment protocols are based must be subject to independent peer review and have ethical committee approval. The consultant said that the first two conditions were already happening. On the third, he said that there had already been a peer review of the doctor and the unit, and that in his view B12 testing and treatment was not research so did not require ethical approval.

Evidence of the doctor, the directorate manager and the director of operations

19. The doctor told my investigator that the Charity, which had financed the work of the B12 unit, stopped doing so in June 1995. He had then tried to organise other forms of funding. The Trust had continued to refer work to him but made no arrangements about payment. At a meeting which he thought had taken place in August 1995 attended by the directorate manager, women's and children's services (the directorate manager) and the clinical director of women's and children's services (the clinical director), financial arrangements had been discussed. The doctor said that his understanding from that meeting was that it had been agreed that he (the doctor) had to submit invoices for the B12 unit's service to the Trust via the directorate manager, rather than direct to the health authorities. The Trust would then invoice the health authorities and reimburse the B12 unit.

20. My investigator interviewed the directorate manager, who recalled attending one meeting with the doctor to discuss administrative issues such as the processing of ECRs and the pricing of B12 services. The clinical director was also present but to discuss the separate issue of consultant cover. The directorate manager was certain that the meeting did not take place in August 1995. It was held on 12 October 1995. She had made contemporaneous notes (which I have seen) of the meeting. During the meeting she sought to reassure the doctor that the Trust did not intend to stop patient admissions involving services from the B12 unit. She recalled that she had not said that the Trust would collect payment from health authorities on behalf of the B12 unit. The clinical director had also told her recently that he did not recall her making such an offer. My investigator also interviewed the director of operations, who has responsibility for the day-to-day management of hospital services, and asked her whether she recalled attending a meeting in August 1995 which fitted the description given by the doctor. The

director of operations said that she became involved with the Medical School's B12 unit in July 1995 in an attempt to resolve problems with ECR arrangements and bed allocations for patients who were to see the doctor. The Trust Executive had decided that she should meet the doctor to discuss the nature of the B12 unit and ECR arrangements since the Charity had ceased to provide funds for the B12 unit. (Note: The Trust's papers show that the meeting took place on 21 August 1995). The director of operations was adamant that she did not say at the meeting that the Trust would collect money on behalf of the B12 unit from purchasers, or that there had been an agreement that the Medical School's B12 unit could bill the Trust for its service.

21. The doctor also told my investigator that his understanding, gained from the meeting in August 1995, of the financial arrangements had been confirmed by a letter also written in August 1995, although he no longer had a copy of that letter. (Note: My investigator carefully examined the Trust's papers. She identified two letters about the B12 unit written in August 1995, although only one mentions invoicing and payment arrangements: a letter dated 14 August from the doctor to the director of operations, which said that the Medical School's B12 unit would commence issuing invoices direct to health authorities for the B12 unit's element of the service to patients. The director of operations told my investigator that she did not think that she had replied to the doctor's letter. Her papers showed that in early September 1995 she was still researching to establish what the correct invoicing arrangement should have been.) The doctor said that he considered that his understanding of the invoicing arrangement was confirmed by the chief executive's letters dated 8 and 24 November 1995 (see paragraph 11 and the Appendix). He therefore began sending invoices to the Trust.

22. The doctor said that the Trust's admissions office would always check that an ECR had been approved before an admission date was given to the patient. On the day of the complainant's son's test everything was ready for the test to go ahead, and at the last minute the doctor went to see the chief executive to check that his costs would be met because he had not received payment of the previous invoices that he had sent to the Trust. The costs of the materials meant that unless he had an agreement to reimburse him, the test could not go ahead. He could not understand why the Trust refused to collect payments on his behalf when health authorities were prepared to pay the invoices and there was no cost to the Trust.

23. The doctor said that it should have been possible to offer the complainant's son an alternative appointment because the Health Authority had approved the ECR. He believed that Trust managers had not wanted the test to go ahead before his contract ran out on 31 January 1996. Since then the doctor had been offered a limited contract which would have enabled the test to take place. The terms of the contract were unacceptable to the doctor because he was expected to carry out the test without assistance and without remuneration. He concluded that the fact the test had not been re-scheduled showed that Trust managers did not want it to go ahead. He thought that the aim of Trust managers was to dismantle the B12 unit: the conditions they had set were a smoke-screen and they had lied about the funding being an issue.

Findings *(a)*

24. The chief executive has said that he became aware of the problems surrounding the B12 unit's services to patients during the summer of 1995. After looking into the matter, he laid down some conditions that he required the doctor to meet. I accept that he made it clear that all those conditions needed to be met. The conditions behind an offer of an appointment to the doctor are personnel matters, which are outside my jurisdiction.

25. Why was the doctor seeking to invoice the Trust for the B12 unit's services? There are conflicts in the evidence on this point. The doctor says that he was told to do so during a meeting with the directorate manager in August 1995. The directorate manager has given evidence that she did not meet the doctor until 12 October, and then did not say that the Trust should be invoiced for B12 unit services. The director of operations says that she did have a meeting with the doctor in August 1995, but did not say that the Trust would pay B12 unit invoices. The doctor says that his understanding was confirmed in a letter in August 1995, but the only letter found by my investigator which was written in August and related to invoicing arrangements, was from the doctor to the director of operations and said that invoices for the costs of the B12 unit's services would be sent by the Medical School direct to health authorities. The doctor said that the letters in November 1995 (paragraph 11 and the Appendix) supported his view of the agreement-that the Trust would pay for the B12 unit's services and charge the health authorities. I do not agree-those letters set out conditions to be agreed, and they were not agreed. I have found no evidence to support the doctor's claim that the Trust agreed to pay the B12 unit invoices from August 1995.

26. Turning to the financial arrangements, I am concerned that the doctor knew that there were problems with the financial arrangements for the B12 unit well before 19 December. He says that previous invoices issued to the Trust for B12 unit services had not been paid (paragraph 22). He must also have been aware that the problem might affect the complainant's son's test, because he told the chief executive that he had checked with the Health Authority that they were prepared to pay. He then waited until the complainant's son had been starved for 17 hours and was in hospital ready for the test to start before approaching the chief executive to discuss the financial arrangements. The result was that the complainant's son's test did not

go ahead because of wrangles over financial arrangements. I agree with the chief executive and the consultant that that was wholly unacceptable. The Trust operate the sensible practice of checking that funding arrangements are in place before a patient is offered an admission date, and the chief executive has acknowledged that. If there was any uncertainty, such as that expressed by the chief executive, whether the Health Authority's funding of the complainant's son's care included B12 services (as well as the hospital admission), that needed to be resolved before an appointment was offered. The consultant says that he arranged the test. It is for the Trust to set up procedures to make sure that appropriate staff are aware of the relevant facts of an admission. If all the issues that needed to be resolved were not resolved before an appointment was offered to the complainant's son, that suggests a failure in the Trust's procedure. Once the appointment was offered, there were no financial or clinical reasons to stop it from going ahead and therefore it should not have been stopped. Doing so was in direct conflict with national guidance (paragraph 5) that administrative arrangements should be sensitive to the needs of delivering good quality health care. It is disgraceful that the differences between the principal players caused the complainant's son's test to be cancelled at such a late stage. Since there was a failure in service because the test was cancelled without warning, I uphold this aspect of the complaint.

Findings *(b)*

27. Turning to the explanations given, the complainant has said that she was not given a clear explanation of why the test was stopped. The chief executive has said that the answers he provided were all correct. I accept his explanation. There had been a funding issue about the complainant's test on the day. Wider ethical questions about the B12 unit's work had been under discussion since August 1995. They underpinned the chief executive's reluctance to be seen collecting money on the B12 unit's behalf before the appointment conditions laid down in November 1995 had been fully met. The contractual issue became relevant after 31 January 1996, when the doctor's previous honorary contract expired. After 31 January the Trust offered the doctor a contract of a different nature which would allow patients already receiving B12 care to continue with it, while still expecting the conditions to be met for future patients. I consider that in an effort to keep the complainant informed of developments after the restriction on referrals was imposed by the Trust, the answers she has been given have appeared contradictory. The reality is that the issues which underlie the situation are complicated: I do not believe that the chief executive intended to give the complainant contradictory answers. The information provided was accurate at the time it was given. I do not uphold this aspect of the complaint.

