Health Service Commissioner

FIRST REPORT FOR SESSION 1997-98

ANNUAL REPORT FOR 1996-97

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Health Service Commissioner - Annual Report

CONTENTS

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1. INTRODUCTION

1.1 This is my first report as Health Service Commissioner. I took up my office in January 1997 on the retirement of Sir William Reid KCB. Like him and all his five predecessors I was appointed to the three separate statutory offices of Health Service Commissioner for England, Scotland and Wales.

1.2 In accordance with tradition this Annual Report covers my responsibilities in all three offices. For most of the year the offices were under the stewardship of Sir William, to whose work and achievements as Commissioner I am happy to add my own appreciation to those expressed in Parliament and elsewhere. I hope to fill this office with the same diligence and success.

1.3 The year has not only seen a change in Commissioner. From 1 April 1996, as a result of the Health Service Commissioners (Amendment) Act 1996, my jurisdiction received its first major change since it was established in 1973. The new Act means that I can now investigate complaints about family health service practitioners, as well as about hospital and community health services. It also enables me to investigate complaints arising from the exercise of clinical judgment by health service professionals, whether in hospitals, community or primary health care. In the past this Office has had to reject many complaints because they related to those two areas, so the extensions are potentially very significant. They provide equal access to my Office for anyone who has a complaint about any aspect of the services they have received from any part of the National Health Service. Over the last year my Office has had to prepare for, and begin to deal with, complaints in these important new areas as well as continuing work under my previous jurisdiction.

1.4 The changes to my jurisdiction complemented the introduction, also from April 1996, of a new complaints procedure in the NHS, broadly on the lines recommended in the Wilson Report [1]. This provides for the first time a unified procedure in the NHS for responding to complaints. It replaces arrangements covering separately, and in very different ways, hospital and community health services, family practitioner services, and clinical complaints about hospital doctors and dentists. Key aspects of the new procedure are:

- early and full response to complaints with an open, non-defensive approach (local resolution);
- the possibility of investigation locally by a lay independent review panel if a complainant is dissatisfied with local resolution;
- decisions on which complaints should go to a panel are made by a lay person (the `convener') - generally a non-executive director of the relevant Health Authority (in Scotland, Health Board) or NHS Trust.

1.5 The legislation extending my powers provides that I should normally investigate only if the complainant has pursued his or her concerns through the appropriate NHS procedure.

1.6 The new complaints procedure and the jurisdictional changes are affecting the way in which I consider and investigate complaints. I set out in Chapter 5 an account of my experience so far in responding to complaints which have gone through the new procedure. I refer there to some areas where I believe there needs to be improvements in the way the new procedure is working. I note here only that I welcome the new procedure. It provides the prospect of complainants getting a more speedy and satisfactory resolution of their concerns at a local level. It also introduces a stronger lay and independent element.

1.7 Experience so far - from the perspective of my Office - has been that it is taking time for the Service to understand and adjust to the new procedure: in particular, to the role of the convener and the use of independent review panels. The NHS Executives in all three countries have provided guidance on the procedure, as well as training materials and opportunities. That has helped but I believe that the Executives need to monitor carefully how the new system is working and pick up and address aspects where further guidance or clarification is needed.

1.8 I believe that my Office can contribute to improving the working of the new complaints procedure, not only through my investigations and publication of selected cases, but also in other ways. Over the last year my staff have contributed to national and regional training events for NHS staff and for conveners and lay chairmen of panels. I am encouraging my staff to support training and similar activities. I hope that my account of the experience of this Office so far, presented in Chapter 5 of this report, will also be helpful. In consultation with the NHS Executives and other bodies as appropriate, I shall consider during the

course of the coming year whether there are other ways in which I can help to make the new procedure work more effectively.

1.9 My predecessor recognised that for family health service practitioners, in particular, the new complaints procedure and the extension of my jurisdiction together represented a radical development. In April last year he sent to all family health service practitioners and Community Health Councils (in Scotland, Local Health Councils) a special booklet (``A Guide to the work of the Health Service Ombudsman''). Before that his leaflet for the general public had been extensively revised.

1.10 In connection with the extension to his jurisdiction to cover clinical issues my predecessor consulted relevant professional organisations about handling complaints on such issues. Arrangements have been made for my Office to seek professional advice on complaints involving clinical matters from professionals in the NHS. In addition, three part-time medical advisers (two medical consultants and one general practitioner) and one nurse (full-time) have been recruited to my Office, and arrangements made for `in-house' professional advice on general dental and community pharmacy complaints. Some additional administrative staff have also been recruited against the prospect of increased workload arising from my wider jurisdiction. This build up has been gradual because my wider jurisdiction applied only to complaints about events which happened on or after 1 April 1996, and because of the requirement that complainants should seek to have their complaints resolved in the NHS procedure before coming to me. I had no occasion during 1996 - 97 to appoint external clinical assessors to assist in investigations of complaints about clinical judgment.

1.11 It has also, of course, been necessary to deal with the Office's existing workload. I am glad to report that the Office has performed extremely well. 238 investigations were completed. This was nine more than in the previous year, itself a record, and 72 more than in 1994 - 95. My predecessor set himself an objective over the last two years of reducing the length of time taken to complete investigations, and a specific target to have no case more than a year old by the end of 1996. In the end that target was just missed, by three cases. However, this represented a considerable improvement over previous years - there were nearly 100 such cases in August 1995. I am committed to maintaining the figure as close to zero as possible throughout next year, and if possible, to reducing throughput times still further. I also wish in the year ahead to give priority to action which may help to resolve a complaint or to satisfy a complainant. The new NHS complaints procedure is affecting how my Office operates; and there may be more scope for informal interventions falling short of formal investigations. In my next Annual Report I shall give an account of progress in that direction.

1.12 In terms of the number of complaints to my Office 1996 - 97 has also been a record year - 2,219 complaints, 24% up on the previous year. My Office also dealt with 2,207 items of supplementary correspondence, an increase of 30%. Three quarters of all correspondence received a reply within 18 days, compared with under two thirds in the previous year. The average was 14 days, compared with 40 and 22 days in 1994 - 95 and 1995 - 96 respectively.

1.13 More detailed analysis of workload is provided in Chapter 7 together with my forecasts for 1997 - 98. Forecasting in this period of change is particularly difficult.

1.14 During the course of the year my predecessor published two volumes of Selected Investigations, the second of which covered April to September 1996. That report included the first three investigations of decisions made by conveners under the new complaints procedure. A further volume, covering October 1996 to March 1997, is being published at the same time as this report. My predecessor also published two special reports in June 1996. One was on complaint handling by the Salford Royal Hospitals NHS Trust. This followed an unprecedented number of investigations into a single Trust. The purpose of this special report was to help promote better standards throughout the NHS in the administration of complaint handling. Last year, my predecessor reported that he had upheld 90% of complaints to him about complaint handling by health authorities or Trusts. In 1996-97 that proportion rose to 93%. Many of those investigations revealed failings in basic administration similar to those detailed in the special report. The other special report set out my predecessor's findings on five of the complaints about the provision of long term health care which he had investigated since his special report in 1994 on the failure by Leeds Health Authority to provide long term care for a brain-damaged patient.

1.15 Since 1995 this Office has dealt, under the Government's Code of Practice on Openness in the NHS, with complaints from people who have sought information from NHS bodies but been refused access to it. Very few complaints have been made so far. In October last year my predecessor published his first volume of completed investigations of that kind. I refer again to complaints in this area in Chapter 6.

1.16 As a former chairman of a NHS Trust I am very much aware of the heavy pressures on all staff working in the National Health Service. I know of the deep personal commitment which they bring to their jobs, often above and beyond any reasonable call of duty. When `things go wrong' the sense of failure, regret and disappointment is felt within the Service as well as by those who complain. My investigations inevitably add to the burdens and anxieties of staff; and I am grateful for the time and effort they put into helping with them. My Office has an important responsibility, not only to investigate and report on complaints

thoroughly and in a way that is fair to all concerned, but also to help the Service learn from things that go wrong. The co-operation of NHS staff in my investigations is essential for that.

1.17 Finally, I am indebted not only to my predecessor for his work and his leadership of the Office over most of the last year, but also to the hard work and commitment of all my staff, who have contributed to a record of achievement of which they can be justifiably proud. It is a good foundation, on which I hope to build in the year ahead, in which I expect to see further challenges for the Office.

MICHAEL BUCKLEY
Health Service Commissioner

June 1997

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1 Being heard: The report of a review committee on NHS complaints procedures, May 1994 Back

2. INVESTIGATION: MAIN TOPICS

(i) Communication between staff

2.1 The importance of communication has been emphasised repeatedly in previous Annual Reports and I make no apology for returning to it this year. The three cases in this section illustrate that failures by NHS staff to communicate with each other can have very serious effects.

E.1507/94 - 95:

2.2 An elderly man who was admitted to Hope Hospital, Salford, with a suspected heart attack had a short time previously had an eye operation at another hospital. The man's son told nurses at Hope Hospital about that operation; but they made no record of the information and did not pass it on. As a result, other nurses were unaware of it, and when the next night the man fell out of bed no special checks were made of his eyes. A few days later he was found to have restricted vision in his right eye, and despite an operation lost the sight of that eye. Salford Royal Hospitals NHS Trust apologised and agreed to make sure that all information relevant to patients' care was recorded and passed on where appropriate.

E.821/94 - 95:

2.3 An elderly man was taken to the accident and emergency department of King George Hospital, Essex because he was having trouble with his breathing. A doctor ordered drugs to be given in an intravenous drip in order to help the man's breathing and assumed that nurses would set up the drip. However, hospital policy placed responsibility for the administration of such drugs with the medical staff; and none of the nurses in the accident and emergency department was qualified to give drugs intravenously. The drip was never set up. Redbridge Healthcare NHS Trust apologised. Their policy on administering drugs has since changed, and now all registered nurses are trained in giving drugs intravenously. The Trust agreed to make sure that all nursing and medical staff were aware of their respective responsibilities for administering drugs.

E.1504/94 - 95:

2.4 In May 1994 a woman developed an infection in her right foot. She was treated at her GP's surgery, and at home, by community nurses employed by Ravensbourne NHS Trust in Kent. The nurses dressed the woman's foot; but her condition worsened. She was admitted to hospital in June 1994, and part of her right leg was amputated. After a second operation, she died in July 1994. The arrangements for communications were haphazard and poorly implemented. In practice no one assumed responsibility for the patient when the named nurse went on annual leave, and the nursing notes were not transferred to her home. A number of visits were not recorded in the patient's records, and the nurses visiting her had little or no information about her previous condition and treatment. The lack of nursing notes made it difficult for the nurses to plan a sensible treatment regime or to know if there was any change in the condition of her foot. I upheld the complaints about communication between community nursing staff and the maintenance of nursing records. The Trust agreed to monitor the implementation of new procedures for record-keeping and communication between community nurses about patients.

(ii) Record-keeping

2.5 In my investigations I often find examples of poor record keeping. This year I wish to draw attention to two cases where disputes about records compounded the grief of bereaved parents.

E.587/96 - 97:

2.6 A woman's baby was delivered at home by staff of Greenwich Healthcare NHS Trust and then admitted to Greenwich District Hospital, where the baby died the next day. The woman found there was a note in her medical records that she had refused to go into hospital for the delivery. That was not true. When the woman asked for a copy of the records hospital staff told her she would first have to meet the consultant paediatrician. The meeting was not a success: the consultant was preoccupied by concerns that the woman was considering legal action; and she found his manner intimidating. The woman then asked for the record to be amended; and although the Trust accepted that she had not refused to go into hospital it took them almost four months to correct the records. The Trust apologised and agreed to review their arrangements for dealing with

requests for access and amendments to records.

E.1074/95 - 96

2.7 Another case involved the parents of a baby who died after being born very prematurely at King George Hospital, Essex. They were very distressed when they discovered that the death had been recorded as a spontaneous abortion. They wished their baby's birth and death to be registered and had what they described as a heated exchange with a consultant obstetrician and gynaecologist. The consultant refused to amend the record because she understood that any death following a birth of under 24 week's gestation had to be recorded as a spontaneous abortion. However, after hospital staff spoke to the local coroner's office they learned that it was possible to register the baby's birth and death. It would have been prudent to make enquiries of the Coroner's Office at the outset.

(iii) Communication with relatives of dead or dying patients

2.8 The five cases in this section show how failures in communication can compound the distress of relatives of patients who are dying or have died. In one case, matters were made even worse by the Trust's insensitivity in handling the relative's subsequent complaint.

E.965/94 - 95:

2.9 Staff at University College Hospital, London failed to contact a woman whose elderly father became gravely ill and died that night. The next morning it was left to an inexperienced student nurse to break the news to the woman; and the same student nurse had to make arrangements for the woman to view her father's body. There was a delay which might have been avoided if someone more experienced had dealt with the matter. When the woman made a formal complaint the letter of acknowledgment from University College London Hospitals NHS Trust contained a number of errors. A full reply was promised within 20 days but despite reminders - including several by my Office - none was ever sent. The investigation revealed a disgraceful lack of sensitivity to a bereaved relative. The Trust apologised and agreed to improve relevant guidance to staff and to make sure complaint-handling procedures were carried out effectively.

W.26/95 - 96:

2.10 In June 1994, a woman who had been experiencing difficulties in swallowing was diagnosed as having cancer of the oesophagus. She had several stays in Ysbyty Gwynedd Hospital before finally being admitted there, as an emergency, on 21 August. The woman's husband complained that although the diagnosis was confirmed by tests on 27 June he learned about it by chance from a nurse, only a few days before his wife's death on 13 September 1994. I found that doctors and nurses were well aware of the diagnosis, which was noted in the woman's medical records on 5 July, but had not conveyed that to the woman's husband until the nurse referred to it in September. Each had assumed that others had passed on the information, although there was no written record of that being done. I strongly criticised the failures in communication which resulted in the husband being told of his wife's diagnosis in an inappropriate way and two months later than he should have been. In the light of the complaint Gwynedd Hospitals NHS Trust amended an audit checklist to make sure that details of interviews with patients and relatives were recorded. They also issued policy guidance on `breaking bad news effectively'.

E.334/95 - 96:

2.11 A man who was admitted to Frenchay Hospital, Bristol on 20 December 1994 for diagnostic tests into a lung condition died on 2 January 1995. The man's family complained that while he was in the hospital they were given inappropriately encouraging information about his condition including, on Christmas Day, that there was no evidence of malignancy and that the man could expect to be discharged in a day or two. The staff maintained that although biopsies reported on 23 December showed no malignancy it was made clear to the family that doctors remained concerned and that further tests were necessary. An entry in the nursing records, however, after a ward round on 26 December, recorded that the family had been told that the man did not have cancer and that he was to have a test to confirm that. I could not be certain exactly what was said to the family; but in the light of the nursing records, and evidence that the man's consultant had a tendency to be too positive about a patient's prognosis, I concluded that, however inadvertently, the family had been led to believe that the man's condition was less serious than it proved to be. Even before my investigation Frenchay Healthcare NHS Trust had taken steps to improve communication, by encouraging nurses to be present during doctors' consultations and to check that patients and relatives had a clear understanding of prognosis and diagnosis. They had also mounted a series of training courses giving all staff advice on how to give bad news to patients and relatives. Following my investigation the Trust reminded staff of their policy on these matters. I also had cause to criticise post mortem procedures at the Trust (see also paragraph 2.16).

W.34/95 - 96:

2.12 I upheld some aspects of a complaint against Prince Philip Hospital, Llanelli. In January 1995 a nurse telephoned a man to tell him that his mother, who was a patient in the hospital, had died. The man informed other members of the family and contacted a firm of undertakers but about an hour later he was told that the nurse had made a mistake and that his mother was not dead. I discovered that the nurse had telephoned the man after finding no signs of life, but when she returned after that the woman was still breathing. I was told that if a patient's death was expected it was usual for a nurse to inform relatives, but only after a medical opinion had been obtained. Since the incident Llanelli/Dinefwr Trust had made it a policy that nurses should not contact relatives to tell them a patient had died until a doctor had certified death. I recommended that they should issue written instructions about these matters without delay. I also criticised the Trust for failing to make sure that staff were fully aware of procedures relating to the issue of death certificates.

E.1072/95 - 96:

2.13 In September 1995 a woman was taken to the accident and emergency department at 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. He complained that the efforts by St George's Healthcare NHS Trust to trace his mother's next of kin had been inadequate. There was no clearly understood policy about who was 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 details of her next of kin. 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 and should 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 contacting 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. The Trust apologised and agreed to complete their written policy on the arrangements for information about next of kin, and to consider making further efforts to avoid the creation of duplicate records. The Trust were also to agree new procedures with the local police and produce written guidance to staff on action to take if the police were unable to assist.

(iv) Mortuary and post mortem procedures

2.14 Continuing the theme of arrangements surrounding the death of a patient, I set out here two cases where distress was caused by problems concerning mortuary arrangements and (in the second case) a doctor's lack of awareness of the procedure for requesting a post mortem.

E.1275/95 - 96:

2.15 In January 1995 a woman died in Barnsley District General Hospital. Her daughter complained to Barnsley District General Hospital NHS Trust about several matters, including the storage arrangements for her mother's body in the hospital mortuary. The body had been stored unrefrigerated for three days before being released to an undertaker; and the undertaker told the woman's relatives that the body had deteriorated to an extent that it was in an unsuitable condition to be viewed. A hospital consultant pathologist, who was jointly responsible for the mortuary, said that no record was kept of the condition of bodies received in the mortuary unless anything untoward was noted. She explained that the woman's body had been too wide to be placed in a refrigerated cabinet. The body had therefore been covered and laid out in the mortuary's general storage area, which was not refrigerated but was unheated. The consultant pathologist could not recall the state of the body when it was released to the undertakers, but she thought that no undue deterioration had taken place. I was persuaded that the condition of the body did deteriorate in the hospital mortuary, and that the situation was not properly monitored and documented by the hospital staff. The Trust agreed to remind staff of the need to monitor carefully the state of bodies in the mortuary and to contact relatives or undertakers if there were difficulties with storage arrangements which might make it important to ensure that a body was released without delay.

E.335/95 - 96

2.16 In another case involving Frenchay Hospital, Bristol a man died in the intensive care unit (ICU) in January 1995 having initially made good progress after an operation to remove a lung. The ICU consultant asked the man's wife to consent to a post mortem because, although there was no doubt about the cause of death, he thought it would be helpful to obtain the further informatiom a post mortem would provide. The woman learned later, after her husband had been cremated, that no post mortem was conducted. It was not done because the ICU consultant failed to complete the necessary post mortem request form. He had not had to do so before, as most post mortems on ICU patients were requested by the coroner's office, and he was unaware of the proper procedure. I considered his lack of awareness to be unacceptable. Frenchay Healthcare NHS Trust agreed to issue written

instructions about the arrangements for obtaining post mortems to all doctors who might have a need to use the procedure.