Findings *(c)*

28. The chief executive, not realising that the complainant's son had left the hospital, tried to arrange for the test to take place on 20 December 1995 by making a temporary arrangement for the Medical School to invoice the Health Authority. The Medical School was not prepared to participate in the arrangement once the immediacy of the complainant's son's December admission had passed. (As I have already said, the actions of the Medical School are outside my jurisdiction.) It is clear to me that it was administratively possible for the Trust to offer the complainant's son another appointment between the cancelled test on 19 December 1995 and what proved to be the end of the doctor's appointment on 31 January 1996. The failure to do so put internal disagreements before the care of a child.

29. I note (paragraphs 10 and 13) that since 31 January the Trust have made efforts to allow the complainant's son to undergo the test. However, no appointment for the test has been arranged. The complainant says (paragraph 7) that she is not prepared to let her son be treated elsewhere. The Trust no longer offer the services of the B12 unit as part of their services to patients: their decision not to renew the doctor's honorary appointment was within their discretion and outside my jurisdiction as it was a personnel matter. It is not appropriate for me to make a recommendation about the future clinical care of the complainant's son, whether at the hospital or elsewhere. I recommend, however, that the Trust, with the complainant, should make every effort to resolve the impasse about the complainant's son's tests, including considering alternative provision. To the extent that until 31 January 1996 the Trust allowed internal disagreements to come in the way of a test which had been arranged by a member of the Trust staff for one of the Trust's patients, I uphold this aspect of the complaint.

Conclusion

30. I have set out my findings in paragraphs 24 to 29. The Trust have asked me to convey to the complainant-as I do-their apologies for the shortcomings which I have identified and to implement my recommendation at paragraph 29.

APPENDIX TO E.1344/95-96

Extract from a letter dated 24 November 1995

I set out here the key information in a letter dated 24 November 1995 from the chief executive to the doctor. The letter

renewed the doctor's existing appointment to carry out research (excluding clinical duties) until 31 January 1996 and went on to say:

> `.... I am aware that you wish to enhance the service of the B12 unit and formalise a relationship with the Trust.
>
> `I am pleased to investigate the possibility of this but as you are aware from my various letters of 8 November 1995 [sic] there are outstanding issues that must be resolved to our satisfaction before there can be any progress with this. In raising these I am seeking to clarify matters of importance for both the Trust and patients. It is essential that these are dealt with fully before matters progress further.
>
> `It may be helpful if I recap the issues previously raised:
>
> 1. Your Honorary Appointment is for research only and does not include clinical functions. It therefore does not include any admitting rights to [the hospital] and accordingly any patients referred to the B12 unit must be referred by a named consultant from our hospital ....
>
> 2. Treatment must be in accordance with written treatment protocols which have the prior approval of the Trust's Ethics Committee and are available to all relevant staff ....
>
> 3. The treatment protocols must be approved by peer review. I would also wish to have clarification of the status of the diagnostic and treatment procedures undertaken by your unit. [Depending on the answer Ethics Committee approval or a peer review would be required before the unit could be enhanced.]
>
> 4. All patients of the Trust must give fully informed consent in writing on the basis of a full explanation of any testing and treatment and the likely benefits/complications and consequences. Specific consent to testing, treatment and (if appropriate) use of unlicensed drugs must all be obtained ....
>
> 5. Financial arrangements will be based on the Trust raising ECRs for any testing, treatment and in-patient costs as an NHS service. Your unit's costs will be a disbursement of the Trust and paid as such but will not be the subject of a separate or direct ECR.
>
> `As I have said the Trust requires all these matters to III be resolved before proceeding. The Trust believes these are necessary safeguards ....
>
> `In the meantime I must make it clear that you do not currently have admitting rights or clinical functions at the Trust .... '

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comments

The complainant's evidence

23. In his letter to the Commissioner the complainant said `.... What I do not accept is the way the initial complaint was handled .... with no investigation involving all parties ....'. The complainant told the investigators that he was dissatisfied with the way his complaint was handled by the Trust. In particular, the Trust's letter of 10 October 1995 was very brief and did not deal with his concerns. He confirmed that he had decided not to pursue a civil action against the Trust.

Evidence of the GP

24. The GP said that if any meeting between Trust staff and the complainant had resulted in the Trust accepting that they had misjudged the position he might have reconsidered taking the complainant back on his list if the doctor/patient relationship had not been damaged.

Guidance

25. Department of Health and Social Security Circular HC(88)37, issued in June 1988, gave guidance on hospital complaints procedures. It stated that those responsible for investigating complaints `must ensure that [they have] a full picture .... of the events complained about'. The Patient's Charter (1995) stated that patients have the right to `have any complaint about NHS services .... investigated and to get a quick, full written reply from the relevant chief executive or general manager'.

26. The Trust's complaints policy at the time included `.... Where appropriate a meeting should be arranged between the complainant and the relevant members of staff to discuss the concerns on a more personal basis. This should be arranged as quickly as possible .... To comply with the Patient's Charter we aim to send a full written response to complaints within one month of receipt. This should be sent out in the name of the Unit Chief Executive ....'.

27. The Trust's new complaints procedure which has been in effect since April 1996, included `[Responses to complaints] will be made in writing by the Chief Executive who will have reviewed the response to the complaint ....'.

The Trust's formal reply

28. In the Trust's formal reply to the Commissioner's office the acting chief executive wrote: `.... The Trust investigated the complaint .... seeking accounts from the members of staff involved, and examining the recorded information following the incident .... As a result of the investigations, the Trust feels that it has provided [the complainant] with the necessary responses ....'.

Evidence of the staff

29. The receptionist told the investigators that she became aware of the complaint in February 1996 when the departmental manager asked her to write a statement. She was later asked by the clinical director, after the Commissioner had become involved, for her opinion on having a meeting with the complainant; she told the clinical director that, although she was reluctant to attend such a meeting, she would be prepared to do so if it would resolve the matter.

30. The departmental manager said that in October 1995 the clinical director contacted her and discussed the incident form, the letter to the GP and her telephone conversation with the GP. The departmental manager did not see the complainant's letter of complaint at the time. In February 1996 the assistant legal services manager asked her to obtain statements from staff. She was not contacted about the complaint again.

31. The clinical director said the assistant legal services manager sent her a copy of the complainant's first letter of complaint and statement and asked for her comments. The clinical director interviewed the receptionist and the departmental manager. (Note: In her reply of 3 October to the assistant legal services manager she stated that she discussed the matter with the departmental manager-see appendix.) The clinical director did not consider having a meeting with the complainant because a decision on that was not her responsibility. She was not contacted about the complaint again until the Commissioner became involved.

32. The assistant legal services manager said that she acknowledged the complainant's first and third letters to the Trust (see appendix) and signed them in the chief executive's name. No consideration was given to having a meeting with the

complainant. At that time meetings tended to be held about complex complaints after the final reply had been sent out. She confirmed that she later asked the departmental manager to obtain statements from staff. She wrote the reply dated 2 May to the complainant's solicitors from a draft prepared by the Trust's solicitors. On their advice, she made no mention of the letter to the GP or to arranging a meeting with the complainant. She again signed the letter in the chief executive's name.

33. The legal services manager, who at the time had general responsibility for complaints, said that she wrote the letter dated 10 October 1995 to the complainant. The reply was shorter than usual on the advice of her manager at that time. When the complainant wrote again she sought advice from a firm of solicitors and her reply dated 20 November was based on their advice. She was uncertain whether she had signed it in the chief executive's name or whether the chief executive had signed it herself. She said that at the time the chief executive did not normally sign letters to complainants. She was uncertain, but thought that she had believed that a meeting with the complainant would be inappropriate because a member of staff felt threatened.

34. The acting director of nursing said that he was now responsible for the complaints department. Under the Trust's new complaints procedure meetings were more regularly held with complainants before an investigation started. The purpose was to confirm the exact nature of the complaint. Such a meeting could often defuse the situation.

35. The chief executive said that she had ultimate responsibility for ensuring that complaints were dealt with appropriately. She expected the complaints department to have the necessary systems in place to handle complaints speedily and in depth. She said that she saw the complainant's original letter of complaint and signed the reply dated 10 October 1995. She was satisfied that the matter had been fully investigated. She also signed the final letter dated 20 November 1995. She thought nothing would have been achieved by having a meeting with the complainant.