(v) Complaint handling

2.17 In 1996 - 97, my predecessor and I have received a large number of complaints where the original grievance was made worse by poor handling of the complaint. This section includes three further examples, one of which involved a sequence of confusion and delays extending over three years.

E.644/94 - 95:

2.18 When a complaint was received by Airedale NHS Trust, a business manager at the Trust obtained comments from staff but then failed to take any further action. The file was put in the wrong place; and arrangements for checking progress broke down. It was over a year before the business manager sent the man a substantive reply; and when he did so it was superficial and inaccurate and was misrepresented as being from the chief executive. The Trust apologised. They had already introduced revised complaint-handling procedures and agreed to keep them under review.

E.447/95 - 96:

2.19 A woman complained in June 1992 about treatment she had received at Pontefract General Infirmary. She received no substantive reply from Pontefract Health Authority, which managed the hospital at that time, until February 1993, a delay of eight months. I found that much of that delay was due to her consultant, who failed to provide his report on her treatment for six months. I also found it unsatisfactory that no holding letters were sent to the woman during that period and that her Member of Parliament was incorrectly told that the Health Authority's investigation into her complaint was at an advanced stage when clearly it was not. In April 1993 the woman asked for her case to be referred for an independent professional review (IPR) under the clinical complaints procedure which applied at that time. Due to confusion about who could refer a case for an IPR, it was a further nine months before her case was referred to the former Northern and Yorkshire Regional Health Authority to consider an IPR.

The woman's consultant did not support the referral; but it was not until October 1994 that it became clear that the Trust did not agree with the consultant's opposition to an IPR. An IPR was eventually held on 24 May 1995, nearly three years after the woman made her original complaint. I strongly criticised the former Pontefract Health Authority and Pontefract Hospitals NHS Trust for their poor administration of this case. I recognised that the delay took place against a background of organisational changes within the bodies concerned but I considered it a disgrace that the woman had to wait so long for her complaint to be resolved. The chief executive assured me that complaints at the Trust were now dealt with promptly; procedures and timescales had been tightened up and he had instituted regular monitoring of progress on complaints.

E.1497/94 - 95:

2.20 In October 1994 a man made a serious complaint to Newham Healthcare NHS Trust about his late father's treatment at Newham General Hospital. After an acknowledgement and some initial correspondence from the Trust he received no substantive reply until April 1995 after intervention by my office. The Trust attributed the delay to the difficulty a consultant had in contacting a locum senior house officer (SHO) who had treated the man's father. However, I found that the consultant had no recollection of seeing the complaint until April 1995, and that he had made no attempt to contact the SHO. I criticised Trust staff for failing to monitor the complaint. Most of the letters sent to the man, including the substantive reply from the chief executive, were addressed to the man's late father which I found to be careless and insensitive. The substantive reply was inadequate in several respects. It contained inaccurate information about the time and date the man's father was admitted to the hospital and it repeated the incorrect explanation that the delay in dealing with the man's complaint was due to difficulty in contacting the SHO. The chief executive also failed to tell the man that he could apply for an independent professional review of his father's treatment under the clinical complaints procedure which applied at that time. I recommended that the Trust should review urgently the man's complaint about his father's clinical treatment. I also recommended that they should review their complaint-handling and monitoring procedures. The Trust agreed to implement my recommendations and apologised unreservedly.

3. CASES OF SPECIAL INTEREST

3.1 Some cases investigated involve significant issues, but do not come under one of the five topics in Chapter 2. In this chapter are cases about policy on resuscitation; policy on funding of incontinence supplies to people living in residential homes; the care received by patients in a private nursing home; mislabelling of test results; a Trust failing to provide treatment for a child because of difficulties in establishing a formal relationship with a doctor; failure to identify and record a private patient; insufficient staff on duty in an accident and emergency department; poor communication between a health authority and local residents; and a dilemma concerning confidentiality.

E.1315/95 - 96:

3.2 A woman died in January 1995 in Eastbourne District General Hospital. Her son complained about several matters, including that the family was not told about a decision not to resuscitate his mother in the event of cardiac arrest. The Trust's policy on `not for resuscitation' decisions stated that relatives were not normally involved in making the decision; but that, where possible and appropriate, relatives should be informed of the decision and why it had been taken. I was not persuaded that the medical staff told the family of the decision which had been taken not to resuscitate the woman in the event of cardiac arrest; and I found that other aspects of the policy were not followed. The Eastbourne Hospitals NHS Trust agreed to remind consultants that it was their responsibility to make sure that all junior staff were aware of - and followed - the Trust's `not for resuscitation' policy. In his Annual Report for 1990 - 91, my predecessor had drawn attention to that responsibility. It was disturbing that lessons had not been learned from the earlier case.

E.1190/94 - 95:

3.3 When national guidance has to be implemented locally, it is important that those responsible for local implementation should act promptly and fairly. Under national guidance, from April 1993 health authorities were required to apply the same criteria with regard to funding incontinence supplies to people living in residential care homes as to those living in their own homes. In June 1993 the proprietor of a residential care home asked Norwich Health Authority (succeeded by East Norfolk Health Authority) about funding for residents of her home. In October the Health Authority told her that funding was available for some, but not all of her residents. The arrangements were not consistent with those for people in their own homes. Although in April 1995 the Health Authority adopted a consistent funding policy, they declined to reimburse the complainants' residents who had paid for their own supplies in the previous two years. I found that the policy which the Health Authority adopted between April 1993 and April 1995 was in contravention of the national guidance and that they had no justification for refusing reimbursement. They apologised and agreed to reimburse the residents' costs.

E.1134/95 - 96:

3.4 My jurisdiction extends to complaints about care provided by private nursing homes if it is funded by the NHS. I investigated a complaint from a woman about the standard of nursing care received by her elderly, infirm husband after he had been transferred from East Hertfordshire Hospital to a new private nursing home. His care there was funded by East and North Hertfordshire Health Authority. I could not establish exactly why the man had developed several sores while in the home, but I concluded that they were a result of inadequate nursing care and that serious administrative failings lay behind that. The record keeping and care planning were inadequate. There were considerable staffing problems in the home at the time, with high turnover, sickness and use of agency and inexperienced unqualified staff. After two staff failed to attend, there had been only two nurses (one unqualified) to care for 30 elderly mentally infirm patients on Christmas Day 1994. 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. The home acknowledged the inadequacy of the nursing documentation. Nursing notes are now audited every three months. The Authority recognised the inadequacy of their monitoring arrangements. They maintained that they now had confidence in the care provided by the home, but agreed to review their contracting and monitoring arrangements further.

E.1312/95 - 96:

3.5 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 Hammersmith Hospitals NHS Trust that the growth removed during the first operation had been mislabelled with the details of another patient, who had 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. I found that several opportunities were missed to identify the problem much earlier. The label and form accompanying the specimen should have been checked in the operating theatre. The apparent lack of a test result for the man should have been noticed when his care was 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 until the family complained in September, no one took responsibility for giving the man a full explanation of the mistake or for taking action to avoid any repetition of the problem. 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 the arrangements for reviewing test results. They also agreed to remind staff of their responsibilities when such errors were discovered.

E.1344/95 - 96:

3.6 I investigated a complaint concerning a child who was referred for a food absorption test by a consultant at Chelsea and Westminster Hospital. 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 Chelsea and Westminster Healthcare NHS Trust. The child attended an appointment for the test in December 1995. He had taken no food or drink for 17 hours when the test was cancelled at 5.00pm without warning. The child's mother also complained that her son was not given a new appointment date for the test - despite assurances by the Trust's chief executive that he would arrange that. My investigation revealed that there was a complex relationship between the Trust and the doctor who headed the unit: the Trust had been trying to formalise the relationship since August 1995. They set a list of conditions which the doctor had to meet for the Trust to continue to allow their consultants to refer patients. The Trust had offered the child an appointment before their relationship with the doctor had been formalised. I found it disgraceful that differences between the principal players caused the child's test to be cancelled at such a late stage. In my view the test should not have been cancelled, since the appointment had been offered and there were no financial or clinical reasons to prevent it going ahead. I also found that although the doctor from the unit had an honorary contract with the Trust for a period of time, the Trust had failed to offer the child a new appointment while it was administratively possible to do so. The Trust apologised and agreed to make every effort, with the complainant, to resolve the impasse over her son's test, including considering alternative provision.

E.934/94 - 95

3.7 A woman complained about treatment her late husband received in November 1992 at Farnborough Hospital. She was told by Bromley Hospitals NHS Trust that she could apply for an independent professional review (IPR) of her late husband's treatment, under the clinical complaints procedure operating at the time; but the regional health authority told her she was not eligible for an IPR because her husband had been a private patient. The woman contended that although he had been admitted as a private patient, in fact he had received treatment under the NHS because private charges had been waived and he had been accommodated in a NHS ward. My investigation showed beyond doubt that the man had been admitted as and treated as a private patient. He had signed an `undertaking to pay' form on admission; but confusion had arisen because private charges for his treatment and accommodation had been waived after his death. I recommended that the Trust review their complaints procedure to make sure that it was in line with current national guidance and, particularly, that it was clear about complaints from private patients. I was particularly concerned that the consultant anaesthetist who had treated the man was unaware that he was a private patient; there was no indication of the man's status in his medical records. I found that to be unsatisfactory and pointed out to the Trust that a handbook about private practice issued by the Department of Health and Social Security in 1986 required a mechanism to be in place to identify private patients. The Trust agreed to implement such a mechanism and also to make sure that all relevant staff were aware of, and understood, the provisions relating to private practice set out in the handbook.

E.379/95 - 96:

3.8 As part of their training, junior doctors change appointments throughout the country every six months. They usually move to different hospitals. This investigation highlighted the responsibility of individual NHS trusts to make sure that effective arrangements are in place on such `changeover' days. On 1 February 1995 (which was a `changeover' day) a man attended the accident and emergency department (A and E) at Hillingdon Hospital with acute abdominal pain; but he had to wait in a cubicle for about eight hours before he was admitted to a ward. I considered the delay to be excessive; and I had no doubt that while waiting the man suffered pain and discomfort. The delay mainly resulted from a failure by A and E staff to contact a member of the on-call surgical team. That was due, in part, to the on-call surgical senior house officer having left the hospital as part of the six-monthly rotation programme before his replacement had arrived. The Hillingdon Hospital NHS Trust agreed to review their

arrangements to make sure that appropriate clinical cover was always provided. They also agreed to remind staff about the procedure for calling more senior medical staff when difficulties arose. My predecessor drew the issues raised by this case to the attention of the Chief Medical Officer for England at the Department of Health.

E.1144/95 - 96

3.9 One case concerned the lack of consultation with neighbours about the intended use of a property to accommodate mentally ill residents. Warwickshire Health Authority were providing some of the funding to a voluntary organisation which was managing the scheme. In May 1995, after a similar complaint about the Authority to my predecessor, they had introduced a policy that local residents would be kept informed where a decision was made to proceed with the purchase of a property intended for such use. The Authority intended the policy to apply where they provided funding to other organisations. The complainant had become aware of the intended use of the property after furniture was delivered there in July 1995 - eight days after the house had been purchased. The Authority expected the voluntary organisation to consult in line with the policy but had failed to make sure that the organisation knew that. The organisation intended to contact neighbours later. I upheld the complaint and expressed my dissatisfaction that another case had arisen with such similarities to the previous one. It was possible to place various interpretations on the policy, on my predecessor's recommendations, and on views expressed when the previous case was discussed by the Parliamentary Select Committee which oversee my work, about exactly when residents should be informed about such schemes. I do not believe that trying to define that further would be helpful. The point is that residents should be informed in time for their views to be taken into account when operational arrangements for the scheme are considered - it is not to give them a right to veto the scheme's going ahead. In this case efforts should have been made to inform the residents before the furniture was delivered, as that was bound to give rise to questions about the property's use. The Authority revised their policy in May 1996 and sent it to all relevant agencies.

E.98/95 - 96:

3.10 A woman complained that in November 1994 a health visitor employed by Wirral Community Healthcare Trust breached confidence by discussing her 19 month old son with his childminder. The Trust replied at first that the health visitor's actions were correct and described the childminder as being `in loco parentis', that is, in place of the parent. I found that description misleading in two respects. First, the childminder had not taken the child to be seen at a clinic in the absence of one of his parents, but was accompanying a friend there when she spoke to the health visitor. Second, even if the childminder had accompanied the child to an appointment she would not have been acting `in loco parentis'. This was made clear in guidance from the social services department, with which the Trust did not seem familiar; and I criticised them for that. The health visitor was in a difficult position when approached by the childminder to discuss the child's development. I did not criticise her for listening to the childminder's concerns; but she did merit criticism for passing on information to the childminder which was effectively part of the medical records.

4. CASE SUMMARIES AND REMEDIES - General

4.1 This chapter gives a brief summary of all the complaints which I investigated this year, whether or not they were upheld. My purpose in doing so is to show what problems and difficulties can arise when delivering an effective health care service. The summaries therefore emphasise shortcomings I have identified and the remedies that were recommended.

4.2 I rarely recommend financial redress for complaints but do so where here has been an identifiable loss or cost as a direct result of maladministration. In 1996 - 7 I made 5 such recommendations.

4.3 This year I have listed the cases in alphabetical order of the NHS body complained against. Where that body has been superseded since the time of the complaint, the name given is that of the sucessor body. Although many of the cases summarised in this chapter were reported on by my predecessor I have used the first person singular throughout to denote the holder of my office.

4. CASE SUMMARIES AND REMEDIES - A - C

Addenbrooke's NHS Trust, Cambridge

E.932/95 - 96

I did not uphold a complaint that there was an unnecessary delay in arranging a young woman's outpatient appointment between November 1994 and June 1995 following a general practitioner's (GP's) referral. I found that the referral was, unusually, considered inappropriate by a consultant and that his decision could have been communicated more clearly to the (GP). A receptionist who had not known the consultant's decision, told the young woman's mother that an appointment had not been made while the consultant was considering the young woman's clinical priority. Guidelines on the service provided by the Trust given to the GP by the consultant misled the GP into making a second referral to another consultant. The Trust apologised and agreed to consider improving the information available to staff dealing with telephone enquiries, and to review the guidelines to prevent future misunderstanding.

E.936/95 - 96

I upheld a complaint about the Trust's unsatisfactory handling of a woman's complaint, made in July 1995, about the Trust's failure to arrange a referral to a second hospital in May 1994. When the woman sought a meeting with relevant staff to discuss her complaint the request was ignored. In the course of my investigation I found that a new complaints procedure, introduced in November 1995, was inadequately monitored. Trust Board to consider my report and, with the chief executive to take an active role in monitoring the complaints system.

Aintree Hospitals NHS Trust

E.101/94 - 95

A woman was inadequately counselled before undergoing sterilisation, particularly about the possible risk of failure. When her consultant was advised that the procedure had failed he contacted her neighbour instead of either approaching her directly or contacting her GP and, when she subsequently complained, the handling of her concerns lacked sensitivity. I found the complaint about the counselling not made out but I upheld the other two aspects. The Trust agreed to revise its leaflet on sterilisation to include information about the rate of failure, and to advise complainants attending meetings about complaints that they can be accompanied if they wish by a friend or relative.

E.1301/94 - 95

I did not uphold a man's complaints about his elderly mother being left on a commode for too long in October 1994, or about a fall which he had been told had happened when his mother was being lifted from the commode. I found that the woman had not fallen, but, while being lifted on to the commode, had been lowered to the floor when nurses could not safely complete the move. I upheld the man's complaint about the Trust's handling of his complaint only to the extent that careless errors in letters about the timing of the lifting incident caused unnecessary confusion. I did not uphold a complaint that the ward manager's response to the man's concerns was inappropriate.

E.1171/96 - 97

I upheld a man's complaint that a convener had exceeded his responsibilities in considering a request for an independent review of the man's complaint against Aintree Hospitals NHS Trust. The man's brother died at Fazakerley Hospital in July 1996 while taking part in the clinical trial of a new drug designed to alleviate his condition. The convener undertook further research and an investigation to provide a clearer explanation of the events complained about instead of asking the Trust to do this as part of local resolution. I was satisfied that the convener had acted with the best of motives and had no reason to question either his findings or his conclusions that an independent review was not appropriate in this case. Trust to remind its conveners of the need to act within the guidance and not to try to resolve a complaint themselves.

E.644/94 - 95: Airedale NHS Trust

A man complained in June 1993 about the circumstances of his mother's death at Airedale General Hospital. He received a response in July 1994 which he did not feel dealt adequately with all his concerns. I criticised the long delay in replying and found that the reasons the Trust gave the man, and me, for the delay were spurious. The Trust did not obtain evidence from all relevant staff before sending the reply to the man and they failed to inform him of the steps he could take through the clinical complaints procedure if he remained concerned about clinical aspects of his mother's treatment. Trust to review effectiveness of complaint monitoring arrangements and of the chief executive's role in complaint handling.

S.108/95 - 96: Argyll and Clyde Health Board

I did not uphold a woman's complaint that inadequate arrangements were made for an independent professional review, held in June 1995, into her mother's treatment while in hospital. I found that the independent assessors followed proper procedures when deciding which witnesses they needed to see. I made no finding on a complaint that her mother's temperature charts should not have been destroyed because, under the relevant guidance at the time, whether they needed to be retained was a matter of clinical judgment.

E.746/94 - 95: Barnet Healthcare NHS Trust

A woman complained about her late mother's hospital treatment. I did not uphold her complaint that because her mother was unable to give consent, a drug should not have been given by doctors. That decision was the legal responsibility of doctors to take. I did not uphold or made no finding on complaints that her mother was refused access to a commode, did not receive a bath or hair-wash, and was given no help to eat and drink. Staff to be reminded of national guidance on discussion of treatment with patients and relatives.

E.209/95 - 96: Barnsley Community and Priority Services NHS Trust

A woman complained that the Trust lost some of her father's nursing records covering a period in 1995. I upheld the complaint and criticised the Trust's policy on the storage of records. Trust to review the policy along with the practical arrangements for security of records.

E.1275/95 - 96: Barnsley District General Hospital NHS Trust

I did not uphold a woman's complaint that in early 1995 medical staff at Barnsley District General Hospital failed to communicate adequately with relatives about the condition of her mother. The woman's mother died in the hospital. I also did not find made out a complaint that nursing staff did not explain that the policy on visiting hours could be applied flexibly. However, I upheld further complaints that the mortuary procedures for storage of the body were unsatisfactory; and that the Trust dealt inadequately with the woman's complaint about a breach of confidentiality. Trust 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 are difficulties about storage arrangements. 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.

E.93/96 - 97: Blackpool Victoria Hospital NHS Trust

I upheld a woman's complaint that, after her partner died in the hospital in April 1995, the Trust failed to safeguard his clothes and other personal effects. I also strongly criticised the inadequacy of the Trust's investigation about that matter. I did not uphold her complaint that the Trust acted unreasonably by refusing to release his valuables to her until after her solicitors became involved. Trust to review procedures for safeguarding property of deceased patients and to remind staff that complaints must be thoroughly investigated.