36. In view of the discrepancies in evidence given by staff I subsequently wrote to the chief executive asking her to confirm which letters were signed by her and which were signed (in her name) by other members of staff; and what the Trust's policy was at the time-and now-in relation to the signing of letters to complainants bearing her name and signature. The chief executive replied as follows:

> `.... As you are aware there has been a major change in the handling of complaints in the last year and like many organisations we have had some problems with the administration of the complaints process. Add to this major changes in the Trust and it is not surprising that there has been some level of confusion between staff on this issue.
>
> `.... All of the letters .... relating to the complaint by [the complainant] were signed in my name by staff in the Quality and Communication Department which includes the Legal Services office.
>
> `At the time of this complaint it was standard practice for staff in the Quality and Communications Department to sign all complaints letters in my name and on my behalf. I have kept abreast of complaints generally and individual complaints specifically via the Director of Nursing who has operational responsibility for that department.
>
> `At the present time we are now happy with the new complaints policy introduced by the Trust and are in the process of devolving general complaints handling to the individual directorates within the Trust. This involves the directorate general manager investigating all complaints and producing a final response on my behalf which will go to the complainant with a covering letter in my name signed by me ....'.

Findings *(b)*

37. I do not consider that initially the Trust adequately investigated the complainant's complaint. The clinical director said that after receipt of the complainant's letter of 19 September 1995 she interviewed the departmental manager and the receptionist. However the receptionist, who was the crucial witness, said that she became aware of the complaint only in February 1996. It is unsatisfactory that statements were not obtained before then. The Trust's first reply of 10 October 1995 was brief and did not deal with all the complainant's points. The Trust's later replies were also in my opinion equally defensive and incomplete. I consider that the Trust should have explained why they were not prepared to provide the complainant with the information he had requested and why they were not prepared to agree to a meeting. It is possible that such a meeting might have helped in the resolution of this long standing complaint. I have seen no evidence that the chief executive was significantly involved in the handling of this complaint; and I am concerned that her oral evidence about the signing of letters in this case was not consistent with the written evidence which she later supplied on that point. It is unacceptable that letters purporting to come from the chief executive were in fact not signed by her. In reports of other investigations such a practice has been criticised by the previous Commissioner. I recommend that the Trust remind staff of the need to deal with all complaints thoroughly and that they comply fully with the terms of their new complaints procedure. I uphold this complaint.

Conclusion

38. I have set out my findings in paragraphs 18-21 and 37. The Trust have agreed to act on my recommendation in paragraph 37 and have asked me to convey through my report-as I do-their apologies to the complainant for the shortcomings which I have identified.

APPENDIX TO E.419/96-97

Chronology of the main events and correspondence

1 September 1995
The Health Authority wrote to the complainant telling him that he had been removed from the GP's list.

19 September
The complainant wrote to the Trust's chief executive stating that the GP had told him that he had asked for his removal from his list because he had received a letter of complaint from the Pathology Department about the complainant's threatening behaviour. He stated `.... I obviously deny any such conduct and want this matter investigated further as I consider the complaint as a slur on my character .... I would be grateful if you could obtain copies of the letter of complaint, statement of the complainant and statement of any witnesses .... If the [Trust's] complainant wishes to withdraw the complaint, I would be willing to accept a letter of apology to be sent to myself and my now ex-GP whom I would hope be willing to reinstate me as a NHS patient at the practice if I wished ....'.

21 September
An acknowledgement letter bearing the chief executive's name and signature was sent to the complainant.

On the same day the assistant legal services manager requested comments from the clinical director.

3 October
The clinical director replied stating that she had discussed `this matter with the person in charge for the Specimen Reception .... I believe [the receptionist] .... did feel rather threatened by the way this gentleman presented himself at the reception desk ....'.

10 October
A letter bearing the chief executive's name and signature was sent to the complainant. It stated `.... The receptionist .... did feel very threatened by your attitude .... So much so, that our Director of Pathology Services [sic] felt compelled to write to your General Practitioner about the situation. The action taken by your GP was a decision made by him and not by this Trust ....'.

1 November
The complainant wrote to the chief executive stating `.... This is certainly not what I asked for .... The total brevity and lack of information .... surely goes against your own complaints procedure ....'. (The complainant sent a copy of the letter to the Health Authority.)

13 November
An acknowledgement was sent to the complainant bearing the chief executive's name and signature.

On the same day the legal services manager wrote to the Trust's solicitors stating `.... I am most concerned about disclosing any further information about this matter to the complainant. Do you agree that we need to protect our member of staff who obviously did feel threatened by this man?'

16 November
The solicitor replied.

20 November
A letter was sent to the complainant bearing the chief executive's name and signature. It stated that the Trust's letter of 10 October had accurately reflected the results of their investigation; that the receptionist had felt threatened; that it was distressing when the efforts by staff `to explain why a particular result may take some time are met with an apparent lack of appreciation'; that the GP had been `asked to ensure that patients be asked to have a realistic understanding of the turnaround time'; and that there was no evidence to suggest that the receptionist had been untruthful.

1 February 1996

The complainant wrote to the chief executive stating that he would now seek legal advice.

8 February
An acknowledgement was sent bearing the chief executive's name and signature.

On the same day the assistant legal services manager wrote to the departmental manager stating `.... I think it would be wise at this stage if you could arrange to get statements from the appropriate people whilst the matter is still relatively fresh in their mind ....'.

15 March
The complainant's solicitors wrote to the Trust asking for a copy of the letter which the Trust sent to the GP and copies of statements. They added that the complainant would be willing to attend a meeting.

21 March
The assistant legal services manager sought advice from solicitors acting for the Trust.

26 March
An acknowledgement bearing the chief executive's name was sent to the solicitors.

1 May
The assistant legal services manager again asked for advice from the solicitors acting for the Trust (They responded on the same day).

2 May
A letter bearing the chief executive's name was sent to the complainant's solicitors. It stated in part that `There is a clear difference of recollection as to what happened .... I can only reiterate that we have no reason to suppose that the recollections of the hospital staff are at fault ....'. It did not provide the statements requested by the complainant's solicitors or offer a meeting.

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comments

Staff evidence

19. The midwife manager said when, at the meeting on 16 December 1994, the complainant asked for changes to be made to the records, she told her she would have to take advice on the procedure to be followed. The service manager for obstetrics and gynaecology (the service manager) was the lead officer in the directorate for dealing with complaints but she was on leave at that time. The midwife manager established from the Trust's personnel department that the SHO was then in South America. The midwife manager passed that information to the complainant. After that, responsibility for dealing with the matter lay with the service manager.

20. The service manager said that her understanding, based on what the first consultant told her, was that no change could be made to the paediatric record unless the SHO agreed. When she first tried to trace the SHO in January 1995 she knew that he had left the Trust but not that he had left the country. She did not know how to contact him and believed that the GMC would only release personal details about doctors to other professionals. That was why she asked the Trust's legal adviser to contact the GMC. Later, the legal adviser told her that he did not receive her letter so no contact was made. When the complainant's friend became involved there were a number of telephone conversations between him and the legal adviser. The service manager understood that at one point the legal adviser told the friend that he could no longer spend time on the matter and that responsibility for it would revert to the service manager. She then spoke to the chief executive as she felt out of her depth in dealing with the case.

21. The legal adviser said that when he received the service manager's letter of 14 March 1995 he telephoned her and explained that the GMC published a register of doctors' addresses which she could consult. His impression at that time was that the service manager was trying to shift responsibility for dealing with the matter to the legal department. It was not necessary for him to become involved in tracing the SHO. When, on 15 May 1995, he wrote to the complainant's friend in response to his letter of 11 May to the service manager, he had not seen the medical records; nor had he been briefed on the case or told of the meetings between Trust staff and the parents. He had had only a short discussion with the first consultant. He had not been aware that the midwifery records had been altered. Had he known that, he would have been prepared to delete the inaccurate words from the paediatric records without contacting the SHO.

22. The first consultant said he had not considered that it was his job to trace the SHO: that responsibility rested with the Trust. He spoke to the SHO after he returned to the UK and advised him that he should not make a change to the records unless he clearly remembered the circumstances.

23. The SHO told the Commissioner's staff that he thought he had given the Trust his mother's address in Australia as a point of contact while he was overseas. It would have been difficult to contact him between October 1994 and March or April 1995 because he was travelling in South America and Europe. It would have been reasonably easy to contact him after that while he was working in the UK. He remembered speaking to someone at the Trust, probably the first consultant or the service manager, about the complainant's request for an alteration to the paediatric record. He could not remember anything different from what had been documented and considered that he could not change the record because he could not clearly recall the events.

24. In his official response to the Commissioner the chief executive wrote:

> `The Trust's response to the request for corrections to the medical notes took longer than the Trust would have wished. However, there were reasons (eg tracing [the SHO]) and until [the complainant's friend] actually wrote to the Trust on 20 February 1995 it was not clear as to what was actually being requested.'

25. When interviewed by the Commissioner's staff the chief executive said that he could understand why the complainant and her husband felt that the Trust had been slow in dealing with their request for amendments to the records. He accepted that lengthy periods of time elapsed because the legal adviser and service manager each believed that action lay with the other. Matters had not been helped by the first consultant's defensive response to the parent's request. The chief executive was also unhappy with the quality of the legal advice which the Trust had received.

Findings *(b)*

26. The complainant first asked for changes to both the midwifery and paediatric records at the meeting on 16 December

1994. I can see no basis for the chief executive's suggestion (paragraph 24) that it was not clear until February 1995 what was being requested. The Trust acknowledged the validity of the complainant's concerns about the midwifery records as soon as she raised them and agreed to make additions to the records to take account of those concerns. The service manager understood, on the basis of what the first consultant told her, that the only way to address the complainant's concern about the paediatric records was to obtain the SHO's agreement to alter his entry. She tried to contact him but her efforts were hampered by the fact that the Trust had no forwarding address for him and her mistaken belief that she could not obtain information from the GMC. There is a conflict of evidence between the service manager and the legal adviser about what happened when she sought his assistance on 14 March. Whichever recollection is correct, the result was that no effective action was taken until the complainant's friend wrote on 11 May asking about progress. The legal adviser became involved then but by his own account he did so without seeing the records and with an incomplete knowledge of the relevant background. He has said that if he had known that additions accepting the validity of the complainant's concerns had been made to the midwifery records he would have felt able to alter the paediatric records without contacting the SHO. Yet the Trust maintained right up to 6 June that without the SHO's agreement to alter the records they could only add a note stating that the complainant and her husband believed the record to be inaccurate. The chief executive did not become involved until the end of May, by which time the complainant's friend had told the Trust that the parents were considering taking High Court proceedings against them. Then, following the telephone conversation between the friend and the chief executive on 8 June, a basis was quickly found for an addition to the records which was acceptable to the Trust and met the parents' concerns. I recommend that the Trust:

a. make sure that staff are aware of the options available for tracing doctors; and

b. review their arrangements for dealing with requests for amendments to medical records to eliminate the shortcomings evident in the response to the complainant's request.

I uphold the complaint.

Conclusions

27. I have set out my findings in paragraphs 14-16 and 26. The Trust have asked me to convey to the complainant-as I do through my report-their apologies for the shortcomings I have identified and have agreed to implement my recommendations in paragraphs 16 and 26.

APPENDIX TO E.587/96-97

Main events and correspondence relating to request for amendments to records

1994
16 December
The complainant and her husband and a CHC officer met Trust staff, including the midwife manager and one of the midwives who had attended the complainant on 3 September. In a statement produced on 16 December for insertion in the complainant's notes the midwife wrote: `These additions were requested by [the complainant] and agreed by myself as some of the sequencing is not in the correct order and some entries need clarification'. One of the additions reads `.... the entry for 11.15 hours, when I informed [another midwife] that [the complainant] was unwilling to be transferred, means that she did not feel she was able to move ....'. The complainant also asked that a statement in the paediatric records that she had refused hospitalisation be removed because it was untrue. The CHC officer's notes of the meeting include ` .... discussion about who [wrote] this and how they got this impression-could have been [the SHO]-[the midwife manager] will find this out. [The midwife] agreed this statement is not accurate and that [the complainant] did not refuse to go to hospital. The notes will be corrected'. Later on 16 December the CHC officer wrote to the complainant that the SHO had made the entry in the paediatric records but the midwife manager had learned he was now in South America.

1995
19 January
The service manager wrote to the SHO, at an address in Greenwich, asking him to contact her as soon as possible.

25 January
The service manager and other Trust staff met the complainant and her husband and the CHC officer. The CHC officer recorded that the service manager `explained that the medical notes could not be re-written but an amendment could be attached to the notes stating which parts are inaccurate. .... she had written to [the SHO] to confirm his address before writing to ask him to correct the record.'

1 February
The service manager wrote to the first consultant that the complainant had told her she had at no time refused hospitalisation. The service manager had told the complainant that she could not remove or alter the entry which the SHO had made without consulting him. She asked the first consultant to `advise me whether you have any information or knowledge, relating to who told [the SHO] that the patient refused to come into hospital'.

2 February
The first consultant replied to the service manager: `As far as I know [the SHO] is in South America .... There is no question of anybody other than [the SHO] altering any note that he has made. I therefore think that his note will have to stand unless he returns to the UK and is then prepared to consider changing what he has written. I can see no point in having this note changed anyway, since it does not alter what subsequently happened to the baby.'

2 February
The service manager asked the Trust's personnel manager whether he had the address of the SHO or his next of kin.

10 February
The service manager and other Trust staff met the complainant and her husband, their friend and the CHC officer. The CHC officer recorded that the service manager apologised for the entry in the paediatric notes. However, it could only be amended under section 6(2)(a) of the Act (paragraph 3) if the SHO agreed. Attempts to contact him were continuing.

20 February
The complainant's friend wrote to the service manager enclosing suggested amendments to be made to the midwifery records under section 6(2)(a) of the Act. He asked her to confirm to the parents that the Trust accepted those amendments and at the same time to tell them what was being done to contact the SHO.

22 February
The service manager sought comments on the proposed amendments from the first and second consultants.

24 February
The first consultant wrote to the service manager commenting that although the complainant's friend had said he was acting as a friend of the parents he was a solicitor and wrote on his firm's notepaper. The first consultant continued: `I will not be replying directly to this letter but will be putting this matter in the hands of my Medical Defence Union'.

14 March
The service manager wrote to the legal adviser about the complainant's request that the paediatric records be amended: `I cannot, nor can any member of [the] Trust, delete or alter these records without [the SHO's] knowledge and approval'. She continued that the complainant's friend had told her that he had established that the SHO was now in Australia and had asked her to contact the GMC to obtain his address. She believed that the GMC would only release addresses to members of the legal profession seeking to trace doctors in connection with litigation. She asked the legal adviser to contact the GMC on the Trust's behalf to obtain the SHO's address. The legal adviser received the service manager's letter and annotated it `file'.

7 April
The service manager wrote to the complainant and her husband that the first consultant had told her that the SHO had returned to the UK and that she would endeavour to contact him `as soon as possible'.

11 May
The complainant's friend wrote to the service manager enquiring about the position on contacting the SHO.

15 May
The legal adviser wrote to the complainant's friend in response to his letter of 11 May that the Trust had `consulted the appropriate health professional' and were unable to make the requested amendment to the paediatric records. However, they were prepared, under the terms of section 6(2)(b) of the Act (paragraph 3), to add a note to the records that the complainant had asked that the words `but refused hospitalisation' be deleted because in her view they were inaccurate.

17 May
The legal adviser made a note that the complainant's friend had telephoned to express dissatisfaction with the Trust's decision and had disputed the basis on which it was made.

18 May
The complainant's friend wrote to the legal adviser that the parents had traced the SHO.

30 May
The complainant's friend wrote to the service manager that unless the Trust agreed to amend the paediatric records under section 6(2)(a) of the Act the parents would take High Court proceedings against them for an amendment pursuant to a court order.

31 May
The chief executive wrote to the complainant's friend that he was giving the matter his urgent attention and expected to able to advise him of the Trust's position within seven days. The service manager wrote to the SHO at a hospital in Wales, enclosing copies of the paediatric notes, explaining the complainant's concern about them and asking if he agreed that the words `refused hospitalisation' should be deleted.

5 June
The service manager made a note that the SHO had spoken to the first consultant and told him that he was going to Australia. He had no clear memory of why he had written as he did in the paediatric notes but assumed that it had been on the basis of information given to him by the midwives. The first consultant had advised that unless he had total recall of the circumstances he should not change what he had written.

6 June
The chief executive wrote to the complainant's friend that `having taken advice from [the SHO] I am unable to be satisfied that the statement in the Medical Records is an inaccurate record of what he had in his mind at the time. Accordingly I am arranging for a note to be made in the Medical Records that the statement is considered by [the parents] to be inaccurate.'

8 June
The complainant's friend and the chief executive spoke on the telephone. The latter agreed to take advice on the possibility of making an amendment to the paediatric records under section 6(2)(a) of the Act.

12 June The chief executive sent the complainant's friend a draft note for inclusion in the paediatric records. This included ` .... the Trust has agreed to append this note to [the baby's] medical records in order to clarify that [the complainant] did not refuse hospitalisation.'