E.884/96 - 97: Berkshire Health Authority

I upheld a complaint made in April 1996 that the Health Authority's convener did not follow the NHS complaints procedure in refusing to grant an independent review of a woman's complaint about a general practitioner (GP) including the decision to remove the woman's mother from the GP's list. The convener failed to set out clearly in writing the reasons for her decision, and did not write personally to the complainant, but left that to the Health Authority's complaints manager. The Health Authority apologised and agreed to make sure that conveners put into practice the national guidance by explaining fully in letters to complainants the reasons for their decisions. Health Authority agreed to draw to the attention of the GP's practice the Commissioner's view that it is good practice for GPs to give a clear and honest explanation when removing a patient from their list.

E.1057/95 - 96: Bethlem & Maudsley NHS Trust

In November 1994 a man complained to the Trust about the conduct of a doctor at a psychiatric consultation. In March 1995 the Trust replied to the man but he remained dissatisfied and, as he did not want to attend a meeting at the Trust, asked for written answers to his remaining concerns. When the Trust insisted that they would only deal with his complaint through a meeting, the man complained to me about the Trust's handling of his complaint. I found that the Trust's arrangements for monitoring the handling of the man's complaint were ineffective and as a result he had to wait four months before he received a reply to his initial complaint. I also found no justification for the Trust making the man's attendance at a meeting a condition for a response and I criticised their failure to provide a full written reply as he had requested. I recommended that the Trust Board make sure that under new complaints procedures all staff understood their responsibilities, full replies were provided wherever appropriate and monitoring arrangements were sufficiently robust.

E.1063/94 - 95: Birmingham Health Authority

A woman complained about the care and treatment which her mother received when she was admitted to Selly Oak Hospital in December 1993. After three further admissions her mother died in the hospital in April 1994. She complained that her mother had received inadequate nursing care, that there were undue delays in providing test results and that the hospital refused the family's request to transfer her mother to a hospital nearer to their home or to discharge her home. She further complained that staff did not provide an adequate explanation why her mother was moved from a side ward into the main ward and that the South Birmingham Health Authority was slow in replying to her letter of complaint. I upheld one part of the complaint about nursing care and the complaint about delay in replying to the letter of complaint. I could make no finding about the delay in providing test results and I did not uphold the other parts of the complaint. The Trust have undertaken to make sure that complainants receive full and prompt replies and to monitor closely the effectiveness of their new complaints system.

E.1135/95 - 96: Bishop Auckland Hospitals NHS Trust

I found that the Trust failed to inform a man that a meeting to discuss his complaint had been cancelled in time to save him a wasted journey. I partly upheld his complaint that the Trust had not answered all the points he had raised in his complaint made to them in April 1995. Trust to remind staff of the importance of making sure that complainants are given notice of cancelled meetings and that replies to complaints cover all points raised.

Bradford Hospitals NHS Trust

E.431/95 - 96

I upheld a woman's complaint that the arrangements for her 84-year-old mother's discharge from the accident and emergency department in February 1995 were inadequate. I found that the Trust's response to her complaint, following meetings with her, was unsatisfactory and lacked detail about action to prevent recurrences of the incident. Trust to keep records of meetings with complainants.

E.975/95 - 96

A woman and her husband complained that when they attended a trauma-clinic with their two-week-old daughter in January 1995, the consultant was rude and dismissive to them on the two occasions when they met him. Because of conflicts in evidence I was unable to make a finding on this aspect of the complaint. I upheld a complaint that the Trust's reply did not cover the couple's concerns adequately. I upheld a complaint that the Trust failed to arrange a meeting with the consultant despite requests to do so to the limited extent that they did not consider alternative ways of allaying the parents' concerns. Trust to remind staff of the importance of giving full replies to complainants.

Bromley Hospitals NHS Trust

E.934/94 - 95

I found that a woman had been given misleading information about whether her late husband's treatment at Farnborough Hospital in November 1992 could be considered by an independent professional review under the NHS clinical complaints procedure in operation at the time, even though it was alleged that the treatment was private. Trust to review their complaints procedure; make sure all relevant staff are aware of the handbook on dealing with private patients and to introduce a system so that medical records clearly show if a patient is receiving private treatment.

E.573/96 - 97

I upheld a complaint that the Trust's convener did not follow the NHS complaints procedures in deciding in July 1996 not to

grant an independent review of the complainant's grievances about the appropriateness of his diagnosis, arising from an incident in September 1995, and the Trust's handling of his complaint. The convener failed to tell the complainant whether he had taken appropriate clinical advice or whether he had consulted an independent lay chairman and failed to tell the complainant of his right to complain to the Health Service Commissioner. No reasons were given for refusing the independent review. Trust to review the convener's decision in the light of the requirements of the new complaints procedures and to make sure that they follow the guidance in future.

E.40/96 - 97: Calderdale Healthcare NHS Trust

I upheld a man's complaint that the Trust failed to safeguard a ring belonging to his elderly mother. It was lost in December 1994 after being removed before an operation. I found that proper procedures for safeguarding property had not been followed and that the Trust had not adequately investigated or explained the loss when a complaint was made. Trust to make sure that staff follow property procedures and to make an ex gratia payment.

Camden and Islington Health Authority and University College London Hospitals NHS Trust

E.883/94 - 95

A man who in November 1993 had two mechanical heart valves inserted at the Middlesex Hospital complained that he was not warned before the operation that the valves would vibrate and make a noise and that the hospital's response to his representations about that had been dilatory and unsatisfactory. Until 31 March 1994 the health authority administered the hospital, since that date it has been the responsibility of the Trust. I found that it was not made sufficiently clear to the man before his operation that the heart valves would make a noise. The Trust failed to undertake a proper investigation of the man's complaint and their response to him was delayed, incomplete and contained inaccuracies. Medical staff to be reminded of the importance of ensuring patients receive and understand all relevant information before being asked to consent to treatment. Trust Board to ensure that their arrangements for monitoring complaint-handling are adequate.

E.1352/94 - 95

During late 1993 and early 1994 a woman received ante-natal care at University College Hospital. She complained that the consultant did not give her an adequate explanation of her treatment, in particular about the side effects of an iron supplement he had prescribed and when she complained he was dismissive and intimidating. He later sent a letter, addressed to her, to her GP but did not provide her with a copy. The Trust failed to provide adequate information about how clinical complaints could be handled and failed to respond to the woman's request for a meeting with a member of the complaints panel. I did not uphold the complaint about the consultant's failure to give an adequate explanation of the treatment provided but I criticised him for his approach in dealing with her concerns about the iron supplement and for not giving her a considered reply. I recommended that the Trust check that they meet the requirement in the new procedure to inform complainants what they can do if they wish to take a complaint further, review their practice concerning meeting with complainants and provide the woman with a copy of the letter addressed to her.

E.926/94 - 95: Canterbury and Thanet Community Healthcare NHS Trust

A man complained about his daughter's care in a residential home managed by the Trust, in June 1994. I upheld complaints that: nursing staff were not adequately informed about the daughter's condition; her records were not adequately maintained; she was left for some time in hot sunlight causing her distress; and the Trust's responses to the man's complaint were inadequate. Trust to issue guidance on the completion of clients' records and accident report forms; to remind staff of the need for attentiveness and prompt action when a patient may be dependent on them for help and to remind staff to give full written explanations of all issues raised when dealing with complaints. I did not uphold the man's complaints that staff could not say who was in charge at the home or that an accident report form was completed in such a way that it appeared erroneously as a contemporary record.

Chelsea and Westminster Healthcare NHS Trust

E.886/95 - 96

A woman complained about a senior registrar whom she saw on 14 and 31 July 1995 at Chelsea and Westminster Hospital. On the first occasion, the woman complained that, while talking to a student on an unrelated matter, he used offensive language. He also did not make it clear to her why she needed a brain scan. Her third complaint was that, on 3 July, he interrupted her during a conversation and tried to intimidate her. I Upheld the first complaint and the second, to the extent that the woman did not know why she needed a scan. I found that, during the conversation on 31 July, both sides were preoccupied with putting their point of view across. I did not find that the senior registrar was attempting to intimidate the woman but I upheld the complaint to the

extent that the senior registrar did interrupt her and should have handled the conversation with greater sensitivity.

The woman met the chief executive on 8 August and, following an investigation of the case, he wrote to her on 14 September. She was not happy with that letter and continued to correspond with the Trust but remained dissatisfied. Although the woman's letters were answered promptly there were several flaws in the investigation of her complaints and there was no investigation of the events of 14 July. The woman's complaints could and should have been swiftly resolved at local level. Complaint upheld. Trust to ensure all complaints are fully and promptly investigated.

E.1344/95 - 96

I upheld a complaint about the cancellation without warning in December 1995 of a child's food absorption test after he had been allowed no food or drink for 17 hours. The child had been referred to the Vitamin B12 unit (which is not a service provided by the Trust) by a consultant at Chelsea and Westminster Hospital. The Trust had been in discussion with the unit since August 1995 and had set conditions which were to be met by the unit if the Trust's consultants were to be allowed to continue referring patients. The Trust did not resolve their concerns before giving the child an appointment for the test. I considered that once the appointment was offered there were no financial or clinical reasons to prevent it going ahead, and it should not have been stopped. The Trust also failed to offer a new appointment during the period when it was still administratively possible to do so. I did not uphold a complaint that the Trust gave conflicting explanations to the complainant: the explanations given had changed as events developed. Trust to make every effort, with the complainant, to resolve the impasse over the child's test including consideration of alternative provision.

E.1465/94 - 95: City Hospitals Sunderland NHS Trust

I did not uphold a woman's complaint that her aunt was not offered assistance and had to rely on help from other patients when she attended Sunderland District General Hospital's accident and emergency department and fracture clinic in January 1995. I made no finding on the woman's complaint that inappropriate discharge arrangements were made for her aunt, who was aged 82 and lived alone, although I criticised the staff involved for the inadequacy of their records in that respect. Trust to remind staff of their discharge policy and the relevant Department of Health circular and of the need to document the assessment process.

Croydon Health Authority

E.1348/95 - 96

A man complained, through his Member of Parliament, that in August 1995 Croydon Health Authority refused unreasonably to continue funding treatment which he had been receiving at Maidstone Hospital for some years. That action was contrary to the Authority's own policy on extra contractual referrals, and I upheld the complaint. The Authority agreed to reverse their decision and to review other, similar cases.

E.859/96 - 97

I upheld a complaint that a convener did not follow the guidance on the NHS complaints procedures in deciding not to grant an independent review of a man's concerns. The man complained about various aspects of the assessment of his clinical condition in May 1996 by his former general practitioner (the GP). I found that the convener did not take all reasonable steps to consider whether a review panel would resolve the conflicting accounts given by the man and the GP. In particular 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. The clinical adviser to the convener did not see the man's medical records. I thought it a matter of self-evident good practice that such an adviser should see the medical records. The convener also failed to address all the man's concerns. I upheld a second complaint that the convener failed to explain correctly to the man the NHS procedures in respect of access to his health records. Health Authority to reconsider the decision of the convener.

4. CASE SUMMARIES AND REMEDIES - D - F

E.625/95 - 96: Dartford and Gravesham NHS Trust

A man complained that when he attended hospital with a broken arm in January 1995, he was left in a cold cubicle without the means to keep warm, had an unreasonable wait before he was given pain relief and was handled unnecessarily roughly by a nurse who applied plaster. He said that staff were rude and unhelpful, and that the Trust's replies to his complaints were delayed and incomplete. I did not find the complaint about waiting in the cold made out, and did not uphold the complaints about the delay in pain relief, about rough handling or about rudeness. I upheld the complaint about unsatisfactory complaint handling by the Trust. Trust Board to continue to monitor the quality and timeliness of their responses to complaints and make sure that complainants receive holding replies where appropriate.

W.66/95 - 96: Derwen NHS Trust West Wales

I upheld a woman's complaint that her husband had unreasonably been refused respite care in Bryntirion Hospital, Llanelli on two occasions in December 1994. I criticised the charge nurse of the ward in question for being unhelpful in his response to enquiries by a general practitioner and a casualty doctor about the man's admission. Staff to be reminded to seek medical advice when appropriate. I found, also, that the Trust's handling of the woman's complaint was inadequate in that they had failed to provide accurate information about the complaints procedure or to fulfil promises made at a meeting. Information now to be provided, and staff dealing with complaints to be reminded of the need to make sure that all of a complainant's concerns are fully addressed. Trust to agree and record action to be taken after a meeting with a complainant.

Dewsbury Health Care NHS Trust

E.1278/94 - 95

A man complained to the Trust in June 1994 about his son's treatment. Despite making several requests, he did not receive an adequate written reply nor did he receive written confirmation of what was said during a meeting between him and his son's consultant. I upheld his complaint that the Trust's handling of the matter was unsatisfactory. I also partly upheld a complaint about the maintenance of the son's medical records because, although they were generally well maintained and complete, medical staff did not make full notes of three outpatient appointments. Staff to be reminded of the need to make sure that all complaints are adequately addressed and to record significant conversations with relatives.

E.443/96 - 97

I upheld a complaint that the Trust's convener did not follow the NHS complaints procedures in deciding in May 1996 not to grant an independent review of the complainant's grievances about the lack of availability of suitable therapeutic counselling. The convener failed to: set out clearly the reasons for her decision; take appropriate clinical advice; and tell the complainant of her right to complain to the Health Service Commissioner. Trust to review the convener's decision in the light of the requirements of the new complaints procedures and to make sure that staff and conveners follow the national guidance.

E.494/95 - 96: Dorset Community NHS Trust

In January 1995 a district nurse refused to help lift a man who had fallen to the floor shortly before her visit. The man later asked the Trust if the nurse had acted correctly. I found that the Trust's replies took too long, contained inaccurate information and, although they indicated that the nurse had acted in accordance with manual handling regulations, were unclear about what alternative action should have been taken. Trust to make sure that all complaints are dealt with in accordance with their complaints procedure.

Dudley Group of Hospitals NHS Trust

E.161/94 - 95

I did not uphold a man's complaint that in April 1993 his father, while an inpatient, had waited unattended in a lavatory for 30 minutes, although there was evidence he had fallen. Nor did I find that the father's request for physiotherapy went unheeded, as

he was given help with mobilisation. I criticised staff of the Trust for failing to organise domiciliary care before the father was discharged from hospital, but did not find that the family were given conflicting advice about the side effects of his medication. There were failures in the handling of the family's complaint about their father's care, but the Trust had since reviewed their complaints procedures. Trust to review discharge policy and remind staff of their duties under that policy.

E.410/95 - 96: Dudley Group of Hospitals NHS Trust

I upheld a man's complaint that the care his wife received one night in August 1994 was inadequate because there was no evidence that the observations required by her care plan were carried out. I made no finding on a complaint that nursing staff failed to act to relieve the woman's pain. Trust to remind medical and nursing staff of the importance of following care plans and recording the action taken. I found that the Trust's handling of the man's complaints was dilatory and unsatisfactory. Trust Board to ensure that new procedures for handling complaints, introduced by the Trust following my recommendations in another case concerning them, result in speedy and thorough investigations of complaints. Trust also to monitor the effectiveness of improvements made to their storage arrangements for patients' records.

E.255/94 - 95: Dudley Health Authority and The Dudley Group of Hospitals NHS Trust

I did not uphold a complaint that inadequate care and attention and a failure to provide call bells led to the complainant's father suffering four falls while in hospital between December 1993 and June 1994. I considered that, due to poor communication between staff, there was some lack of urgency about providing the man with pain relief after the first of his falls. Apart from that I did not uphold complaints about failures in his nursing care.

Dundee Teaching Hospitals NHS Trust

S.102/94 - 95

A woman complained that after her late father's operation in February 1994 nurses did not encourage or assist him to eat, although his consultant said that getting him to eat was a priority. I did not uphold the complaint because I was satisfied that the nurses paid particular attention to the man's nutritional state and that they gave him a great deal of support and encouragement.

S.15/95 - 96

I made no findings on a woman's complaints that after her mother's admission to Ninewells Hospital, Dundee on in February 1994 there was a delay of four days before she was seen by a consultant and a scan was delayed. I found that the decisions taken on those issues were matters of clinical judgment. However I partly upheld a complaint relating to delays in providing pain relief. I also found that the Trust's handling of the complaint was dilatory, their replies were inadequate and the copy of her medical records which they supplied to the woman was incomplete. Trust to amend their complaints procedure to make it clear that the chief executive is personally responsible for signing replies to complaints or sending a covering letter, to remind staff to adhere closely to the procedure; and to offer the woman an opportunity to examine her records and obtain a copy of any outstanding documents.

E.308/95 - 96: Ealing, Hammersmith and Hounslow Health Authority

I did not uphold a woman's complaint that proper consideration was not given to her request for an extra-contractual referral for anorexia treatment at a private clinic in October 1994 and that adequate alternative treatment was not offered. I upheld a complaint that the Authority's reply to a letter from her MP was inadequate and misleading. Authority to reimburse the woman for the cost of attending an initial assessment at the clinic and give unsuccessful applicants for ECRs written reasons for refusal.

Ealing Hospital NHS Trust

E.772/95 - 96

I did not uphold a man's complaint that his wife had experienced an excessive wait in the accident and emergency department (A and E) at Ealing Hospital in August 1995, but I found that communication with the man was inadequate to the extent that he had been told incorrectly that the Trust were waiting for a bed to admit his wife. I did not find that the Trust's response to the man's complaint was selective or inaccurate. Trust (and relevant health authority) to review and update information available to patients on charter standards in A and E.

E.1055/95 - 96

A woman complained that her husband had to wait an hour and a half to be seen in an outpatient clinic and was then refused a

proper consultation. She also complained that the Trust's response to her complaint failed to answer her questions satisfactorily and contained inaccuracies. I made no finding on whether a consultation was refused but upheld the complaint in respect of the wait to be seen and the Trust's response. Trust to remind staff of the importance of making full records of consultations with patients and to make sure that its replies to complaints deal adequately with all points put.

W.44/95 - 96: East Glamorgan NHS Trust

A woman complained about the nursing care her husband received in East Glamorgan General Hospital during April and May 1995. I did not uphold complaints that her husband failed to receive adequate nourishment because of a lack of attention from staff; that full vomit and urine containers were left by his bedside; or that the level of staffing in the ward was inadequate. I partially upheld a complaint that medication should not have been left on the man's bedside locker. Trust to review their drug administration procedures to make sure that nursing practice in the administration of drugs is consistent.