21 August
The complainant's friend wrote to the chief executive (apologising for the delay in doing so) and enclosing a proposed revision of the note for inclusion in the paediatric records. For the passage in the chief executive's draft which is quoted above was substituted: `.... the Trust agrees to the above correction pursuant to Section 6(2)(a) of the Access to Health Records Act 1990.'

23 August
The chief executive wrote to the complainant's friend `The amendments you have suggested are acceptable to the Trust and I confirm that a copy of the statement you attached to your letter of 21 August will be included in [the baby's] medical records.'

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comments

Dietetic staff

20. The head of the dietetic services (the first dietitian) said that in the week the complainant's husband was admitted three of the five dietitians covering three hospitals were not available. Usually they saw referrals within 24 hours but in the complainant's husband's case it took 72 hours. It was possible that he had postponed his attendance because of the complainant's husband's operation and the fact that he was vomiting; unless that was controlled there was little he could do. He found the complainant's husband could eat and retain some food and drink, but only irregularly. He had recently been put on an anti-emetic but there had been insufficient time to see if that would be effective. The first dietitian had arranged to send supplements which was all he could do for him. There was no point in visiting the complainant's husband regularly-that only distressed him as he could not keep food down. By periodic telephone conversations with ward staff the dietitians had been kept aware of his current state which was that he continued to vomit. He was next seen by a dietitian on 9 September.

21. Anther dietitian (the second dietitian) said that on 9 September a surgical registrar (the registrar) referred the complainant's husband to her department for peripheral feeding. The registrar's instruction had surprised her as the complainant's husband was already on vitrimix. She asked if he could be fed by NG tube because the registrar had told her that he was tolerating food. The registrar replied that the complainant's husband had a muscle at the bottom of the stomach which was starting to close and they needed to establish if they could pass the blockage to provide NG feeding or whether TPN was necessary. She waited for instructions-there was nothing she could do if the patient was being fed intravenously-and on 16 September the registrar told her that the second endoscopy had identified a total blockage and so NG feeding was not possible. The registrar said that the complainant's husband was to have surgery to pass the blockage.

Medical staff

22. The urologist said that when the complainant's husband was in ward 24 there was no evidence that there was a stomach blockage although that was likely because he was being sick after eating. That had not necessarily indicated a total blockage. He would not have considered TPN for the complainant's husband at that time because that would have been too radical a change in his management. The complainant's husband was only passing through ward 24 and a change to TPN could have affected or held up treatment which the next discipline had planned for him.

23. The registrar said that on 6 September the complainant's husband underwent an endoscopy. He doubted there was a total blockage at that stage but on Friday 15 September an endoscopy indicated a total blockage. They recommended that the complainant's husband should have surgery urgently, which would have been on Monday 18 September, to establish the nature of the growth and to help him to eat. TPN had not been considered because investigations were still continuing when the complainant's husband died.

Findings *(b)*

24. Although the complainant said that the urologist told her that her husband had a blockage in his stomach he said that there was no clinical evidence for that while the complainant's husband was in ward 24, although he had considered it likely. The total blockage was not identified until 15 September and until then the nursing staff continued to try to persuade the complainant's husband to take some diet. I can understand the complainant's distress when this occurred but the nursing staff were following instructions. The dietitians were late in seeing the complainant's husband and visited rarely thereafter for reasons they have explained. I accept that there was little they could have done for the complainant's husband as he was unable to retain his food. The method of feeding and whether TPN should have been used was for the medical staff to decide. The urologist and the registrar have said why TPN was not used. Their decisions were matters for their clinical judgment and as such, at the time, were outside the Commissioner's jurisdiction. I agree with the director of nursing that the complainant's husband's nutritional state was inadequately managed in ward 24 and to that extent I uphold this aspect of the complaint.

Complaint *(c) Arrangements for infirmary visit*

25. The complainant's sister-in-law said that on 2 September her brother was taken to the infirmary in a single-manned passenger ambulance and that his drip had been taken down before leaving. She thought that was so that he would not have to be accompanied by a trained member of staff. The staff at the infirmary had not been aware that he was in hospital, not an outpatient, and had made no preparations for his specific needs. He could not eat the sandwiches he was offered for lunch and

so he had nothing to eat all day. The infirmary staff had said they would make proper arrangements for his return journey. The complainant's sister-in-law and the complainant were appalled at the way in which the complainant's husband was treated that day.

The staff evidence

26. The first staff nurse said that on 2 September the complainant's husband had been able to walk short distances and she had considered he was fit enough to be accompanied by an auxiliary nurse; the nurse concerned was very competent. The ambulance had a driver and a second ambulanceman although, as the complainant's husband had not needed a stretcher, a driver would have been sufficient. It was not usual to inform another hospital that they would be receiving an inpatient. As far as she was aware the complainant's husband had had no special needs but such requirements as diet could have been met by any hospital without advance notice. The complainant's husband was on intravenous fluids which she had discontinued for his transfer to the infirmary. She should not have done that: when patients were to have a bone scan their fluid intake had to be increased. Normally they were required to drink a quantity of water which the complainant's husband would probably not have been able to manage. If his intravenous fluids had been maintained he would not have needed to drink so much water at the infirmary. She accepted full responsibility for her error. As it was a theatre morning she preferred to keep as many trained nurses on the ward as possible. But her reason for taking down the drip was not to send an auxiliary nurse escort rather than a trained nurse, but rather to make the journey more comfortable for the patient, and a usual practice. If she had remembered the need for additional fluid for patients such as the complainant's husband she would have maintained the intravenous fluid and sent a trained nurse with him.

27. The auxiliary nurse who accompanied the complainant's husband to the infirmary said they left the hospital at about 8.15 am in an ambulance with a two-man crew, arriving at the infirmary after about an hour and a quarter. The complainant's husband was taken to and from the ambulance in a wheelchair. At the nuclear medicine department he was told he would need to drink a quantity of fluid; he doubted he could do that without being sick and a drip was put up; that was about 15 to 20 minutes after arriving. He was given an injection for his scan and put to bed where he slept, being very tired. She was aware that the complainant's husband had difficulties in eating and presumed that was why he had refused sandwiches offered for lunch. After his scan they had waited at about 3.30 pm for collection by an ambulance. The complainant's husband had still been on intravenous fluids which meant, they were told, that he would have to wait for a ambulance crewed by paramedics. He was very uncomfortable sitting waiting; a trolley with blankets provided helped but he wanted to get back to the hospital and offered to sign anything to authorise the drip to be taken down so that he could leave sooner. Shortly after 5.00 pm the patient transport system closed down and the complainant's husband was taken to a bed in a ward. At 6.30 pm he left on a stretcher in a paramedic-crewed ambulance reaching the hospital at about 6.45 pm. The auxiliary nurse said they would have arrived back probably at about 4.00 pm if the infirmary staff had allowed the drip to be taken down. It was a very traumatic day for the complainant's husband.

28. The first sister explained that a two-man ambulance was used for the complainant's husband which was satisfactory. All patients taking intravenous fluids had to be accompanied in an ambulance by a trained nurse. As the complainant's husband was to be sent without intravenous fluids an auxiliary nurse escort was appropriate. When she came on duty on 2 September the complainant's husband had already left the ward. She was told by the first staff nurse that she had taken his drip down, having forgotten that extra fluid was needed for bone scans. The first sister accepted that they had made a mistake but said that the infirmary staff could have put the complainant's husband back on intravenous fluids on arrival - it should not have caused a major problem. She understood that the infirmary staff had insisted that the drip they put up remained which had meant he arrived back at about 6.00 pm rather than 2.00 pm, and he was exhausted. In her view it would have been better to have taken down the drip in the infirmary rather than delay his return. The complainant's husband had no special needs about which the infirmary needed to be told for the short time he was to be there. The auxiliary nurse would have attended handover reports, which was their practice, and would therefore have been aware of the complainant's husband's needs.

29. The director of nursing confirmed that a patient on intravenous fluids during transfer was expected to be accompanied by a trained nurse. In some cases it was acceptable to discontinue fluids when transferring a patient to another hospital but that was not appropriate for the complainant's husband. It had not been necessary to advise the infirmary about the complainant's husband's change in patient status because there was nothing they needed to know unless it would adversely affect the scan.

30. The urologist said that if the complainant's husband's intravenous fluids had been discontinued for up to about eight hours that would have made little difference except that he might have felt thirsty. There was an argument for taking drips down during journeys as they were difficult to manage in ambulances.