E.1195/95 - 96: East Gloucestershire NHS Trust

A man complained to the Trust that following an operation on his hand at Cheltenham General Hospital on 31 January 1995 he still had limited flexibility in his fingers. He was not satisfied with the explanation provided by the Trust and complained that their investigation had lacked thoroughness. I partly upheld the complaint on the grounds that the Trust failed to offer the man a meeting to discuss his concerns and their reply to him did not did not respond to all the points he raised. Trust to review their complaints procedure to make sure that all aspects of complaints are addressed and that, where possible, complainants are offered a meeting to discuss their grievances.

E.1134/95 - 96: East and North Hertfordshire Health Authority

I upheld a complaint from a woman that, because of inadequate nursing care in late 1994, her husband developed sores on his toes, both knees and hip in a private nursing home where his care was funded by the Authority. Although my investigation was not able to establish exactly how her husband acquired the sores, I concluded that they were a result of inadequate nursing care and that serious administrative failings lay behind that : an inadequate level of record keeping and care planning, considerable problems with staffing in the home, the rapid rate of admission of residents and the inadequacy of the Authority's monitoring arrangements.

E.1190/94 - 95: East Norfolk Health Authority

The proprietor of a residential care home complained that between June 1993 and November 1994 the Health Authority were dilatory in replying to enquiries and complaints about the funding of incontinence supplies to her residents. She also complained that the Health Authority were unreasonable in refusing to reimburse her residents for the cost of incontinence supplies in a two year period from April 1993. I found that there were repeated delays and failures by the Health Authority in acknowledging and replying to several letters received from the complainant, her MP and her solicitor. A substantive response was finally sent only because she made enquiries through the Department of Health. The Health Authority have now changed their procedures for handling enquiries and complaints. I also found that the Health Authority's policy from April 1993 until 1995 of funding incontinence supplies for some but not all persons in residential homes contravened the national guidance. The Health Authority agreed to reimburse the costs incurred by residents of the complainant's home.

E.479/95 - 96: East Somerset NHS Trust

I upheld a complaint against East Somerset NHS Trust that, in May 1995, a six-year old boy waited for 40 minutes in the accident and emergency department of Yeovil District Hospital before his priority for treatment was assessed. Responsibility for assessment of patients to be clearly defined and procedures to be reviewed so that no patient is overlooked.

E.1119/94 - 95: East Surrey Health Authority

In September 1994 a woman sustained a broken hip while she was an inpatient at West Park Hospital. Her husband complained that a letter from the chief executive about the cause of the injury was at variance with information from staff at another hospital where the injury was treated, and failed to reassure him that a thorough investigation had been carried out. I upheld the complaint to the extent that a thorough investigation had not been carried out. Trust agreed to remind staff of the need to conduct thorough, well documented investigations which include comprehensive statements from all key witnesses involved.

East Surrey Healthcare NHS Trust

E.72/95 - 96

I found shortcomings in aspects of a man's nursing care while he was in hospital in mid-1994, and that the Trust's response to his wife's subsequent complaint was dilatory and unsatisfactory. Trust to remind medical staff of prescribing guidelines; nurses to be reminded of the importance of preserving patients' dignity and of maintaining and safeguarding full and accurate records of patients' care; written referrals to district nurses to describe fully problems which require their attention; transport arrangements to be revised; complainants to be kept informed of the progress of their complaints and prompt action to be taken to address any identified shortcomings.

E.1465/95 - 96

I did not uphold a woman's complaint that on 1 February 1996 her father experienced an unreasonable wait in the accident and emergency (A&E) department of East Surrey Hospital before being moved to a ward. Although the ward was designed as a five day stay ward, the Trust decided to keep it open that weekend. However, I found that the staffing and domestic arrangements were unsatisfactory. I also upheld the woman's complaint that there was unacceptable delay before her father was given pain relief, but I made no finding on her further complaint about a bladder wash out procedure. Trust to remind staff of the need to complete A and E records properly and to issue guidelines to senior nurse managers on their responsibilities for arranging staffing for a ward which is kept open at short notice.

E.777/94 - 95: East Sussex, Brighton and Hove Health Authority

I upheld a complaint that the Health Authority took too long to process and approve an extra contractual referral made in November 1993 for a woman's dental implant treatment. I found that it was unreasonable that the Health Authority decided their policy for such referrals only in September 1994 and did not approve the woman's treatment until October 1994. The woman was given misleading and contradictory information during her wait for a decision. The Health Authority have taken steps to ensure decisions are taken more quickly in the future. Performance of staff involved in handling complaints to be monitored carefully.

Eastbourne Hospitals NHS Trust

E.1315/95 - 96

In January 1995 a woman was admitted to Eastbourne District General Hospital where she later died. Her son complained about aspects of her care and treatment. I found that there were no structures in place to make sure that the woman received adequate amounts of fluids and in general that the care which the woman received was not fully and properly recorded. Because of inadequate documentation, I was unable to make a finding on the complaints about the frequency of the nursing observations and that a doctor's specific instruction in relation to that was not followed. I upheld the son's complaint that staff did not tell the family of a decision which had been taken not to resuscitate his mother in the event of cardiac arrest. Trust to give guidance to staff about the monitoring of fluid intake for patients who are sedated, drowsy or confused; to remind staff of the need to make full records about fluid intake; to issue written instructions about their responsibilities for recording care given to patients; to remind ward managers and consultants to make sure their staff are aware of and implement the protocol on patient observations; and to remind all medical staff of the requirements of their `not for resuscitation' policy.

E.1338/95 - 96

I did not uphold a man's complaint that his wife was not provided with a suitable pressure-relieving mattress when she was admitted to hospital in August 1995. Though I found no evidence that the Trust had intended to mislead him, I found that the man had been given unsatisfactory and contradictory explanations about the cause of an injury sustained by his wife while she was being lifted from one bed to another. I found that there had been a delay in administering analgesia on one occasion and that a doctor had not followed the Trust's drugs policy - which he claimed not to have seen - when writing a prescription. I also upheld a complaint that the man was not consulted about a decision that his wife should not be resuscitated in the event of a cardiac arrest. The consultant who made the decision not to resuscitate did not speak to the man about it as he believed, mistakenly, that the man had said that he did not want any active treatment for his wife. I expressed concern that no record was kept of a meeting between the man and Trust staff and that the consultant said he had not seen the Trust's resuscitation policy. Trust to remind staff to keep records of meetings with complainants and to remind consultants of their responsibility to make sure that they and their staff are aware of, and follow, policies concerned with patient care.

E.1028/96 - 97

I upheld a complaint that the Trust's convener did not fully follow the NHS national guidance in deciding, in September 1996, not to convene an independent review panel to consider a woman's complaint about her late husband's care and treatment at Eastbourne District General Hospital, and about related communication issues. I found that the convener pursued aspects of the

complaint which had not been previously considered under the Trust's local resolution arrangements and attempted to resolve the complaint himself. He also did not adequately distance himself from those involved in the complaint. Trust to remind conveners that they are required to act wholly within the national guidelines.

E.805/96 - 97: Enfield and Haringey Health Authority

I upheld a complaint that the Health Authority's convener in mid 1996, applied unreasonably the transitional arrangements set out in the NHS complaints procedures in deciding that a woman's complaints about a dentist were made too late. The convener failed to take sufficient account of all the circumstances of the case: in particular the time taken by a family health services authority to invite the woman to provide more information which led to her making new complaints, and the detailed reasons given by a community health council on the woman's behalf for the delay. I did not uphold a second complaint that the convener did not write personally to the woman to convey her decision because the convener rectified that error after my investigation had started. Health Authority to comply with the complaints procedures in future and to consider afresh the convener's decision.

E.1366/94 - 95: Enfield and Haringey Health Authority and Haringey Healthcare NHS Trust

On 12 March 1994 a woman, who had been receiving day care for a depressive illness at the Victoria day unit at St Ann's Hospital, Haringey, was admitted to another hospital after a fall. The woman's daughter complained that a clinical assistant at the day unit reneged on an agreement to admit the woman as an inpatient to St Ann's Hospital after she had been discharged from the other hospital. I was persuaded that the clinical assistant did give the woman's relatives to understand that the woman would be admitted as an inpatient at St Ann's Hospital after she had been discharged from the other hospital: I found that there had been a serious failure of communication on the clinical assistant's part. I also found that the Trust failed to carry out a thorough investigation of the complaint. Trust to remind staff of the need for effective communication with relatives and to record any significant conversations. Also Trust to consider clarifying their complaints procedure.

E.320/95 - 96: Enfield Community Care NHS Trust

I upheld a woman's complaint that the Trust's explanation for how her grandmother injured her ankle while an inpatient in September and October 1994 was inconsistent with entries in her grandmother's hospital records. I criticised the Trust for taking insufficient action about the woman's serious allegation that the injuries were caused by a nurse. I did not find made out the woman's complaint that the Trust gave an incorrect explanation of how her grandmother came to be on the floor on the evening of 4 October. Because of shortcomings in the Trust's investigation I could not establish if staff had known that she was there. Trust to devise clear procedures for dealing with allegations of rough handling of patients and make sure that any such allegations are investigated promptly and rigorously. Trust to monitor closely the quality and thoroughness of investigations and replies to complaints.

Epsom Health Care NHS Trust

E.28/96 - 97

A woman complained that while her aunt was a patient at Epsom General Hospital in May 1995 she sustained an injury to her arm as a result of a lack of care on the part of nurses. I found that the reporting and investigation of the injury was inadequate; an accident report form was not completed until two days after the injury was first noticed and a detailed investigation did not take place when the woman claimed that the injury was caused by nurses. As a result, I could not determine precisely what happened and I could make no finding on the complaint to me. I did not uphold another complaint that because of poor communication between nursing and medical staff the patient's dietary needs and incontinence were neglected. Although I criticised the nurses for not passing on to the medical staff sooner than they did the woman's requests for her aunt to have a drip and catheter, I found no evidence to suggest that their omission had an adverse effect on her condition. Trust to review their arrangements for reporting and investigating accidents and untoward incidents, and to make sure that they are adequate for effective handling of allegations against nurses.

E.944/96 - 97

I upheld a complaint that the Trust's convener did not follow the NHS complaints procedures in refusing to grant an independent review of a man's complaint about failure to carry out a blood test when his daughter attended the accident and emergency department at Epsom General Hospital in August 1995. The man's daughter was later diagnosed as having leukaemia. I found that the convener: misdirected the man by applying an inappropriate test in deciding to refuse an independent review; defended those complained against; and failed to tell the man that she had taken clinical advice on his complaint. That advice supported key elements of the man's complaints and I strongly criticised the convener for failing to take due account of it. Trust to apologise and tell complainant that they accept the conclusions of the independent clinical adviser.

Essex Rivers Healthcare NHS Trust, Colchester

E.1123/93 - 94

A man who was admitted to Colchester General Hospital in October 1993 suffering from neck pain complained to the Trust about aspects of his treatment and that x-rays were not available when he attended a later outpatient appointment. The chief executive replied in January 1994 but when the man disputed much of what he said the chief executive's response was that he had nothing to add. The man complained to me that the Trust's response to his complaint had been inaccurate and dismissive. The chief executive's first letter to the man failed to deal with one issue which he had raised but I found that otherwise it was a reasonable attempt to deal with the man's concerns and was neither inaccurate nor dismissive. The chief executive's second letter was not an adequate response to the man's continuing concerns and the Trust should have taken steps to deal with his complaints about his treatment under the nationally agreed clinical complaints procedure. The Trust apologised and agreed to keep complaint-handling arrangements under review to make sure that responses dealt with all issues raised and explained what could be done if the complainant remained dissatisfied.

E.926/95 - 96

A man complained that from January 1994 the Trust failed to provide him with suitable orthopaedic shoes. I upheld the complaint to the extent that problems with the Trust's orthotic service at the time contributed to the delay in the supply of his footwear. I also found that the Trust's handling of the complaint was dilatory and unsatisfactory: Trust to monitor arrangements for despatch of letters and to answer an outstanding aspect of the man's complaint.

E.1018/96 - 97: Exeter & District Community Health Services NHS Trust

I upheld a man's complaints that at an outpatient appointment in October 1995 staff did not introduce themselves to him or give him all the help that he needed; that his confidentiality was breached by the presence of a number of persons not involved with his treatment; that the consultant gave instruction to a medical student without his consent; and that a wall of the examination room was dirty. I did not uphold his complaint that an internal examination was carried out without his consent. The Trust had taken appropriate action on most of the man's complaints when he first made them and they accepted my recommendations for some further improvements.

Forest Healthcare NHS Trust

E.778/94 - 95

The relatives of an elderly lady who had been admitted to Whipps Cross Hospital in June 1993 complained that, when her breathing worsened, a nurse told them it was due to the fact that they had requested she be allowed to lie down in bed rather than sit up. On the night that she died her son telephoned to ask if the doctor who had been requested to visit his mother had done so but the nursing staff were unable to tell him. When the family complained about the care their mother had received the Trust's investigation was delayed and their answers did not reassure the family that steps had been taken to deal with failures that had been identified. I was unable to make a finding on the remark allegedly made by the nurse but I upheld those aspects of the complaint which dealt with the doctor's visit to the patient and the Trust's handling of the complaint. I recommended that both medical and nursing staff should be reminded of the importance of recording in their notes their treatment of patients and that the Trust review the thoroughness and monitoring of their complaints investigations. I further recommended that the Trust ensure that assurances given to complainants about action taken to prevent a recurrence of events were carried out.

E.440/95 - 96

A man complained that, after his mother attended the accident and emergency department of Whipps Cross Hospital in July 1994 because of chest pains, the results of cardiac enzyme tests were not made available to her GP until he contacted the hospital about nine days later. I found that the Trust had no system to monitor the proper and speedy handling of such test results: if the GP had not telephoned he might never have received the results. The Trust had since introduced a system so that results were available before patients left the hospital. I also upheld a complaint that the Trust's response to the man's complaint was dilatory and misleading in not making it clear that the GP, rather than Trust staff, had initiated contact about the test results. Trust to audit the system for clinical review of test results, monitor timeliness of replies to complaints, make sure notes are made of all telephone calls and meetings about complaints and make sure that complainants receive copies of such meetings.

The Freeman Group of Hospitals NHS Trust, Newcastle-upon-Tyne

E.350/95 - 96

I did not uphold a complaint that staff acted unreasonably in refusing to admit a boy to an orthopaedic paediatric ward in April 1995. The ward did not deal with emergencies and the staff acted within established hospital policy in telling the boy's mother that she she should take him to her nearest accident and emergency department. However I upheld the woman's complaint that the Trust did not adequately address the complaint she made to them. Staff were reminded of the need to respond fully to complaints and a full reply was sent to the woman.

E.1290/95 - 96

I upheld a man's complaint that he was not given an explanation of why the Disablement Services Centre at Freeman Hospital had been unable to provide him with a correctly fitting prosthesis. The man had been discharged by his consultant in July 1995 after nine unsuccessful attempts to fit a socket. In reply to the man's complaint the Trust said that as he had not been satisfied with the nine sockets manufactured for him there was nothing more they could do. I found that there had been clinical difficulties in fitting the man's socket. This had been explained at various appointments but was not set out in the correspondence. Trust to review their complaints procedure to make sure that full explanations are given to all the concerns expressed by complainants.

Frenchay Healthcare NHS Trust, Bristol

E.334/95 - 96

A man was admitted to Frenchay Hospital, Bristol on 20 December 1994 for diagnostic tests into a lung condition. Several days later he was told he was to be discharged, but his condition deteriorated and he died on 2 January 1995. I found that inappropriately encouraging information was given about the man's condition. I found, also, that there were failures in the arrangements for a post mortem which resulted in the man's body being released prematurely to a funeral director. Trust to remind staff about their policy on communication with patients and relatives, and to consider producing more detailed guidance about post mortem procedures.

E.335/95 - 96

A man who had a lung removed at Frenchay Hospital, Bristol on 10 January 1995 made good post-operative progress at first but his condition then deteriorated and he died on 27 January. I upheld complaints that the man's wife was not told about the seriousness of her husband's condition, that her requests to speak to a manager were not met and that a post mortem examination to which she had consented was not conducted. Trust to consider introducing a procedure to make sure that staff consider, and record, the information to be given to relatives; monitor the effect of recently introduced guidance about communication with patients and relatives; remind staff how to deal with oral complaints; and issue written guidance about post mortem procedures to all doctors who might need to use those procedures.

E.1127/96 - 97

I upheld a woman's complaint that the Trust's convener did not follow the NHS complaints procedure in September 1996 when he refused to arrange an independent review panel (IRP) to look into her complaint about the treatment provided for her late mother at Frenchay Hospital, Bristol. I found that the time taken before the convener reached his decision was in excess of the standard set by the national guidance and that he failed to tell the woman that he had taken appropriate independent clinical advice. I also found that the convener failed to explain fully why he did not consider it appropriate to set up an IRP or why he felt that there was no further scope for local resolution. Trust to monitor future compliance with time limits set down in NHS national guidance; to review their administrative arrangements; and to produce guidelines to clarify the issue of responsibility in dealing with requests for independent reviews. They also agreed to consider reviewing the convener's decision.

E.1501/94 - 95: Frimley Park Hospital NHS Trust

I did not uphold a woman's complaint that treatment of her husband's cancer was delayed because staff at Frimley Park Hospital failed to convey to him in February 1993 the potential seriousness of his condition and took no steps to make sure that he attended follow-up appointments. I agreed with the consultant concerned that patients should take responsibility for their own actions in attending appointments. For the hospital to have followed up the man's non-attendance at the clinic would have required an appointments system which identified all cancelled patients and included a reappraisal of the clinical priority of each such case, I considered that to be an unreasonable expectation.

4. CASE SUMMARIES AND REMEDIES - G - I

Good Hope Hospital NHS Trust

E.168/96 - 97

I upheld a complaint by a woman that in 1996, her baby was given a vitamin K injection without consent. The Trust's policy on parental consent for vitamin K injections had not been made sufficiently clear with regard to babies requiring special care. Trust to review written information about the policy to make it clearer.

E.1203/96 - 97

I upheld a man's complaint that the Trust's convener failed to implement correctly the transitional arrangements of the new NHS complaints procedure in June 1996. Although the convener considered there were clinical aspects to the complaint she decided that the transitional arrangements did not apply as the Trust had dealt with the complaint as though it was a non-clinical complaint. Because of that she did not seek clinical advice before taking a decision on the man's request for an independent review. I found that the convener misdirected herself and proposed an inappropriate course of action. Trust to consider afresh the decision of the convener to refuse the man an independent review of the clinical aspects of his complaint, taking account of appropriate clinical advice.

E.587/96 - 97: Greenwich Healthcare NHS Trust

A woman whose baby died on 4 September 1994 in Greenwich District Hospital, was concerned about various aspects of her care and treatment during her labour at home and the baby's treatment in the hospital. In September 1994 she requested access to the midwifery and paediatric records. Hospital staff made a meeting with the consultant a precondition of releasing copies of the record and the consultant's manner at that meeting was intimidating. The response to her request in December 1994 for corrections to the paediatric record was dilatory and inadequate. I upheld all aspects of the complaint. Trust to remind medical staff how to respond to applications under the Access to Health Records Act 1990.

Guy's & St Thomas' Hospital NHS Trust, London

E.138/95 - 96

A consultant rheumatologist at St Thomas' Hospital who in February 1994 saw a woman about back pains which she had been suffering for some time, wrote to her general practitioner suggesting that he consider making a psychiatric referral. The woman complained to the Trust that the consultant had not discussed that suggestion with her but she was not satisfied that their replies answered the points put. She also asked for a meeting with the consultant but her request was refused. The Trust's handling of the complaint showed ignorance of some important procedural points and ineffective management. I upheld the complaints to me and recommended that the Trust make sure that all staff with responsibilities for dealing with complaints be given clear instructions and training; that medical staff be given guidance on the importance of responding to complaints and the proper handling of requests for meetings, and that when senior staff needed to be involved the issues were referred to them without delay.

E.299/95 - 96

I upheld a woman's complaint that the Trust failed to reply to her enquiry about whether a post mortem examination of her baby had been carried out. I did not uphold a complaint that their action in writing to another hospital was not a satisfactory way of responding to her concerns. Trust to ensure issues covered in induction training of medical staff and written policies and to monitor compliance. The Trust also agreed to reimburse the charge made for the signing of a cremation certificate.

E.1040/95 - 96

I found no evidence that the staff of the Trust's community psychiatric service did not take seriously a man's grievances about the service that he had received since August 1991. I upheld his complaint that the Trust's responses to some of his letters of complaint were slow and that the Trust's general manager failed to follow the correct procedure when dealing with the man's

request for an Independent Professional Review (IPR). I found no evidence that the general manager had been intentionally obstructive by not passing the request for an IPR to the Regional Medical Officer.

E.1407/95 - 96

A man complained in January 1995 to the chief executive of Guy's & St Thomas' Hospital NHS Trust about aspects of the diagnosis and treatment which he had received at the National Poisons Unit, which is managed by the Trust. I found that the Trust's handling of his complaint was dilatory and inadequate. Trust to make sure that all complaints staff receive adequate training (see also E.138/95 - 96); Trust Board to monitor closely the effectiveness of their complaints procedure.

Gwynedd Hospitals NHS Trust

W.26/95 - 96

I upheld a man's complaint that he learned about his wife's cancer only by chance in September 1994 although it was diagnosed in Ysbyty Gwynedd in June 1994. I strongly criticised failures in written and oral communication between doctors and nurses, and between them and the man. The Trust issued policy guidelines on breaking bad news effectively and amended a medical audit checklist to make sure that, in future, interviews with patients and relatives were recorded. The man also complained that his wife received inadequate nourishment because her food intake was not monitored but I did not find that to be so. I considered that if the man had known his wife's diagnosis and prognosis at an earlier stage he might have understood why her appetite was lacking, why her food intake was not monitored in the way he expected and why alternative nourishment was not given.

W.91/95 - 96

I upheld a woman's complaint that the Trust failed to answer her complaints about gynaecological treatment she received at Llandudno General Hospital and St David's Hospital, Bangor between December 1994 and June 1995 because they had lost her medical records. Trust to review procedures subsequently introduced to the medical records and complaints departments to ensure that intended improvements were achieved; and to reply as fully as possible to the woman's outstanding complaints using other information which I found was still available. Staff to be reminded that complainants are entitled to a full and thorough investigation of their complaints.

S.64/95 - 96: Hairmyres and Stonehouse Hospitals NHS Trust, East Kilbride

A woman complained that at her husband's outpatient appointment in August 1994 and after his admission to hospital later that month he was not told of the strong probability that cancer, for which he had previously had surgery, had recurred. I found that the man and his family were left without adequate information mainly because while he was in hospital his care passed among a number of different clinicians. I also found that for part of the man's time in hospital his nutritional state was inadequately managed; that his intravenous fluids were discontinued inappropriately for an ambulance journey to another hospital for a bone scan, and the lack of a trained nurse escort substantially delayed his return; and that nurses should have been more alert to his needs when he felt cold. Trust to ensure that where a patient is passing 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.

Hammersmith Hospitals NHS Trust, London

E.622/95/96

A man complained that in September 1994 when he was admitted to Charing Cross Hospital, staff failed to explain why he was refused pain-killers. He complained also about his discharge from the ward, that the Trust lost his nursing notes and that their handling of his complaint was dilatory and unsatisfactory. I upheld the complaint about the lack of an explanation about the provision of pain killers, but I did not uphold the man's complaint about his discharge from the ward. I also upheld the complaints about the missing nursing records and the unsatisfactory handling of the complaint. Trust to provide the complainant with a full and clear explanation about the refusal of pain-killers; staff to be reminded to safeguard records; and new complaints procedures to be closely monitored by the Trust Board.

E.1312/95 - 96

I upheld some aspects of a man's complaint about the mislabelling of a specimen of a growth removed from his father's heart during an operation at Hammersmith Hospital in February 1995. Tests on the growth indicated that different treatment was needed but that was not given, as the specimen was labelled with another patient's name. I upheld complaints that inadequate

steps were taken to make sure the specimen was correctly labelled, that the Trust failed to check for results of tests on the specimen, and about their failure to inform the patient or his family of the error for several months after it was discovered. I did not uphold a complaint about delay in informing doctors of the error. Staff to be reminded of the importance of completing theatre documentation accurately and of their responsibilities when such errors occur; audits of theatre documentation to be carried out; theatre policy to be amended and Trust to review and audit arrangements for review of test results.

E.963/95 - 96: Haringey Healthcare NHS Trust

A woman's son took his own life three weeks after being discharged from St Ann's Hospital in May 1994. I did not uphold the complaint that the Trust made inadequate efforts to arrange for her to discuss with a consultant her concerns about his care. I upheld her complaint that her son's medical records were missing and that that hindered the Trust's investigation of her complaint. The Trust had recognised that improvements were needed in their management of medical records and were acting on recommendations of a District Audit review. Trust to monitor improvements in record tracking and to take further action if necessary and to collect any of the patient's records which may be available from other sources.

E.532/95 - 96: Harrow and Hillingdon Healthcare NHS Trust

In July 1994 a consultant psychiatrist in the psychiatric department of Northwick Park Hospital Harrow agreed to look into the possibility of arranging treatment for a man's phobia about needles before a dental operation he had to undergo. I did not uphold the man's complaint that the consultant psychiatrist failed to provide that treatment; but I did uphold his complaint that the consultant psychiatrist failed to respond to his enquiries about the delayed treatment between September 1994 and January 1995 I found that the Trust did not adequately investigate and respond to the man's complaints about the consultant psychiatrist. I also expressed concern that the chief executive did not act in accordance with the Patient's Charter in that she did not reply to the complaint. I recommended that the Trust keep their new arrangements for handling complaints under close scrutiny to ensure that they are operating effectively and comply with the requirements of the Patient's Charter and national guidance.

Hastings and Rother NHS Trust

E.1288/94 - 95

I upheld a man's complaint that arrangements for his wife's discharge from the Conquest Hospital in April 1994, following overnight observation, were inadequate. Her husband had expected her to be discharged at about 9 am but she was discharged at 4 pm without seeing a doctor. I also upheld the man's complaint that the Trust's handling of his complaint was dilatory and inadequate.

E.1408/95 - 96

I upheld a complaint that staff at the Conquest Hospital, St Leonards-on-Sea, allowed a man's catheter bag to be caught on a swing door during his transfer from the high dependency unit (HDU) to a ward in April 1995. I did not uphold a complaint that the man had not been given a proper explanation for the move. Staff had reassured him that he was fit to transfer and had explained that another patient was in greater need of the HDU bed. I commended staff for the efforts they made subsequently to allay the man's concerns about his treatment although I found some shortcomings in the Trust's handling of his complaint. Trust to check operation of swing doors at the hospital, remind staff of the importance of completing accident reports and to give the man a full written reply to his complaint.

E.926/96 - 97

I upheld a complaint that a man's clinic appointments at the Conquest Hospital, St Leonards-on-Sea, had been changed or cancelled at unreasonably short notice in June and July 1995; that was because of the difficulty in arranging locum cover at senior house officer (SHO) level. The man was also booked to see a SHO at his next clinic appointment although he had been led to believe he would be seeing his consultant. I found that the consultant had responded unreasonably to the man's subsequent complaint in that he did not comply with the Trust's complaints procedure. Trust to review their arrangements for providing locum cover and for informing patients of changes in clinic appointments. Trust to take steps to make sure that all staff, including consultants, comply with local and national guidance on complaints.

E.1138/95 - 96: Heatherwood and Wexham Park Hospitals NHS Trust

I upheld some aspects of a woman's complaint about the nursing care provided in Wexham Park Hospital in March 1995, to her mother and communication with the patient's family. The Trust accepted that the patient should not have been left on a stretcher after returning from x-ray, but I was unable to make a finding about whether she received the care planned for her because of failures in nursing record keeping, for which I criticised the Trust. I did not uphold complaints that a nurse had shouted at the

patient's family and that nurses failed to keep the family informed of deterioration in the patient's condition. I upheld a complaint about the Trust's handling of the woman's complaint, which I found to be poor. Trust have reminded porters of the need to tell nurses when patients are returned to the ward; Trust to take steps to make sure that nursing records are completed satisfactorily; Trust have introduced formal training on complaint handling and will make sure systems are in place to monitor the speed and thoroughness of complaint handling.

E.758/95 - 96: Herefordshire Health Authority

A woman complained that, when a GP referred her to an allergy clinic in Yorkshire in April 1994, the Authority acted unreasonably in expecting her to travel to Southampton for an assessment by an independent consultant immunologist of the proposed treatment. I did not uphold that complaint; but I did uphold, in part, her complaint that the Authority were dilatory in dealing with the matter.

E.379/95 - 96: Hillingdon Hospital NHS Trust

I upheld a man's complaint that when he attended the accident and emergency (A and E) department in February 1995 with acute abdominal pain he experienced an excessive wait before he was admitted to a ward. The delay was mainly due to the failure to contact a member of the surgical team. This related, to a degree, to the hiatus caused by the on-call surgical senior house officer leaving the hospital on the national six-monthly rotation programme for all junior doctors, before his replacement had arrived. Due to a lack of evidence I could make no finding on the man's complaint that he received inadequate care in the A and E department or that he was subjected to insensitive remarks. Trust to review their clinical cover procedures and remind their staff of the procedure for contacting senior staff when necessary and of the need to keep adequate nursing records. I invited the Trust to introduce a formal standard for maximum admission times for A and E patients.

E.1376/94 - 95: Hounslow and Spelthorne Community and Mental Health NHS Trust and Ealing, Hammersmith and Hounslow Health Authority

A woman's relatives complained that they had been told by an Authority employee that the woman was to be transferred to a private hospital from a hospital ward managed by the Trust. The transfer did not take place and when the relatives complained no adequate explanation was given by the Authority or the Trust. I upheld the complaint. Neither body had made sure the matter was investigated properly and the Authority had acted on an assumption that such an offer was unlikely to have been made. I found that it had been. Authority to check that staff understand their policy on such transfers.

E.368/94 - 95: Ipswich Hospital NHS Trust

A 90-year-old woman attended the accident and emergency department of Ipswich Hospital in June 1993 with a fractured femur. She was told that she would need an operation to replace the hip joint. Her son-in-law complained on her behalf that the Trust had denied her treatment because a senior house officer had told her that the Trust had a policy of putting patients over the age of 55 at the bottom of the waiting list for such operations and she had therefore had to have the operation done privately. The son-in-law also complained that the Trust had failed to carry out a thorough investigation of his wife's complaint about the matter. I found that the Trust had not denied the woman NHS treatment. The decision not to operate on her at once had been based on a clinical judgment, not on Trust policy. I found that the Trust had not carried out a satisfactory investigation: in particular they had failed to speak to the senior house officer and establish what he had said to the patient and the clinical reasons for his actions. I upheld the complaint about lack of thoroughness and recommended that the Trust remind staff of their duty and to reply fully to complaints.

4. CASE SUMMARIES AND REMEDIES - J - L

E.976/95 - 96: Kent and Canterbury Hospitals NHS Trust

I upheld a complaint that there was an unreasonable delay between 2 February and 13 April 1995 in making a referral to another hospital for a man who had already received treatment for a malignant tumour. It was unacceptable that two weeks of the delay was because of delays in typing a referral letter. A consultant surgeon considered the man's condition clinically urgent, but failed to mark the referral letter he received to show that an urgent appointment should be arranged for the man, further contributing to the delay. I also found that the Trust were dilatory in responding to the complaint made by the man's daughter in June 1995 about the delay to her father's treatment. The Trust apologised for the shortcomings and agreed to review the effectiveness of improvements made to the complaints handling system.

E.985/94 - 95: Kidderminster Health Care NHS Trust and Worcestershire Health Authority.

I upheld a man's complaint about the circumstances of his mother's discharge from Kidderminster General Hospital to a private nursing home in March 1994. Although Trust staff had discussed with the woman's family the care she would need at home and its likely cost, they had failed to explain clearly, or provide written details about who should pay for her care in the nursing home. The Trust revised their procedures to make sure that patients and their relatives were fully informed in future. The Authority, whose policy on continuing care I had criticised in an earlier case, accepted responsibility for funding the woman's care, including the additional cost of specialist feeding equipment, which the NHS has a duty to provide free. They agreed to reimburse the family by means of an ex-gratia payment.

King's Healthcare NHS Trust, London

E.1242/95 - 96

In December 1994 a man was admitted to King's College Hospital where he died two days later. In January 1995 his wife complained to the Trust that his body was not properly laid out in the ward and about aspects of his care. In June 1995 the Trust wrote informing her that they could not locate his medical records. On the available evidence, I could make no finding on the woman's complaint about the preparation of her husband's body. I upheld her complaint that the medical records were misplaced because of inadequate monitoring procedures and I found that the Trust had mislaid other documents relating to this case. I also upheld her complaint that the Trust's investigation of her concerns was inadequate and dilatory. The Trust had already taken action to improve their handling of complaints and the safeguarding of records. They agreed to monitor closely and audit the effectiveness of their revised procedures for handling medical records.

E.1319/95 - 96

I upheld a complaint about the way in which the Trust handled a complaint made in May 1995 by a woman whose mother was an inpatient at King's College Hospital. Deadlines were missed, there were communication failures between the staff involved, and the system failed to maintain basic records of the action taken and the complaint's progress. Contrary to national guidance, substantive replies were not always signed by the chief executive. Trust to remind staff involved in complaints handling about the importance of recording action taken during an investigation. I did not uphold a complaint that due to confusion of the mother's medical notes with those of another patient, she was offered incorrect medication, although I criticised the nurse who mistakenly offered the patient her prescribed drugs in oral form, rather than intravenously. I found that doctors had amended prescriptions rather than writing new ones. Trust to remind staff that changes in drug therapy must be by a new prescription, and to monitor compliance.

E.1434/94 - 95: King's Mill Centre for Health Care Services NHS Trust

In February 1994 a 93-year-old woman was taken by ambulance to the accident and emergency department at King's Mill Hospital, Nottinghamshire with abdominal pains. X-rays were taken and she was admitted to a surgical ward five hours later. I did not uphold a complaint that she did not receive sufficiently urgent attention but I found that there were delays in obtaining x-rays and the attendance of a doctor once the x-ray results were known. I found, too, that analgesia would have been given sooner if the other delays had not occurred. Trust to remind staff about procedures for identification of urgent x-ray cases and to review

the system for contacting doctors who are in theatre.

E.267/95 - 96: Lancaster Priority Services NHS Trust and Lancaster Acute Hospitals NHS Trust

A severely mentally handicapped hospital resident swallowed a snooker ball at the hospital social club in November 1994 and was transferred to an infirmary where he underwent surgery. However he developed pneumonia and died on 2 December. I did not uphold complaints from his sisters that lack of supervision and poor communication between staff allowed him to swallow the ball without being noticed, that lack of attention by staff to symptoms of physical illness delayed his referral to the infirmary and that poor collaboration and communication between staff at the hospital and the infirmary adversely affected his care while he was a patient in the infirmary.

E.1153/94 - 95: Lancaster Acute Hospitals NHS Trust

I did not uphold a woman's complaints that her father's condition was inadequately monitored and that there was an unreasonable delay in a doctor attending to examine him and arrange treatment when he was admitted to the Trust as an emergency in December 1993.

S.71/95 - 96: Law Hospital NHS Trust, Lanarkshire

I did not uphold a woman's complaints about her late husband's nursing care in Law Hospital in May 1995, nor did I find any maladministration in the way the Trust handled her complaints. However I recommended that the Trust remind staff of the need to inform relatives and carers about a patient's skin condition and treatment.

E.848/94 - 95: Leicestershire Mental Health Services NHS Trust

A woman complained about her late father's nursing care in the psychiatric department of Leicester General Hospital in June 1994. I did not uphold a complaint that they failed to deal with his incontinence, but I found that nursing staff failed to explain laundry arrangements to his family and that a carpet around his bed was not washed. I found failures in record keeping by a dietician and by nurses and poor communication between them. I was unable to make a finding on whether adequate information was given to the family. Trust to make sure that relatives fully understand laundry arrangements in the ward, to remind nursing and dietetic staff of the need to maintain full records and to review communication between those staff.

E.1128/94 - 95: Leicester General Hospital NHS Trust

I found that a man and his family had been treated unreasonably by a sister in the maternity unit at Leicester General Hospital, in October 1994 while she was trying to enforce visiting restrictions. Insufficient action had been taken to tell visitors about restrictions on the number of visitors allowed or to make sure that the rules were applied consistently. I also upheld the man's complaint that the Trust had not replied to all the points he raised in his complaint. Trust to arrange for permanent notices with full details of visiting restrictions to be displayed outside the maternity ward and to remind staff to respond as fully as possible to all points raised by complainants.

E.441/96 - 97: Lifespan Healthcare Cambridge NHS Trust

I upheld a complaint that the Trust's convener did not follow the NHS complaints procedure in deciding in June 1996 not to grant an independent review of the complainants' grievances about the care and treatment of their children who were patients at The Croft Children's Unit in April 1996. The convener misdirected herself by telling the complainants that a conflict of evidence between them and staff at the unit could not be resolved by her further investigation. She applied an inappropriate test of proof on the complainant's accusations, which was a decision for an independent panel to make. The convener failed to tell the complainants that she had sought independent clinical advice. The Trust will notify complainants in future when such advice has been sought. Trust to consider whether there is further scope for local resolution and to reconsider the decision of the convener not to grant an independent review.