31. A control superintendent at the ambulance service's local control centre told the investigator that the booking from ward 24 for the ambulance to take the complainant's husband to the infirmary was for a two-manned patient transport service

vehicle, which was what they supplied. There was no mention on the booking of any special requirements. A drip could be used on a patient transport service ambulance provided a trained nurse was present to supervise it. Staff from the infirmary telephoned at 2.10 pm on 2 September to ask for an accident and emergency ambulance to be supplied for the return journey because the complainant's husband had a drip in place.

Findings *(c)*

32. I believe that the complainant was misinformed about the type of ambulance used to take her husband to the infirmary as the ambulance service have confirmed that a double manned ambulance was booked, and supplied, for that journey. I have noted the urologist's views about the effects of discontinuation of intravenous fluids for ambulance journeys; the clear evidence of nursing staff is, however, that in the complainant's husband's case it should not have been discontinued and the first staff nurse has accepted responsibility for that error. Discontinuation caused difficulties for the complainant's husband at the infirmary in taking the required quantity of fluid for the bone scan. No doubt that caused him discomfort and led to delay. While I am not persuaded that the presence of a trained nurse would have significantly affected the complainant's husband's care, the lack of a trained nurse substantially delayed his return to the hospital. I accept the explanations of the first sister and director of nursing that there was no reason to inform the infirmary of the complainant's husband's change in patient status or of any special needs. It was very regrettable that the complainant's husband, as the auxiliary nurse has said, experienced such a very traumatic day. To the extent that I have indicated, I uphold this aspect of the complaint. **I recommend** that the Trust remind nursing staff of the fluid requirements of patients being sent for bone scans.

Complaint *(d) Continually cold*

The complainant's and the complainant's sister-in-law's evidence

33. The complainant said that because her husband was so emaciated he suffered from cold. In ward 23 his bed was by the door in a draughty area and he normally sat up with a house coat round his shoulders with a light blanket on his legs; he had been unable to put on more blankets because they were too heavy for him. She had asked a nurse if her husband could have a duvet but was told curtly that they were not available on the ward. It was agreed that she could bring one in. The complainant's sister-in-law said that although the ward did not have duvets, staff could have used some imagination and, for instance, put a blanket over his knees and a cage with more blankets on top of that to keep some warmth in and they also could have obtained a sheepskin for underneath him.

The staff evidence

34. A staff nurse (the fourth staff nurse) said that at first the complainant's husband was nursed in the cubicle nearest the swing door entrance to the ward. He had cared for the complainant's husband regularly but he had not complained to him about the area being draughty or about being cold. The complainant complained that the area was draughty and they moved her husband to a cubicle further away from the doors and by a radiator. He recalled that the complainant's husband had a quilt brought in by his wife. The second staff nurse confirmed that the complainant's husband was moved to a bed further away from the door. She said that he was a good communicator and if he had complained of draughts, she would have moved him elsewhere, if a bed had been available.

35. Other nurses gave similar evidence. None had any recollection of the complainant's husband appearing to be cold or complaining of being cold. If he had they would have provided extra blankets or moved him to another bed away from the door, if there had been one free. Several said that the complainant's husband was able to tell them if he was cold and because of his emaciated condition they would have asked him as a matter of course if he was warm enough.

36. The second sister had no recollection of the complainant's husband looking cold or being cold but said that patients had complained of draughts in the area of the ward near the door. She expected nurses to pay particular attention to the comfort of patients who were elderly or emaciated and to provide extra blankets if they were cold. If patients were cold they usually told the staff and were given extra blankets or moved if possible.

37. The director of nursing said that if patients were emaciated they would be more likely to feel the cold and it was for the nursing staff to ensure the comfort of patients. Beds by doors could be draughty and nursing staff were asked to keep doors closed as much as possible. In their response to the Commissioner the Trust said that the request for the duvet should have alerted nurses to the fact that the patient was uncomfortable and they expressed regret that the complainant's husband's needs were not met.

Findings *(d)*

38. I have no doubt that the complainant's husband suffered from the cold although I do not believe that nursing staff were aware of that until the complainant brought it to their attention. It was known, however that the area by the door was draughty and that the complainant's husband, because of his condition, was likely to suffer from the cold. To an extent, I consider that nursing staff should have been more alert to his needs for warmth, and to that extent I uphold this aspect of the complaint.

Conclusion

39. I have set out my findings in paragraphs 10, 24, 32 and 38. The Trust have assured me that they will act on my recommendations in paragraphs 10 and 32 and have asked me to convey to the complainant through my report-as I do-their apologies for the shortcomings I have identified.

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comments

Findings *(a)(i)*

20. Staff interviewed from the first hospital could not remember the complainant's mother and there was no documentary evidence from the period 18 to 27 October 1994 as to whether or not she needed help with her food or a special diet. Contrary to the complainant's views a sister, a senior staff nurse and a staff nurse all said separately that they encouraged their patients to eat and tried to arrange for food they liked. In the absence of specific evidence from the nursing staff I cannot reach a conclusion about the standard of care provided for the complainant's mother in this respect at the first hospital. Her dietary problem was recognised at the second hospital but the efforts of staff to encourage her to eat were unsuccessful. The complainant has acknowledged (paragraph 4) that his mother became more determined in the latter stages of her stay and that it was unlikely she could have been persuaded to eat. I have noted the evidence of a staff nurse (paragraph 15) that little could be done if a patient refused to eat and also that of the consultant, who was kept informed about her poor eating, that force-feeding would not have been appropriate. I note with approval the actions taken to involve hotel staff in the dietary care of patients. I am not persuaded that there were failures in supervision and assistance at mealtimes at the second hospital and I do not uphold this aspect of the complaint against the first Trust.

Findings *(a)(ii)*

21. During drug rounds nursing staff were required to initial administration charts to confirm that patients had taken their prescribed medication. If, for some reason, a patient refused medication the chart was to be marked accordingly. The complainant's mother became increasingly unco-operative during her time in hospital, exemplified by her unwillingness to take medication. The evidence of the ward nursing staff that they made sure medication was taken is contradicted by their managers and by the first Trust in their formal response to the Commissioner on this issue; their enquiries revealed that the complainant's mother's prescribed medication was, on occasions, found discarded in her bed or on the floor. If that was so, and I have no reason to doubt that it was, she must have been left with her medication which she either refused to take or discarded leaving the impression that it had been taken. I do not underestimate the difficulty of checking that medication has been taken by a person who does not want it but I share the view of the director of nursing (paragraph 17), reflected in the policy introduced in August 1995, that it was unacceptable that nurses might have left patients before making sure that they had taken their medication. To that extent I uphold the complaint against the first Trust and I recommend that they remind staff that patients must be properly supervised in taking their medicines and that drug administration records must be fully completed.

Findings *(a)(iii)*

22. The complainant and his wife found on one occasion at the first hospital that his mother had been left after being incontinent. The staff evidence was that patients known to be incontinent, and the complainant's mother was assessed as such on admission to the first hospital, were checked every two hours, offered bedpans and given pressure area and other care if required. It is possible, however, that she might not have been included in the two-hourly checks as she had been assessed by the ward staff as `self caring' and for the first week or so of her stay no care plan was prepared to deal with her incontinence. That was a serious omission. On the basis of only one incident, which could have occurred between the regular checks, I cannot find made out the complaint that the complainant's mother's hygiene needs were neglected. **I recommend**, though, that the first Trust remind their staff that patients' specific needs should be identified accurately and care plans prepared promptly, and that they monitor that that is done.

Complaint *(b) Informed, incorrectly, that the patient had died*

23. On 20 January the complainant's mother collapsed and was transferred from the third hospital to the first hospital. The complainant said that on the morning of 21 January he was told that she had made a remarkable recovery. The complainant visited her and later in the afternoon left the hospital so that his mother and sister could be together. At about 5.00 pm the complainant was telephoned by an enrolled nurse informing him that his mother had died. He made a number of telephone calls to tell the family and had contacted an undertaker but an hour later his sister telephoned to say that the nurse had made a mistake.

24. The enrolled nurse told the Commissioner's staff that on the afternoon of 21 January the complainant's mother's condition deteriorated and her daughter ran into the main ward saying that her mother had passed away. The enrolled nurse went to her

and carried out the usual checks for signs of life, which took about ten minutes. She asked the daughter if she wished her brother to come to the hospital to which she replied that he should just be told that his mother had died and she did that. When she returned to the complainant's mother's bedside she found her to be breathing. She tried to speak to the complainant to tell him about the mistake but could not contact him. The daughter eventually did so and as soon as he came to the hospital she and a doctor spoke to him and apologised for the error. The enrolled nurse said that if relatives knew a patient was dying and were themselves in good health it was usual for a nurse to pass on the information about a death but normally a doctor confirmed that death had taken place before the call was made.