S.85/95 - 96: Lothian Health Board

I strongly criticised the Board for their inept handling of a man's complaint that his wife suffered damage to her arm when chemotherapy drugs being administered intravenously leaked into the surrounding tissue. The man first complained to the hospital in August 1992. His complaint was not resolved and in March 1994 he put it to the Board. The Board's chief administrative medical officer did not send a substantive reply until September 1995. I found unacceptable delays; no effective monitoring procedures; inadequate and defensive replies; failure to contact a key witness; failure to involve the consultant in dealing with the complaint and misunderstandings about the clinical complaints procedure. The Board apologised.

E.908/95 - 96: Luton and Dunstable Hospital NHS Trust

I upheld complaints that following a woman's fall from her bed in February 1995 her relatives were given contradictory explanations about who was present when she fell and that nurses who gave the woman prescribed drugs did not check that they had been swallowed. I criticised the failure to record the fall in the medical and nursing records. I did not uphold a complaint that inadequate precautions were taken to prevent the fall. Trust to review and write down their policy for the level of supervision required when administering drugs and make sure that all medical and nursing staff comply, and to investigate thoroughly alleged drug errors.

4. CASE SUMMARIES AND REMEDIES - M - O

Mid Essex Hospital Services NHS Trust

E.375/95 - 96

Following the death of her husband in June 1992 at Broomfield Hospital, a woman complained to the Trust about the failure of medical staff to discuss their decision that he should not be resusitated if he suffered cardiac arrest and the lack of discussion with her about the plan for his treatment and the level of care to be provided. In November 1994 an independent professional review of the woman's complaint took place and, in reporting the outcome of that to her, the Trust said that a consultant claimed to have made several attempts to contact her to discuss her husband's treatment. The woman complained to me that the claim was inaccurate and that the Trust had refused to reply to her complaint about it. I found no evidence to support the consultant's claim and recommended that medical staff be reminded of the need to make sure that requests to meet relatives were clearly put, recorded and acted upon. I also found that there was no justification for the Trust declining to answer the woman's complaint and that they should have checked the consultant's claim against the documentary evidence and the recollections of other staff. I upheld the woman's complaints to me. Trust to remind complaints staff of the need for care when assessing and commenting on conflicting claims by staff.

E.631/96 - 97

I upheld a complaint that the Trust's convener did not follow the NHS complaints procedures in deciding in June 1996 not to grant an independent review of the complainant's grievances about her late husband's hospital treatment in June 1995. The convener failed to take appropriate clinical advice from someone not associated with the complaint. Trust to review the convener's decision in the light of advice obtained from an independent clinical assessor, and to follow the requirements of the new complaints procedures.

E.918/96 - 97

I upheld a complaint that the Trust's convener did not follow the new NHS complaints procedures in deciding in July 1996 not to grant an independent review of a woman's complaints. The convener exceeded the time limit of 20 working days set out in national guidance, and took over four months to reach her decision. She did not keep the woman informed of progress. The convener's first letter to the woman did not say if there were grounds to convene an independent review or whether there was scope for further local resolution. Her second letter failed to address the 11 detailed complaints made by the woman. Trust to reconsider, addressing each of the grievances, and say whether there is scope for local resolution or whether an independent panel should be convened.

W.102/94 - 95: Mid Glamorgan Ambulance NHS Trust, South and East Wales Ambulance NHS Trust and Bro Taf Health Authority.

I upheld a man's complaint that his mother-in-law, who was taken from one hospital to another for a scan in September 1994, waited an unreasonable time for her return transport. Because of a lack of suitable ambulances the woman waited at least two and perhaps as much as four hours. The Health Authority and Mid Glamorgan Ambulance NHS Trust had a service agreement that return transport should be available within one hour in 95% of cases, yet Mid Glamorgan Ambulance Trust did not monitor journeys outside their area. Before I issued my report Mid Glamorgan Ambulance Trust added to their fleet and changed operational practices to improve the service they provided; and they are to introduce procedures to enable them to monitor their own performance against service agreements.

E.1293/96 - 97: Mid Kent Healthcare NHS Trust

I upheld a woman's complaint that the Trust's complaints convener, in considering her request for an independent review of her complaint, failed to take appropriate clinical advice and to give the complainant adequate reasons in writing for the decision to refuse the panel. Trust to reconsider the convener's decision after taking appropriate clinical advice.

E.1254/95 - 96: Milton Keynes General NHS Trust

A man complained that in April 1995 staff on a medical ward were not adequately prepared to provide the care his wife needed after she was transferred from the hospital's intensive therapy unit (ITU). I upheld the complaint in part as equipment was not in place upon her arrival because of a failure of communication. That was remedied and staff who later reviewed the woman were satisfied that she was receiving adequate care. I criticised entries made by a staff nurse in the patient's records which purported to show care given at times after she had been certified dead. Trust to make sure that practice stopped immediately and to remind all nursing staff of the need to maintain accurate, contemporaneous records. Trust also to review communication between ITU and the wards and within the wards to make sure that in future all necessary equipment is in place before patients are transferred.

W.96/94 - 95: Morgannwg Health Authority

I partly upheld a man's complaint that, in June 1994, his son did not receive the medical attention he needed because an emergency ambulance crew failed to appreciate the seriousness of the son's condition and did not remove him to hospital promptly. I found that the crew had decided on their course of action in the light of their professional assessment of the situation but noted the view of the crew's senior officers that additional ambulance support might have been called for sooner; that the ambulance control officer failed to pass information fully and accurately between the crew and an on-call doctor; and that although there was no intention to withhold information the Health Authority failed to provide the man with a full and accurate transcript of control room tape recordings.

E.162/95-96: Mount Vernon and Watford Hospitals NHS Trust

I upheld some aspects of a woman's complaint about the nursing care provided, in September 1994, to her mother, who had a rectal tumour. I found failures in record keeping: care plans were not amended to reflect the needs of the patient and instructions contained in nursing records were not always followed. The Trust had already taken steps to improve record keeping but further undertook to make sure that staff followed instructions in patients' records, or note the reason for not doing so, and that they record any change in regime. I did not uphold a complaint that doctors did not set up an infusion when nursing staff became concerned that the patient was dehydrated as tests were conducted which showed this was not the case. I did not uphold a complaint that the woman and her father were left alone for several hours on the day her mother died.

Newham Healthcare NHS Trust

E.1297/94 - 95

A woman complained that on 27 August 1994 a doctor at Newham General Hospital spoke insensitively to her when seeking agreement that resuscitation would not be appropriate for her father. I did not uphold the complaint as I found no evidence that the doctor had done other than give necessary information about what was involved in resuscitation procedures. I found that the Trust's handling of the woman's complaint to them was dilatory and I recommended that they remind all staff of the need to record oral as well as written complaints and make sure that all complaints are answered promptly and fully.

E.1497/94 - 95

I upheld a man's complaint that the Trust's handling of his complaint of 6 October 1994 about his late father's treatment at King George Hospital lacked thoroughness and was insensitive. The Trust sent several holding letters addressed to the man's late father and their final reply, sent six months after he made his complaint, contained factual errors. Trust to review the complaint and their handling procedures.

E.681/95 - 96: NHS Executive, South Thames Regional Office, formerly South Thames Regional Health Authority

A woman requested an independent professional review (IPR) of the care her father received while he was a patient at Nelson Hospital, Wimbledon in December 1993 and January 1994. The RHA were dilatory in arranging the IPR and the delivery of the report. When the RHA corresponded with the woman they made many mistakes of fact and spelling. The IPR assessors were insensitive and uncaring at their meeting with the woman and her husband on 12 May 1995, and the RHA did not respond adequately to her complaints about the assessors' conduct of the review. The Regional Office accepted the invitation to consider what action is needed to ensure that correspondence with the public is being monitored satisfactorily.

S.97/95 - 96: North Ayrshire and Arran NHS Trust

A woman complained that when she attended an outpatient clinic in March 1995 she received inadequate information from a doctor about her condition. While I considered that the doctor had not intended to be unhelpful, I upheld the complaint to the extent that he failed to recognise the woman's anxiety and her need for more information. I also found that the Trust's replies could have contained more information to reassure the woman that action was being taken and that she was not told about her

right to complain to me. Trust to remind staff to tell complainants what action has been taken as a result of their complaint.

North East Lincolnshire NHS Trust

E.813/95 - 96

A woman's husband was admitted as an emergency to Grimsby District General Hospital in December 1994. The woman was concerned that he might not have been given oxygen overnight, as recommended by theatre staff, after an operation and that that might have adversely affected his condition. He died the following day. She complained that her husband was nursed in an area which did not have piped oxygen. The nurses on night duty were sure that the man had received oxygen. It was possible that either the man had been moved to an area with piped oxygen after his wife left or she was mistaken about where he had been nursed. I concluded that he had received oxygen overnight. I criticised the Trust for the standard of record keeping and recommended that staff should be reminded of the importance of keeping appropriate records but I did not uphold the complaint

E.74/96 - 97

A woman gave birth to twins in April 1995 at Grimsby Maternity Hospital. One of the babies died ten days later. I upheld the woman's complaint that some of the records of her delivery were inaccurate and inconsistent with each other. Also there were failings in the way a decision was made to amend the recorded assessment of the baby's condition immediately after birth to tell the paediatrician treating the baby about that change. Trust to remind staff of standards for record keeping, arrange regular audit of records and review communications between midwives and doctors.

E.920/95 - 96: North Essex Health Authority

I upheld a woman's complaint about failures in nursing and medical care when her father was a patient at Princess Alexandra Hospital, Harlow in early 1995. Inadequate nursing care resulted in neglect of her father's mouth care and personal hygiene. The family learned that aspects of the man's care and condition had not been recorded and staff were evasive when the family asked questions. It was unacceptable that the family did not find out about the circumstances of the man's death until the following day, when they were told by the coroner's office. The hospital had since introduced an action plan for ward staff to address the identified inadequacies. I commended that approach, but was concerned that a recent complaint had led senior staff to doubt the effectiveness of that plan. Princess Alexandra Hospital NHS Trust (who have been responsible for managing the hospital since March 1995) to carry out a planned independent review of nursing care and take immediate action to implement its recommendations; review their systems for auditing nursing and medical records and improve and increase awareness of their policy on untoward incidents.

E.602/95 - 96: North Essex Health Authority and Essex and Herts Community NHS Trust

I upheld a complaint that the Health Authority and the Trust failed to safeguard and trace a patient's nursing and medical records. In November 1994 a woman complained about the care her mother had received at Princess Alexandra Hospital, Harlow. In June 1995 the Trust told the woman that because the records were missing they could not further investigate the complaint. It was not possible to discover what had happened to the records. However, the investigation revealed shortcomings in the handling of the complaint and weaknesses in the Trust's procedures for storing, tracking and safeguarding records. Trust to make a further full scale search for the records and, on the completion of a current review of the records system, to issue written guidelines to staff.

E.921/95 - 96: North Essex Health Authority and The Princess Alexandra Hospital NHS Trust

I upheld a woman's complaint that the nursing and clinical records relating to her late husband's admission to the Princess Alexandra Hospital, Harlow, in August 1994 were inadequate. I also found that the Trust gave the woman unsatisfactory explanations on two particular aspects of her complaint. The Trust agreed to monitor progress on steps they had already taken to improve the standard of record keeping. They also agreed to remind staff dealing with complaints of the need to consult fully with those directly involved and to check that information given in replies to complainants is comprehensive and accurate.

North Middlesex Hospital NHS Trust

E.1473/94 - 95

I upheld a man's complaint that in November 1994 he had to wait in the accident and emergency department for seven and a half hours before he was admitted to a ward; I also found it unsatisfactory that he was left for seven hours before being given a drink I upheld the man's further complaint that his medical records were unavailable when he attended various outpatient clinics between February 1994 and January 1995 and found that some aspects of the Trust's handling of the man's complaints were

unsatisfactory. The Trust agreed to review their procedures for providing emergency cover; to remind staff of the need to make full and timed entries in the records; to contact clinicians if there is any doubt about a patient's food and drink requirements; to file reports promptly; to notify the health records department whenever records are transferred; and to remind staff to comply fully with the Trust's complaint procedure including checking replies for completeness and accuracy.

E.1264/95 - 96

A woman complained that she was kept waiting for eight hours when she attended the accident and emergency department in June 1995, to collect a pair of crutches. She had attended previously when she first injured her foot. She also complained that there was only one doctor on duty there. I upheld the complaint about the wait but commented that Friday night was not the best time to visit the department for what did not appear to be an emergency. Although the presence of only one doctor, rather than the usual two, was confirmed in the Trust's reply to the complainant, I found that that was incorrect: there had been two on duty. The Trust had given the complainant incorrect information rather than investigate her complaint properly and I criticised them for that. Trust to remind staff dealing with complaints of the importance of investigating thoroughly.

North Staffordshire Hospital NHS Trust

E.1098/94 - 95

I upheld a man's complaint that his wife had been mis-informed, in September 1994, about her eligibility for infertility treatment. Recognising the distress that had caused, the Trust subsequently provided treatment at their own expense. The man complained, too, about the Trust's handling of his wife's enquiries but I upheld that complaint only in respect of the way the ineligibility decision was conveyed to her.

E.591/96 - 97

I upheld a complaint that the Trust's convener did not follow the new NHS complaints procedure in deciding not to grant an independent review of a man's grievances about the care and treatment his mother received at North Staffordshire Hospital in November 1995. The convener obtained independent medical advice from the Trust's medical director who had not seen the patient's medical records at that time. The convener gave no explanation of how he had reached the view that the patient's medical treatment had been consistent with normal practice; failed to address the specific issues raised by the complainant; and did not set out fully the reasons for his decision to refuse an independent panel. Trust to consider the further scope for local resolution and to reconsider the decision of the convener not to grant an independent review.

E.423/95 - 96: North Staffordshire Hospital NHS Trust and West Midlands Ambulance Service NHS Trust

Transport arrangements for a man to attend outpatient appointments failed on three separate occasions, between December 1994 and February 1995. I found that the problems were attributable to different mistakes by hospital staff but not to any inherent fault in the system for making the arrangements. I upheld the complaint against the Hospital Trust, but not against the Ambulance Trust. I recommended the re-introduction of a computer-generated data list to improve liaison between the trusts about changed appointments. I found that the man's complaint had not been handled in accordance with the hospital trust's complaints procedure.

E.1129/95 - 96: The former North Thames Regional Health Authority

In 1995 a woman complained about the way the Regional Health Authority (RHA) dealt with her complaint about the failure of a community health council (CHC) to pursue with the RHA her concern about their refusal to grant an independent professional review of her late sister's care. Some RHA staff were not sufficiently aware of relevant national and local guidelines on handling complaints, and left the woman with a false expectation that her case was being transferred to another CHC. The RHA was slow to respond about the IPR, and did not tell the CHC chair about the problem in getting a response from the CHC chief officer. I upheld the complaint. NHS Executive to make sure that, since the abolition of RHAs, regional offices are clear about who is now responsible for handling complaints against CHCs.

North Tyneside Healthcare NHS Trust

E.97/95 - 96

In August 1994 an elderly woman recovering from surgery was transferred to Preston Hospital, North Shields, for rehabilitation. Her daughter complained that, although one of the aims of the transfer had been to improve her mother's mobility, her mother was not encouraged to use a commode. She also complained the side room in which her mother was nursed was hot and lacked ventilation and that because adequate precautions were not taken, her mother fell out of bed, after which an insecure cot rail was

fitted. I did not uphold the complaint about the use of a commode but found evidence of inadequate assessment, poor record keeping and lost records. I upheld aspects of the other complaints. I made recommendations about the completion and safeguarding of records, the need to report faulty equipment without delay and the need for the Trust to issue promptly planned local guidance on the use of cot rails.

E.437/95 - 96

I upheld a man's complaint about the inadequate nursing care received by his mother in March 1995. She had fallen while in a side room of a hospital ward and remained there until found by her family. I made no recommendations because the hospital had closed but I raised various concerns including that an elderly lady admitted to the hospital because she had suffered a fall was placed into a side room with a faulty door mechanism which impeded effective supervision. Also during her time in hospital she was allowed to walk in a corridor unsupervised by nursing staff.

E.419/96 - 97

A man complained that in August 1995 the Trust wrote to his GP conveying an unsubstantiated allegation about his behaviour: the allegation related to an incident which occurred when the man had attended the pathology department at North Tyneside General Hospital. As a consequence of the Trust's letter the GP removed the man from his list. I found that the Trust's letter to the GP lacked balance; and that before writing in the terms which they did the Trust should have raised their concerns with the man. I also found shortcomings in the Trust's handling of the man's complaint about the matter. Trust to remind staff to deal with complaints thoroughly and to comply with the terms of their complaints procedure.

E.421/96 - 97

A woman complained about a delay in taking her mother's temperature while she was in hospital in February 1995 suffering from acute leukemia. I found that the nurses had made a reasonable assessment of how urgent it was to take the woman's temperature and I did not uphold that complaint. In responding to the daughter's complaint to them the Trust sent her two letters containing errors or omissions. I upheld that aspect of her complaint to me. Trust to ensure that replies are both accurate and comprehensive.

W.90/95 - 96: North Wales Health Authority

A woman who considered that her son's ill health was a result of in-utero (in the womb) exposure to chemicals while she was employed by the Authority, complained in February 1996 that the Authority had failed to grant continuing funding for his treatment at a particular non-NHS hospital. I found that the Authority had refused that funding because they were not satisfied that the boy's clinical needs could best be met by treatment at the hospital, and that there were no satisfactory alternatives. There was no maladministration in the Authority's refusal and I did not uphold the complaint.

E.1482/94 - 95: North Yorkshire Health Authority & Harrogate Healthcare NHS Trust

I did not uphold a woman's complaint that in December 1992, when her husband was discharged from the Royal Bath Hospital, Harrogate, to a private nursing home, the hospital staff failed to inform her of the financial consequences. The Trust to make sure that patients discharged from their care receive the appropriate information. I also did not uphold a complaint that the Health Authority failed in their duty to fund the man's continuing care. I upheld a complaint that the Health Authority's handling of the woman's complaint was dilatory and unsatisfactory, and I criticised them for not having had, at the material time, an adequate complaints procedure.

E.206/95 - 96: Northern and Yorkshire Regional Health Authority (RHA)

In November 1993 a man requested an independent professional review (IPR) under the clinical complaints procedure of aspects of the treatment provided for his late brother-in-law. The review took place in February 1995 but the man's request to be accompanied at it by his sister-in-law was refused. The IPR was unsatisfactory as the assessors did not see all the records relevant to the case or interview the consultant who made the final diagnosis. I upheld both complaints and recommended that the Northern and Yorkshire Regional Office of the NHS Executive (successor to the RHA) ensure that all complainants were told of their right to be accompanied at IPRs. The Regional Office also agreed to consider what action could now be taken to deal with the man's unanswered concerns.

E.1356/94 - 95: Northumberland Mental Health NHS Trust

On 27 May 1994 a man suffered an accident in hospital when he fell and struck his head. Some three weeks later he was transferred to another ward where he died on 26 June. I did not uphold complaints from his daughter and her husband that lack

of care contributed to the accident; that the circumstances of the accident were not satisfactorily explained; that there was a delay in telling them about the accident and that they were given conflicting information about whether an x-ray took place. However I upheld a complaint that the daughter was given contradictory information about why the man was put on sick notice (a means of alerting family and staff to the possibility that a patient might die) shortly after his fall. She was misinformed because some staff did not understand the circumstances in which a death has to be reported to the coroner. I also upheld to a limited extent a complaint that not all of the man's records were transferred between wards. Trust to make sure all medical and nursing staff are made aware of the circumstances in which the coroner must be informed of a death.

E.536/94 - 95: Optimum Health Services NHS Trust, London

A man who attended a chest clinic during 1993 because his work had brought him into contact with a person suffering from TB, complained that a clinic visitor had without his consent disclosed confidential information about his treatment to his employer and a friend. The clinic visitor had telephoned the man's place of work because she needed to contact him. She spoke to one of his colleagues and I concluded that while doing so she probably made a reference to the man's treatment. I upheld that aspect of the complaint. I did not find the complaint about the call to the friend made out. The Trust apologised and agreed to remind all their staff of the importance of paying the strictest regard to maintaining patient confidentiality.

4. CASE SUMMARIES AND REMEDIES - P - R

E.23/95 - 96: Parkside Health NHS Trust, London

A woman complained that her five-year-old son was vaccinated by a school nurse in November 1994, although she had signed a form to say that she did not want him to receive the vaccination, and that the Trust's response did not adequately answer her concerns. I upheld the complaint. I found that various aspects of the organisation of the vaccination session increased the risk of such a mistake. Trust to give careful consideration to organisational arrangements and suggestions to schools about that in any future campaigns.

E.50/95 - 96: Phoenix NHS Trust, Bristol

I upheld a complaint that the Trust had delayed improving hygiene arrangements for a woman's autistic son who had been a resident at Hanham Hall Hospital since July 1981. I found that until the woman complained there had been no documented planned approach to cleaning her son after he had defecated or teaching him to clean himself. There was also a delay in providing some basic facilities (such as towels) for residents who could use them. I could understand why the woman was concerned about whether a continence adviser's report had been properly considered, when the Trust, despite considering much of the report inaccurate or irrelevant, did not pursue those concerns further. The woman also complained about a ban on her seeing her son unless she was supervised. I made no finding on that complaint because the decision depended largely on clinical judgment which, at the time of the events complained about, was outside my jurisdiction.

E.943/95 - 96: Pilgrim Health NHS Trust, Lincolnshire

I upheld a woman's complaint made in March 1995, that over a period of a number of years she had experienced unacceptable delays before she was seen by a doctor in an outpatient clinic and that the Trust's reply to her complaint about the delays was unsatisfactory. I found that many patients regularly waited longer than the Patient's Charter standard of 30 minutes. The Trust have rearranged timetables and increased the number of consultants. When the Trust replied to the woman's complaint they did not address her main concern - the amount of time she had to wait to see a doctor - until three months after her original complaint.

E.906/95 - 96: Plymouth Hospitals NHS Trust

I did not uphold a man's complaints about his aunt's discharge from hospital to a private nursing home in May 1995. Although I criticised the failure to give her written details about payment of the home's fees before she was discharged, the only difference that made was that she was given that information by social services rather than the Trust. I did not conclude that she had been entitled to NHS funding.

E.898/96 - 97: Poole Hospital NHS Trust

I upheld a complaint that the Trust's convener did not follow the NHS complaints procedures in deciding in August 1996 not to grant an independent review of a woman's grievances about a consultant's failure to obtain a bone scan in mid-1995 and a failure in communication involving that consultant's secretary. The convener failed to consult a lay chairman before referring the woman's complaint back for further local resolution. The convener later failed to take appropriate clinical advice from someone not associated with the complaint; he obtained advice from the Trust's medical director who had previously been involved in the Trust's own investigation. Trust to review the convener's decision in the light of the requirements of the new complaints procedures and to make sure that relevant staff and conveners follow the national guidance.

Pontefract Hospitals NHS Trust

E.1156/94 - 95

I upheld a complaint that during an outpatient consultation in May 1994 a consultant displayed an unsatisfactory attitude when a patient asked persistent questions about his diagnosis and the side effects of medication. I did not find that the Trust acted maladministratively in not arranging for the patient to see another consultant, as the patient had been referred back to the care of his GP.

E.501/96 - 97

I did not uphold a complaint that the Trust failed to make adequate arrangements for care of an 80-year-old man after his discharge from hospital in March 1995; nursing staff had referred him to social workers. However, I recommended improvements to discharge planning. Trust staff omitted to make a necessary outpatient appointment and that led to problems when the man was later readmitted. A diagnosis of cancer was then given inappropriately when it had not been fully confirmed. I upheld a complaint that the communication of that diagnosis was inadequate and insensitive. Trust to improve compliance with discharge planning procedures.

E.447/95 - 96: Pontefract Hospitals NHS Trust Northern and the former Yorkshire Regional Health Authority (RHA)

I upheld a complaint from a woman who complained in June 1992 about treatment she had received at Pontefract General Infirmary but did not receive a substantive reply from Pontefract Health Authority until February 1993. There was then a further nine-month delay before her request for an Independent Professional Review (IPR) was sent to the RHA. The IPR was not held for a further 16 months because of confusion between the Trust, who by then managed the hospital, and the RHA. I noted that the Trust's complaints procedure had since been improved and that the chief executive took a more personal role in the management and monitoring of complaints.

Preston Acute Hospitals NHS Trust

E.583/94 - 95

The family of an elderly man who died from a rare lung disease in Royal Preston Hospital on 3 April 1993, complained that they had been denied the opportunity to view his body and prepare it for the funeral. The Trust had sent a standard letter to the undertaker, incorrectly stating that he had been suffering from an infectious disease so his body should be neither removed from the body bag nor embalmed. The Trust replied that the letter had been used as there was a possibility that the body was infectious and refused the family's request that the standard letter be amended, in cases of possible infection, to state that the body was `potentially' infectious. I upheld the complaint and drew to the Trust's attention national guidance on preventing the spread of infection. They agreed to implement the suggested change to the standard letter.

E.650/95 - 96

A man wrote to the Trust in December 1994 complaining that he had suffered an injury to his right foot while being lifted from a wheelchair by two nurses. He did not receive a reply until nine weeks later and that reply referred to his left toe. He wrote again in March 1995 but remained dissatisfied with the Trust's reply which was sent several weeks later. I upheld the man's complaint that the Trust's investigation was dilatory; and to an extent I upheld his complaint that it was also inadequate and that the Trust's first reply was based on inaccurate information. I recommended that the Trust remind staff of the need to deal with complaints promptly and in line with their complaints procedure. I also recommended that they should remind staff of the need, when dealing with a complaint of this nature, to interview all potential witnesses and to make sure that the complaint has been directly and accurately answered.

E.999/95 - 96

I upheld a complaint that arrangements made in April 1995 for a patient to be sent home for the weekend were unsatisfactory, in that staff failed to distinguish between a discharge from hospital and a period of home leave. I also upheld a complaint that arrangements for informing the patient of the results of diagnostic tests were unsatisfactory. I considered a complaint that the patient and his partner were not kept adequately informed of his condition and prognosis. I found that they were adequately informed from 20 April onwards, but I was unable to resolve conflicting evidence relating to an earlier period. Trust to clarify their policy on discharge and home leave and to review their procedures for giving patients the results of diagnostic tests.

E.978/95 - 96: Queen Victoria Hospital NHS Trust, Sussex

I upheld a woman's complaint that in July 1995 she waited to see a doctor because she had been wrongly informed that he would discuss her late husband's test results with her, when in fact he had gone off duty. I did not uphold her complaints that the food given to her husband was unsuitable, that his fluid intake was insufficiently monitored and that inadequate mouth care was given.

E.1504/94 - 95: Ravensbourne NHS Trust

I upheld a man's complaints that, when the district nurses treated his mother for an infection of her right foot from May 1994 to

June 1994, they failed to communicate adequately with each other and to maintain adequate nursing records. Eventually part of the woman's leg had to be amputated. I criticised the Trust for their haphazard and poorly implemented arrangements. I made no finding on a complaint that the district nurses also failed to communicate adequately with the GP about the woman's deteriorating condition: I found no administrative failings in that and the frequency and type of contact with the GP was a clinical judgment which was then outside my jurisdiction. As a result of the complaint the Trust had set up a study group which made recommendations to improve record keeping and communication. Trust to monitor implementation of recommendations.

Redbridge Health Care NHS Trust

E.58/94 - 95

I upheld a woman's complaint about the arrangements for her discharge from King George Hospital in December 1993. There were serious deficiencies in her physiotherapy records and poor communication with the woman about her physiotherapy in that the woman had been discharged home without a necessary assessment of her need for aids and adaptations in her home. The Trust's initial investigation of her complaint was badly co-ordinated and the woman had not been given a full explanation of why she had not received an occupational therapy assessment before her discharge. Trust to remind staff of the expected standards of record keeping and to review their discharge policy to make sure it is in line with national guidance and good practice.

E.821/94 - 95

A woman complained about the circumstances of her father's death, following his attendance at the accident and emergency department (A and E) of King George Hospital, Goodmayes. I did not uphold her complaint that she had not been informed that her father was seriously ill; the doctor had properly explained to her her understanding of the man's condition. I upheld a complaint that an intravenous infusion ordered by the doctor was not administered. Doctors had assumed nurses would set up the drip although hospital policy placed responsibility for the administration of drugs with medical staff. I recommended that the Trust satisfy themselves that nursing and medical staff were aware of their respective responsibilities for the administration of drugs. I also criticised the Trust for giving the woman conflicting information about a fall which her father suffered. Trust to remind staff of the importance of ensuring the accuracy and completeness of information given to complainants.

E.1036/94 - 95

I did not uphold a complaint that no prior agreement was obtained from a woman patient for two surgical procedures carried out at King George Hospital, Goodmayes, in August 1994, or that she was given inadequate information about the operation before it took place. There were conflicting accounts from the woman and the medical and nursing staff, but I was satisfied that she did receive an explanation, although there was a failure to record key discussions in the medical and nursing records. I upheld a complaint that the consent form the woman completed for her operation was amended by a consultant without her knowledge, despite a clear warning on the form that amendments must be seen by the patient, and that the form was not checked with the woman immediately before her operation. Trust to remind staff to document key communications with patients and relatives about treatment, and to remind medical staff to show patients and obtain the patient's signature for any changes to consent forms. Trust also to amend pre-operative care check lists to include a specific check that a patient had read and understood what was written on the consent form, and what the operation would involve.

E.1452/94 - 95

A woman complained that when her mother was taken to the accident and emergency department at King George Hospital, Goodmayes, in May 1994 there was a delay in contacting a hospital which had previously treated her. I found that the nurse who was asked to make the contact should have told the nurse in charge, or a doctor, of the request. I did not uphold a complaint that the woman waited two and a half hours to be seen by a doctor and I was unable to make a finding on a complaint that there was a further delay in the woman's transfer to a third hospital for emergency surgery. I upheld a complaint about the Trust's handling of a complaint about these events. Medical and nursing staff to be reminded of the importance of recording times of entries in patients' records.

E.803/95 - 96

I upheld a woman's complaint about the care and attention her mother received after she was taken to the accident and emergency department (A and E) at King George Hospital, Goodmayes, in February 1995. I found that she had waited for nearly ten hours when she suffered a cardiac arrest, and later died. She was not seen by a doctor as promptly as her triage classification required; was not admitted to a ward as a doctor had instructed; nursing observations were not carried out as they should have been; medical staff were not informed when an infusion was stopped; and there was no call bell for her to attract the attention of

staff. I also found that the Trust's handling of the woman's complaint was unsatisfactory: although the Trust had said that action would be taken in response to the complaint, some of that remedial action had not been taken. Trust to make sure as a matter of urgency that all outstanding action has been taken, and to review systems for monitoring performance in A and E so that monitoring results are accurate. Trust Board to make sure that the numbers and skills of staff in A and E are adequate to meet required standards and to ensure that their new complaints procedure addresses the serious shortcomings which I identified in the handling of the complaint. I drew the case to the attention of Redbridge and Waltham Forest Health Authority.

E.1074/95 - 96

A woman was admitted to King George Hospital, Goodmayes, in March 1995 and gave birth to a baby of 22 weeks' gestation. The baby was born with a heart beat but died after 90 minutes. The woman and her husband complained that when they were handed the baby after the birth, they were not told whether he was alive or dead and were given no explanation of what care and treatment would be provided. I found that a doctor had given them detailed explanations both before and after the birth about their baby's condition and did not uphold the complaint. The woman said that she had found the baby's death had been recorded as a spontaneous abortion (that was subsequently changed and a birth certificate issued). The woman and her husband also complained to me that during a meeting a doctor had been uncaring and reluctant to correct the record of the baby's death. I made no finding on that aspect of their complaint but found the doctor was not fully informed about the requirements for registering the births and deaths of premature babies and should have sought advice about that before speaking to the parents. Trust to review the practice of their staff and the advice they give to parents about registering births and deaths.

E.1114/95 - 96

I did not uphold a man's complaint that he was not told that his wife had leukaemia or that she was seriously ill until after she was transferred from King George Hospital Goodmayes, to The Royal London Hospital in May 1995. I did not uphold a complaint that he was given inaccurate information about the timing of her transfer, although I criticised the Trust for a lack of documentation which hindered their investigation of his complaint. Trust to make sure that accurate nursing care records are made by staff and also records of significant discussions with patients and relatives.

E.788/95 - 96: Richmond Twickenham and Roehampton Healthcare NHS Trust

In September 1994 a man attended the accident and emergency (A and E) department at Queen Mary's University Hospital, London, after being injured in an assault. He complained that staff in the A and E department refused to help him contact the police. He also complained that the Trust's handling of his complaint was unsatisfactory in that they refused either to concede that he should have been given help to contact the police or to name the nurses about whom he wished to complain. I did not uphold the complaints.

E.539/95 - 96: Riverside Mental Health NHS Trust

In January 1995 a woman, who lived in a housing association hostel and who had a history of mental illness, consulted a psychotherapist. The psychotherapist referred her to a consultant psychiatrist. The woman complained that the psychotherapist and the consultant psychiatrist breached her right to confidentiality by passing on, without her permission, personal information to a support worker in the hostel. I found that while technically the psychotherapist breached the woman's right to confidentiality, he did so in the interest of the woman and of other residents and staff at the hostel. I did not uphold the complaint against him. I found that the consultant psychiatrist's action in contacting the support worker without the woman's consent was taken in the exercise of clinical judgment, and thus, at the time in question, outside my jurisdiction, so I could make no finding on that part of the complaint.

E.151/95 - 96: Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust

A man complained that he had not been warned of the likely reduction in his mobility following an operation to his right knee in September 1994, and was not properly assessed before his discharge, with the result that his safety was at risk when he returned home. I upheld the complaint about the discharge arrangements to the extent that he was not instructed in the use of crutches on stairs. I did not uphold the complaint about the arrangements to warn the man about the likely effect of his operation.

E.13/94 - 95: Royal Berkshire and Battle Hospitals NHS Trust and West Berkshire Priority Care Service NHS Trust

I upheld a woman's complaints that she was not notified of a hospital appointment in April 1993; that she was not given a prompt appointment for the removal of a cyst; that a meeting with a gynaecologist was unsuccessful as he did not have her records and that he failed to follow up the matter as promised. I found that the appointments system at Newbury Hospital was casual but that procedures had since been changed. I recommended that the Royal Berkshire Trust ensure more effective

management of the gynaecologist's waiting list and that the new procedures for dealing with patient records required in more than one department be reviewed after a year. I upheld the woman's complaint that the Royal Berkshire Trust's reply to her complaint was unacceptable and recommended that the Trust reply to complaints in accordance with national guidance; respond to all aspects of the complaint; and liaise with the West Berkshire Trust when the complaint involves aspects of their services.

Royal Bournemouth and Christchurch Hospitals NHS Trust

E.1453/94 - 95

A man's parents complained about the care their son received at the Royal Bournemouth Hospital in May 1994; he collapsed in the treatment area and subsequently died. I was unable to make a finding on the complaint that staff did not help him to transfer from a car to the accident and emergency department. I upheld a complaint that a health care assistant did not provide sufficient help when the man asked to go to the lavatory to the extent that he failed to take the trolley side down to enable the man to move into a wheelchair. I did not uphold a complaint that the man was left alone in the lavatory cubicle because the consensus of nursing and medical opinion was that the health care assistant had acted correctly in not remaining in the cubicle.

E.1094/96 - 97

I upheld a complaint that the Trust's convener did not follow the NHS complaints procedure in refusing to grant an independent review of a man's complaints about the care and treatment of his wife at The Royal Bournemouth Hospital in December 1995. The convener failed to set out clearly in writing the reasons for her decision, and to tell the man that she had taken professional advice on the clinical aspects of his complaints. Trust to consider afresh convener's decision having obtained appropriate advice; and if appropriate, to explain reasons for refusal.

E.1023/95 - 96: Royal Cornwall Hospitals NHS Trust

On 31 January 1995 a man was admitted to Treliske Hospital for tests for lung cancer. On 1 February he suffered a severe fainting attack and later that day doctors discovered that he needed urgent surgery for a strangulated hernia. After an operation on 2 February the man's condition deteriorated and he died that evening. His daughter complained that her family were not kept fully informed of their father's worsening condition. I found that the medical staff had failed to inform the nurses about the hernia and the likelihood of surgery. I also considered that a telephone call in the early hours of 2 February to the family had been made at an inappropriate time and had not provided precise information. I recommended that the Trust should remind staff of the importance of effective communication between clinicians and nurses and that relatives should be clearly and promptly informed of significant developments.

E.1010/95 - 96: Royal Cornwall Hospitals NHS Trust and Cornwall Healthcare NHS Trust

I upheld a man's complaint that in December 1994 he was not offered food during a one-day stay in a hospital managed by Royal Cornwall Hospitals NHS Trust. The man was overlooked and did not receive food until after 6 pm. I also upheld his complaint against both Trusts that they did not explain adequately why his records were not available at an outpatient clinic he attended in June 1995. Both Trusts to review their procedures to make sure that records are obtained in good time and that sufficient information is recorded about the action taken to locate records to enable that to be monitored effectively; Royal Cornwall Hospitals NHS Trust to remind staff of the importance of updating computer systems on which the movement of records is recorded. I partly upheld a complaint that the Trusts' responses to other matters the man had put to them were unsatisfactory. The Royal Cornwall Hospitals NHS Trust did not make it clear that a bed had not been booked for the man when he attended hospital in December 1994; and the Cornwall Healthcare NHS Trust failed to give a full reply because their investigation did not identify a nurse whom the man said had been rude to him. I was satisfied, however, that the Royal Cornwall Hospitals NHS Trust had accurately reported the outcome of their enquiries into the man's allegation that a consultant had been rude to him.