25. The consultant said that nursing staff contacted junior medical staff when a patient died. The doctor would then examine the patient to confirm that death had taken place. If a death was expected it was usual for a nurse to inform relatives but only after a medical opinion had been obtained.

26. The director of nursing told the Commissioner's staff that she had never known a case of a nurse making a mistake about a patient's death. Since this incident, their policy had been revised and the instruction was that nurses must not contact relatives until a doctor has certified death. The Commissioner's staff were unable to obtain a copy of a written instruction to that effect.

Findings *(b)*

27. There is no dispute that, due to an error by a nurse, the complainant was incorrectly informed that his mother had died. Nurses should always obtain confirmation of death from medical staff before informing relatives that a patient has died. I uphold the complaint against the first Trust and recommend that they issue, without delay, written instructions about nurses' responsibilities in these matters.

Complaint *(c) Instruction about revival following a collapse*

28. The complainant said that during the second week of his mother's stay in the first hospital, in October 1994, he had told the nursing staff that if she collapsed again she should not be revived. He had also said that she should not be force-fed in order to keep her alive. He had repeated his wishes at the second hospital. Three or four days after his mother's transfer to the third hospital (16 December) a clinical assistant had told him that she appeared to have suffered a small stroke. The complainant told the clinical assistant that he did not wish his mother to be revived should she collapse. He could not recall mentioning that to the nursing staff. On three occasions he had given instructions that his mother was not to be revived in the event of a further collapse. He therefore questioned the justification for transferring her back to the first hospital following her collapse on 20 January at the third hospital.

Staff evidence

29. None of the staff from the first hospital interviewed by the Commissioner's staff recalled any discussion about not reviving the complainant's mother and there was no documentary reference to it.

30. The ward sister at the second hospital said that any such request would be discussed between medical and nursing staff and any decisions recorded in the care plan. I have seen that a staff nurse, who could not be interviewed because of illness, wrote in the nursing records on 6 December that the complainant requested `no intervention e.g. artificial feeds.' There was no corresponding reference to that in the medical records. Neither of two staff nurses interviewed recalled instructions not to revive the complainant's mother. They said that any such instructions would be given by medical staff and written in the patient's clinical notes. One of them said that the complainant's mother's condition had not warranted such measures.

31. Another staff nurse employed by the second Trust, who admitted the complainant's mother to the ward at the third hospital on 16 December, said that she had an intravenous drip in place when transferred. As her nursing notes included a request from her son that there was to be no intervention e.g. artificial feeds she had informed the ward charge nurse and on medical instructions the drip was removed. The following day the complainant had repeated that he did not want his mother force-fed which he explained as any tube or drip-feeding. She had recorded that in the nursing notes. If the complainant had specifically mentioned resuscitation she would have recorded that too, which she had not, and made an appointment for the family to see a doctor. The clinical assistant at the third hospital could not recall the complainant's mother or her family. He confirmed that he had written in her clinical notes on 22 December: `Spoken to the son. Explained [his mother's] clinical condition and it seems likely that she has had a [cerebral vascular accident] (stroke). Son realises that she is not eating or drinking [very] much, but he wouldn't want any active intervention like IV drip'. The clinical assistant said that if the complainant had said that he did not want his mother revived or resuscitated he would have made a specific reference to that in the records.

32. A locum senior house officer said that he saw the complainant's mother on 20 January when she was transferred back to the first hospital. He considered the transfer appropriate as there were no facilities to treat her at the third hospital and she might have had a condition that was treatable. He was not aware that she was not to be resuscitated; there was a clear difference between resuscitation and active treatment. He wrote in her clinical notes on 20 January: `To speak to relatives- prognosis poor, they are very understanding and do not want any active intervention and [taking] into consideration the overall history she is not for a call [to resuscitation team]'. The consultant said that there was no evidence in the medical records that the complainant had requested that his mother should not be revived if she collapsed until the entry following her final admission to the first hospital. There were references to her not being force-fed and entries such as `no active intervention' but they concerned artificial feeding, drip feeding or inserting an intravenous drip. If medical staff considered that intervention in the form of treatment was required, they would give it. The complainant's mother had collapsed at the third hospital where a full medical assessment could not be made of whether there was a readily treatable cause and the prognosis. If there had been a treatable condition, it would have been for the complainant's mother to say whether she wanted treatment or not. Another consultant physician, whose team cared for the complainant's mother following her transfer back to the first hospital in January 1995, wrote to the chief executive of the first Trust that when transferred she was `in the middle of an acute episode which had to be diagnosed and managed'.

Findings *(c)*

33. The complainant spoke to staff about his mother's care in the event of a deterioration in her condition. Their clear, recorded, understanding was that there was to be no artificial feeding or similar intervention rather than that she was not to be resuscitated. However, even if staff had understood the complainant's wishes it would not have affected his mother's transfer from the third to the first hospital, which he says was his main concern, because, as the consultants have explained, she was suffering from an acute condition which needed assessment and decisions taken about active treatment, which could not be done at the third hospital. I do not uphold this complaint against either Trust.

Complaint *(d) Incorrect death certificate*

34. The complainant said that on 23 January 1995, the day after his mother's death, he had collected the medical certificate of cause of death from a senior house officer (the SHO) at the first hospital. He took it to the Registrar of Births and Deaths to register the death where he was told that the certificate was invalid as the doctor who had signed it had not seen his mother within the last 14 days of her life. He returned the certificate to the SHO who told him that he was not aware of the 14 day requirement.

Documentary evidence

35. The notes issued by the Office for National Statistics, for medical practitioners completing medical certificates of cause of death, state that `A registered medical practitioner who was in attendance on the deceased person during the last illness is required to give a medical certificate of the cause of death on the prescribed form .... It is for the practitioner to decide whether he was in attendance during the last illness .... Where the practitioner was in attendance during the last illness but the conditions in Regulation 41(1)(b)(ii) are not fulfilled the registrar will notify the death to the coroner'. The Regulation in question states:

> `41(1) Where the relevant registrar is informed of the death of any person he shall, subject to paragraph 2, report the death to the coroner .... if the death is one-
>
> a. ....
>
> b. in respect of which the registrar-
>
> i. ....
>
> ii. has received such a certificate with respect to which it appears to him .... that the deceased was not seen by the certifying medical practitioner either after death or within 14 days before death;
>
> ....'

Staff evidence

36. The SHO said that he had apologised to the complainant about the certificate and confirmed telling him that he was not aware of the 14 day rule. He had completed the certificate in good faith having treated the complainant's mother in October and November in what he believed was part of her final illness leading to her death in January 1995. He had not however seen

her after she was transferred to the third hospital in December. He could not say what he had been told about completing certificates when he started work at the first hospital. He was aware that he could sign certificates if he had been involved in the care of a patient during his or her last illness but not that that involvement had to be in the last 14 days of the patient's life.

37. The consultant said that junior medical staff were given information about completing certificates of cause of death by the pathologist when they started to work at the hospital (Note: I have seen an induction programme which confirms that.) Until they gained experience he expected his junior staff to discuss all deaths with him.

Findings *(d)*

38. As the SHO had not seen the complainant's mother within 14 days before her death or after it the certificate he provided would not have enabled the registrar to register the death on 23 January and issue the death certificate to the complainant. In accordance with the Regulations she would have had to notify the death to the coroner. The complainant, therefore, returned to the first hospital to obtain a certificate from another doctor who had been involved within the required time. This error, which caused the complainant avoidable trouble and a waste of his time, was due to the ignorance of the SHO about his responsibilities in the provision of medical certificates of the cause of death. I criticise the first Trust for failing to make sure that their staff were fully aware of their duties in this regard. **I recommend** that they satisfy themselves that their induction training and supporting written guidance provided to junior medical staff in respect of their contacts with registrars and coroners fully meets requirements. I uphold the complaint.

Conclusion

39. I have set out my findings in paragraphs 20, 21, 22, 27, 33 and 38. The first Trust have agreed to implement my recommendations in paragraphs 21, 22, 27 and 38 and have asked me to convey to the complainant through this report-as I do-their apologies for the shortcomings I have identified.

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comments

APPENDIX A TO E.110/95-96

4 Preliminary comment

The Panel feels bound to record that evidence given to it has included comment highly critical of the Independent Review, in particular:-

4.1 The Report goes well beyond the remit of `second opinions' nominated to deal with a matter under the Third Stage procedure set out in Annex B to HC(88)37. The Independent Review should have confined itself to an independent clinical review and not introduced managerial issues.

4.2 Allegations are made which are not justified by the facts. Evidence given to the Independent Review has been misconstrued or recorded wrongly.

4.3 Those criticised have had no opportunity to respond prior to, or indeed after, publication of the Independent Review.

4.4 Key staff were not interviewed by the Reviewers.

4.5 The confidentiality of the Reviewer's task was not fully respected.

It is not within the Panel's Terms of Reference to take these matters further but it will be appreciated that its comments have, where appropriate, taken note of the evidence given to it.

APPENDIX B TO E.110/95-96

Details of recommendations by the IPR, the Trust's responses, and other relevant evidence

Section (a) of each paragraph below is the IPR recommendation, section (b) is the Trust's response in the Panel report and (where appropriate) section (c) is relevant additional information from documents or evidence given at interview during my investigation.

1. (a) The Trust should have an agreed policy for investigating serious incidents and for taking action against staff when their actions fall short of an acceptable standard. A senior manager should be designated for each enquiry to make sure that staff had provided all necessary evidence.

(b) A serious incident policy was instituted in late 1993.

(c) The chief executive said that there had been a number of inquiries and the policy was working. The chairman of the Panel said he satisfied himself that the policy was widely understood by hospital staff and that it was working.

2. (a) The complainants should receive a copy of the full IPR report as their allegations had been proven.

(b) The RHA sent a copy of the full IPR report to the complainants and the Panel met them and heard their comments.

3. (a) Despite `grave concern' at the `clinical inadequacies' no further action was recommended against the junior doctors and nurses as it would not be possible to attribute blame accurately, not least because they were not informed of the allegations until the IPR. Blame for those staff not being interviewed formally much closer to the event rested with the medical director and the consultant involved, particularly when they had accepted at the outset that major errors had been made.

(b) The actions of the junior doctors fell well short of the desired standard but the Trust was not able to take action against them because they were no longer employed there. An induction and training programme was recommended for junior medical staff on the signs and treatment of salicylate (aspirin) poisoning and the dangers of complacency and prejudice when

dealing with overdoses. Nursing standards fell well short of desired practice and action was required in terms of education and improvement of nursing procedures. Two nurses involved were given specific education programmes and a newly appointed director of nursing prepared a plan of action for staff training for the accident and emergency (A and E) department which the Panel asked to be extended throughout the hospital. The medical director and the consultant should have conducted a more formal investigation and review process, though they did counsel the junior doctors. Responsibility for not taking statements from nursing staff at the time rested, in part, with nursing managers. The failures of the medical director and the consultant were largely due to a lack of knowledge of formal disciplinary procedures and a lack of a policy for investigating serious incidents. The Panel decided that no action was necessary. More than two years had passed and the nursing manager who did not investigate at the time was retiring. The Panel decided that under the circumstances disciplinary action would be inappropriate.

(c) The RHA passed the names of three junior doctors and the consultant involved in the complainants' daughter's care to the General Medical Council and drew their attention to the concerns about the standard of care she received.

4. (a) There was evidence of inadequate professional understanding and a lack of empathy towards overdose patients by some staff. Training was recommended.

(b) No evidence of widespread lack of empathy had been found but every effort should be made to warn of the dangers of complacency when treating patients who had overdosed. This issue was to be included in the training programmes for junior doctors and nurses.

(c) The second clinical director (who is a psychiatrist) said that the conclusion that there was no lack of empathy was based on evidence given to the Panel by the clinical staff involved.

5. (a) The chief executive might take the view that he had been misled by the medical director and the consultant about the nature of their initial investigation. He should pursue those matters further.

(b) Most careful consideration was given to this but the Panel did not consider it to be correct. The Panel's view was that the medical director and the consultant misunderstood what was required of them. They conducted a clinical enquiry which was not properly structured, sufficient or complete and the chief executive failed to see that. There was a collective failure to investigate the tragedy properly and the key to that was the lack of a serious incident policy. No action was recommended against the chief executive, the medical director or the consultant.

(c) The chairman of the Panel said that he did not think the medical director or the consultant should be criticised any more than they had already been for the administrative failure in the investigation and that the Panel did not consider action against the chief executive. The chief executive said that in late 1993 he told the medical director and the consultant that they had made mistakes in their investigation of the complaint and explained to them their roles in the disciplinary procedure. He did not think they had tried to mislead him.

6. (a) Clinically important information was withheld from the coroner. The coroner should be given a copy of the clinical parts of the report.

(b) The coroner was given a copy of the clinical notes and he did not ask for any further information.

(c) The RHA sent the clinical parts of the IPR report to the coroner. The chief executive told my staff that the Panel took external legal advice on the doctor's obligations to the coroner. He said that that had confirmed that none of the Trust employees failed to comply with their obligations and that after discussions the coroner said he was satisfied with how he dealt with the Trust. The chief executive of the NHS told the complainants in a letter on 3 May 1996 that he had been unable to find any specific guidance for NHS staff on what evidence they should pass to the coroner. Staff were expected to do what the law required.

7. (a) New standing instructions for A and E (the poisons protocol) were welcome and should be audited carefully.

(b) Compliance with the poisons protocol had been audited and the Panel were satisfied with the design and findings of the audit.

(c) The medical director told my staff that he had made a mistake in one draft of the poisons protocol in the section which dealt with paracetamol poisoning. That was picked up by the complainants. The first audit of the protocol showed some low compliance but he felt that some of the aims, such as assessment by a registrar or SHO within 45 minutes of the first assessment, might not be 100% achievable. The second audit report, in June 1996, showed general improvement although there were still some concerns. A minute of the final Panel meeting in June 1996 acknowledged that action might be needed to

achieve further improvement: staff were to meet to discuss that.

8. (a) Proposals for all medical admissions to be seen by a registrar or SHO within 45 minutes of referral, for doctors not to have conflicting duties and for a limit on the number of junior staff allowed to be absent should be adopted and audited.

(b) Those proposals had been adopted before the IPR. Registrars and SHOs no longer had conflicting duties and more middle grade doctors had been appointed. Cover arrangements for SHOs and registrars should be strengthened and audited.

(c) The proposal for medical admissions to be seen by a registrar or SHO within 45 minutes was covered in the audit of the poisons protocol (see paragraph 7 above). The June 1996 report showed that that happened for 43% of relevant patients. A letter from the head of service for adult medicine to the legal manager on 11 December 1995 said that the cover arrangements for SHOs and registrars had been checked twice and the arrangements were working satisfactorily.

9. (a) Proposals that the nurse in charge of a ward would call a consultant directly if necessary were welcomed but that depended on the ability of the staff to recognise when it was necessary.

(b) The Panel report agreed and referred to its commitment to additional training for nursing staff (see paragraph 3 above). It recommended development of a protocol.

(c) The first clinical director said that the protocol was in place and had been audited by the director of nursing. The medical director said there were still problems persuading nurses to contact consultants but there was now a requirement for nurses to write in the medical notes if they wanted to draw a doctor's attention to something.

10. (a) The Trust should examine the adequacy of staff numbers in the A and E department.

(b) At the time of the incident the numbers of medical and nursing staff were inadequate. More staff had been appointed, including a registrar in A and E medicine. Extra nurses had been appointed and were no longer also responsible for work in the fracture clinic.

Other action

1. The Panel report also gave responses to 13 points raised by the complainants and points in the RHA's letter (see paragraph 10 of the report). It included its own list of findings and recommendations. Changes referred to in the Panel report included the following.

2. The move to a new hospital site had brought improved premises and layout. The A and E department was now in the same building as the main biochemistry laboratory and samples were delivered by vacuum tubes so there was less delay.

3. All blood samples from overdose patients were routinely tested for paracetamol and salicylate levels. Reports were made back to A and E within one hour. Compliance had been proved by audit. A and E staff could now get direct access to pathology results on the computer.

4. A protocol on the oral transmission of clinical information was recommended-and produced.

5. Back up arrangements for consultant cover were recommended and put in place on 1 January 1996.

6. The development of a protocol to establish clearly how patients should be monitored in A and E was recommended. In a letter to my staff the corporate business manager said that that recommendation was considered `wholly unworkable'. Instead it had been decided to make the following statement: `a nurse will be assigned to every patient waiting in A and E and will be responsible for ensuring that the care (including appropriate monitoring) is delivered as prescribed.'

7. The writing of a protocol was recommended to establish the duties of a locum consultant covering the A and E department. The chief executive said that a second A and E consultant had been appointed and therefore locums were no longer necessary.

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comments