Royal Hospitals NHS Trust, London

E.421/95 - 96

In December 1994 a man was transferred to a previously unoccupied ward where he died two days later of pneumonia. His wife complained that the ward was cold because of faulty windows. Several of the staff remembered the ward being draughty or cold, and one of the windows was still in need of repair on 23 January 1995. Trust to ensure that wards are checked to make sure everything is in good order before patients are moved into them. I upheld the complaint. I found that the Trust's handling of the complaint was very poor and their final response did not answer all the woman's concerns. Trust Board to make sure that complaints are dealt with thoroughly and speedily under newly-agreed arrangements.

E.483/95 - 96

On 6 July 1994, a woman left an appointment with a consultant orthopaedic surgeon believing that she would be admitted for an operation on her back about two weeks later. The woman complained to the Trust on 26 July 1994 about the failure to inform her of a date for admission and that complaint was not resolved until she received the offer of admission 15 months later, in October 1995. She had by then received treatment elsewhere. She complained to me that the Trust had not kept her adequately informed about when she could expect admission and had taken too long to deal with her complaint. I found that, although the consultant categorised the woman as `urgent' Trust records always showed her as `routine'. Although the Trust had planned in September 1994 to produce a standard letter to tell patients of likely waiting times, that had still not happened by August 1996. I upheld both aspects of the complaint and recommended regular monitoring of waiting lists and that patients should be informed of likely admission dates. Trust to make sure that staff are fully aware of their responsibilities under the complaints procedures; Trust Board to monitor the effectiveness of complaints handling.

E.436/96 - 97

A woman complained to the Trust about the diagnosis and treatment which she had received after she fell and hurt her arm. Although she wrote to the Trust's chief executive in July 1995, she did not receive a substantive reply until July 1996. I upheld that aspect of the complaint. In August 1996 the woman requested that the Trust convene an independent review and their convener refused to do so. I invited the Trust to reconsider the convener's decision, and I recommended that they ensure that conveners obtain appropriate clinical advice when considering clinical complaints.

E.687/94 - 95: Royal Hull Hospitals NHS Trust

I found that a woman's complaint about consent procedures used for her mother's operations in February and March 1994 was justified. Staff were unaware of national guidance on obtaining consent. They misled the family about signing consent forms, were inconsistent in explaining when and why relatives should sign such forms and used inappropriate forms. Trust to review consent policy to make sure local guidance fully meets national requirements; staff to be made aware of their responsibilities and implementation of the policy on obtaining consent to be monitored regularly.

S.140/94 - 95: Royal Infirmary of Edinburgh NHS Trust

I found that the Trust had been dilatory in only minor respects in investigating a woman's complaint but I upheld her complaint that they had not kept her informed of progress. The Trust agreed to clarify their policy on complaints handling and to remind staff of the need to comply fully with their complaints procedure.

Royal Liverpool and Broadgreen University Hospitals NHS Trust

E.585/95 - 96

I upheld a man's complaint about delay in arranging a scan in June 1994 only to the extent that there appeared to be some unnecessary delay before the scan request reached the radiology department. I upheld a further complaint about delay in referring him for a consultation at another hospital. A consultant at Broadgreen Hospital intended to make the referral following a consultation in October 1994 but the referral letter was never typed and, despite telephone enquiries from the man, no effective action was taken to remedy the situation until July 1995. I also found that the Trust did not give the man adequate explanations of those delays. Trust to advise staff to retain records of telephone enquiries at least until they are sure the matter has been dealt with, and to remind staff of the need to adhere strictly to their complaints procedure.

E.792/95 - 96

I upheld a woman's complaint that while her late mother was in hospital in November 1994 pressure sores were allowed to develop to the extent that there was no clear evidence of pressure area care. I upheld her complaint that there was a failure to prepare a care plan and that there was poor record-keeping. Trust to ensure satisfactory procedures are put in place for dealing with pressure sores and nursing staff to be reminded of the importance of full documentation of patient care, including the prompt preparation of care plans.

E.1319/94 - 95: Royal London NHS Trust and the former South Thames Regional Health Authority

I investigated a complaint that on six occasions in 1994 ambulance transport failed to collect a woman requiring physiotherapy treatment. Responsibility for the first three occasions which occurred before 1 April 1994, lay with The Royal London NHS Trust and for the last three with the London Ambulance Service. I found that the ambulance used before 1 April 1994 suffered several mechanical breakdowns and the woman was not collected, or told that the ambulance could not collect her on at least

three occasions, and she was not collected by the London Ambulance Service on at least one occasion after 1 April. I partially upheld the complaint.

E.541/96 - 97: Royal National Orthopaedic Hospital Trust, Middlesex

I upheld a complaint that the Trust's complaints convener did not follow the NHS complaints procedure in deciding in June 1996 not to grant an independent review of a woman's complaints about the misdiagnosis of her condition, lengthy waiting times and lack of communication. The convener failed to take appropriate independent clinical advice in coming to her decision. I did not uphold a complaint that the convener failed to tell the complainant of her right to complain to me. Trust to review the convener's decision in the light of the new complaints procedures and to follow the national guidance.

E.1352/95 - 96: Royal Shrewsbury Hospital NHS Trust

I upheld a woman's complaint of undue delay by the Trust in replying to her complaint, made in May 1995, about their oncology service and her care and treatment in hospital. However I did not find that the complaint was investigated inadequately or that their response did not fully address her concerns. Trust to remind staff of the importance of dealing timeously with complaints, adhering to the complaints procedure and making sure that all replies are signed by the chief executive or accompanied by a covering letter from him.

E.413/94 - 95: Royal Surrey and St Luke's Hospitals NHS Trust

On 16 April 1994 a woman received an appointment for admission to Royal Surrey County Hospital on 18 April for a tonsillectomy. The admission was cancelled on the morning of 18 April. On 20 June she received a second appointment for 27 June but on 23 June that was also cancelled. She complained that communications about and arrangements for her admission were unsatisfactory. I found that it was reasonable for the Trust to have given her two days' notice of her first appointment as she had previously indicated that she wanted to be included on a short notice waiting list. However, when faced with a high number of emergency admissions, the Trust's management of appointments for operations fell short of the standard required by the Patient's Charter and they failed to keep the complainant properly informed about when she would receive a second appointment. When they did send her an appointment, it was based on insufficiently detailed thought and planning. Trust to remind staff to keep patients fully and realistically informed about appointments and to make sure procedures are in place to prevent the same failures from being repeated.

E.802/94 - 95: Royal United Hospital Bath NHS Trust

I upheld some aspects of a man's complaint about his wife's treatment at the Royal United Hospital, Bath in late 1993 and early 1994. The woman was eventually diagnosed as having cancer but there were delays in arranging appointments and reporting test results. She had to wait three hours for drugs to take home and I regard that time as excessive. Trust to review reporting procedures to avoid delay, tell general practitioners whenever referrals are redirected elsewhere and give explanations to patients about postponed appointments; also to review procedures for the prescription and issue of drugs to take home and to review their complaints procedure. I did not uphold complaints that an ultrasound scan had covered the wrong area or that the woman's husband was put under pressure to have her discharged.

E.315/95 - 96: Royal Victoria Infirmary and Associated Hospitals NHS Trust, Newcastle-upon-Tyne

In November 1993 a woman was placed on the waiting list of a consultant for an operation. In September 1994 she was told that she was near the top of the list but a few days later the hospital wrote that treatment could not be given because the Newcastle and Tyneside Health Authority would not pay for it. The Newcastle Community Health Council complained on the woman's behalf and the Trust delayed replying to that complaint and then gave the woman misleading information about her situation. Trust to make sure that complainants receive full and prompt replies and to monitor closely the effectiveness of their new complaints system.

E.651/95 - 96: Royal West Sussex NHS Trust

I did not uphold a woman's complaints that, while her father was in hospital in February 1995 recovering from surgery to his ankles, nurses gave him insufficient help with daily washing and failed to notice that he was suffering from acute urine retention. Regular entries in the man's nursing records showed that he had been given help with washing and that his urinary output had been monitored for a time. I did not consider it unreasonable for staff to expect the man to tell them if he felt unwell or had difficulty passing urine.

4. CASE SUMMARIES AND REMEDIES - S - U

Salford Royal Hospitals NHS Trust

E.1397/94 - 95

A woman complained that when her husband attended a neurology clinic at Hope Hospital, Salford, in March 1994 a consultant neurologist did not examine him and ignored his concerns; and that in September 1994 the consultant failed again to respond to their concerns. I did not uphold the complaint about the March consultation, and was unable to reach a finding on the second complaint. I upheld a complaint that the Trust's handling of the second complaint was dilatory and unsatisfactory.

E.1507/94 - 95

A woman whose father was admitted to Hope Hospital, Salford, in March 1994 with a suspected heart attack, complained that although staff were aware that he was restless and confused he was left alone and fell. She complained that no record was made of an eye operation he had had shortly before his admission to Hope Hospital with the result that insufficient attention was paid to his eyes after the fall. As regards the man's fall, I established that staff were aware of his restlessness and confusion and took what they considered to be appropriate precautions for his safety. I did not uphold the complaint. I found that information about the eye operation which the man's son gave to nurses was not recorded and was not passed on to the staff who dealt with him after the fall. I strongly criticised that failure. The Trust had already introduced improved forms and arrangements for record keeping and agreed to keep those arrangements under review to make sure that all information relevant to patients' care and treatment was recorded and passed on where appropriate.

E.497/95 - 96

A woman complained that when she attended the urology clinic at Hope Hospital, Salford, in July 1994 a consultant was rude to her and unreasonably refused to treat her that day; and that the Trust's handling of her complaint was contradictory and inept. I did not uphold the complaint about the actions of the consultant. I upheld the complaint that the handling of the complaint was inept, but not that it was contradictory.

E.762/95 - 96

I did not uphold a man's complaint that the Trust failed to plan adequately for his mother's discharge in September 1994, by not informing social services, resulting in some home help visits being missed. Social services had been contacted but that was not recorded in his mother's nursing notes and I criticised that failing. Trust to remind nursing staff responsible for discharge planning to record the action taken to arrange services for patients. I found that the Trust's complaints manager had dealt adequately with only two of three aspects of the man's complaint. Trust to remind complaints manager to investigate fully every matter raised by a complainant.

E.889/95 - 96

A man who was referred to the orthopaedic department at Hope Hospital, Salford, in October 1993 complained to me in October 1995 that he had still received no treatment. I found that tests had been needed to establish the cause of the man's problems before treatment options could be considered. Those were matters of clinical judgment which, at the time, were outside my jurisdiction. There had been a small delay in arranging a bone scan and reporting its results and a delay of about six months because of confusion about how another test was to be done. Trust to make sure arrangements were in place for tests decided on during outpatient appointments to be arranged without avoidable delay.

E.1049/96 - 97

I did not uphold a complaint that a convener failed to consider the scope for further efforts at local resolution of a man's complaint about the care and treatment received by his mother while she was a patient at Hope Hospital in June and July 1995. She considered such scope and decided there was none. I upheld a complaint that the convener failed to take appropriate clinical advice in deciding whether to convene an independent review of the man's complaints. The convener relied on the clinical advice of a lay chairman appointed by the NHS Executive regional office as he was a retired general practitioner with personal

experience of the illness suffered by the complainant's mother. The appointment by the regional office of the NHS Executive of practising or retired clinicians as lay chairmen contravened the national guidance on the subject and led to confusion between the very different roles of independent lay chairman and independent clinical adviser. I took the matter up separately with the regional office. In any event I did not consider that a retired general practitioner was an appropriate source of advice on the clinical concerns raised by the man, which included the level of consultant input into his mother's care and the drug regime. The Trust apologised for the shortcoming I identified and agreed to review the convener's decision not to hold an independent review, in the light of appropriate clinical advice.

Salford and Trafford Health Authority

E.1388/94 - 95

I upheld a woman's complaint that in February 1994 she and her husband were unable to meet a consultant obstetrician to discuss the birth of their daughter because there was a long delay before the medical records were found. The woman also complained that, at the rearranged meeting, the consultant failed to identify herself, did not respond to their concerns and was aggressive towards them. I upheld the complaint to the extent that the consultant failed to make it clear that she was responsible for the birth of their daughter and that she lost control of the discussion. I did not uphold the complaint that the consultant failed to respond fully to the parents' concerns. Trust to remind staff of the importance of safeguarding medical records and to review their procedures for booking appointments to make sure appropriate time is allocated to deal with each patient's needs.

E.972/95 - 96

I partially upheld a woman's complaint that the Health Authority's handling of her request, made in February 1995, that they fund surgery for her chronic back condition was unsatisfactory and led to her having the surgery done privately. The woman sought redress. In June the Health Authority told the woman that they would not fund the surgery unless she saw a NHS consultant. As the woman's understanding was that she would have to wait at least a year to see a consultant, she paid privately for the surgery in July but the following week she received an appointment to see a consultant in October. I criticised the Health Authority for an initial delay in their handling of the woman's request and for lack of clarity when they explained to her their policy on funding. However, I considered that the Health Authority had sound reasons for believing that the surgery might not be justified and for asking the woman to see a consultant before they could approve the funding. I also found no evidence that the Health Authority was directly responsible for the woman's misunderstanding about when she would see a consultant and therefore I did not uphold her claim that they should reimburse the costs of the private treatment she received.

Salisbury Healthcare NHS Trust

E.110/95 - 96

I upheld a complaint that the Trust's response in December 1994 to a critical independent professional review (IPR) report was inadequate and unsatisfactory. The report dealt with the treatment given in 1992 to the complainant's 18-year-old daughter, who died after being admitted to Salisbury General Infirmary, and the handling of her parents' complaint. I found that the Trust put a lot of effort into addressing the problems highlighted by the IPR report and saw nothing to make me question the seriousness with which they took it. I considered it appropriate for the Trust to ask a panel to study the report and produce a detailed action plan but the Trust did more than that. I considered that the panel re-investigated the case to an appropriate extent; and that it was bound to appear as if the Trust were acting as a court of appeal on their own case. The involvement of the chief executive and the legal manager in the panel, both of whom were involved in the handling of the original complaint, was inappropriate. There was some insensitivity on the part of the Trust to the appearance of what they were doing, and it was unwise to start the panel's report with a comment criticising the IPR. When the Board decided to accept the panel's report those involved in the complaint withdrew from the meeting but that was not recorded. Trust to make sure that their revised arrangements for noting any withdrawals from Board meetings are to be followed.

E.712/95 - 96

A man complained that the Trust's handling of his complaint in late 1994 and early 1995 about the misdiagnosis of his late son's condition was dilatory and inadequate. I upheld the complaint and criticised the Trust for failure to follow their own complaints procedures and for the fact that the complainant was given inaccurate and misleading information.

E.1009/95 - 96

A man complained that his wife experienced unacceptable delays when she attended renal outpatient clinics in August and November 1995 at a hospital run by Salisbury Healthcare NHS Trust (the first Trust). The clinic was provided by a second Trust

I found that the delays were excessive and there was confusion between the Trusts about which was responsible for which aspects of the clinic, including outpatient waiting times. First Trust to approach second Trust and the Health Authority to agree a statement outlining the responsibilities of each Trust and arrangements for monitoring its performance. First Trust also to review the arrangements for clinics involving them but provided in, or by, other Trusts to make sure that there was no similar uncertainty. The first Trust failed to pursue adequately the need for a realistic clinic schedule until a longer term solution could be found. I upheld the man's complaint that the first Trust's reply was unsatisfactory and recommended that they review their complaints procedures to make sure that guidance included arrangements for complaints involving other Trusts.

S.76/95 - 96: South Ayrshire Hospitals NHS Trust

I partly upheld a man's complaint about the way in which the Trust dealt with complaints which he put to them in April 1995. I also found no evidence to justify the Trust's refusal to provide the man with the name of a physiotherapist who had treated him. Trust to review their position about disclosing the physiotherapist's name.

E.935/95 - 96: South Devon Healthcare NHS Trust and South and West Devon Health Authority

A woman complained that Trust staff did not follow correct procedures when discharging her mother to a private nursing home in August 1994. She also complained that the Authority were wrong in refusing to pay the home's fees. She believed that the placement was a NHS responsibility as it was arranged by staff at the hospital. I did not uphold either aspect of the complaint. I found that although nurses at the hospital made the practical arrangements to transfer the patient to the home, they did so only after social services had approved the placement and accepted responsibility for it, and in the belief that the woman herself had agreed. I found that national guidance had not been followed in that the woman had not been told in writing whether the cost of the home would be met by the NHS, but I did not consider that to have caused injustice or hardship as it was clear that she was aware from an early stage that they would not.

E.1406/95 - 96: South Humber Health Authority

I did not uphold a complaint that in February 1995 the Health Authority's dental public health adviser failed to explain fully to a woman the reasons for the Authority's decision not to approve funding for dental implants. I found that he had given reasons for his refusal, although there was delay in the woman receiving that explanation due to an error by a third party. I also upheld a complaint that despite repeated requests, the dental public health adviser unnecessarily delayed giving the woman details of alternative treatment options which might have been suitable for her - although prime responsibility for discussing future treatment options with the woman rested with her general dental practitioner.

E.1423/94 - 95: South Lincolnshire Community and Mental Health Services NHS Trust

A woman complained about the Trust's investigation of her complaint that staff in a psychiatric unit had been negligent in failing to prevent an assault on her by a patient in October 1994. I accepted that the Trust's investigation was impartial but I upheld the complaint to the extent that the Trust failed to interview all possible witnesses and that their response lacked sufficient detail. Trust to remind staff of the need to interview all potential witnesses when dealing with such a complaint; to ensure that it is fully answered; and the need to record significant interviews which form part of an investigation.

E.1116/94 - 95: South Staffordshire Health Authority (formerly Staffordshire FHSA)

I upheld a man's complaint that because of the FHSA's dilatory and inept handling of his complaint, from November 1993 to November 1994, he was denied the opportunity to have his complaint against his late mother's GP considered under the formal procedure. The Health Authority agreed to consider the man's complaint under the correct procedures.

South Tees Acute Hospitals NHS Trust

E.1057/94 - 95

I upheld complaints from the husband of a woman who attended hospital in May 1994 for a planned admission. Her room had not been prepared and she experienced a significant delay before being seen by a nurse. While she was waiting, two male cleaners entered her room. I criticised staff for poor communication and lack of adequate explanations. Due to inadequacies in the hospital's computer system and carelessness by staff the woman was not given a follow-up appointment and was twice given appointments when her consultant was not available. Trust to remind staff of the need to communicate with patients and to review the system for monitoring and filing test results and for despatch and receipt of radiology reports.

E.1186/94 - 95

A woman who was put on a waiting list for fertility treatment in 1993 understood that it would start once funding was made available by her health authority. In September 1994 she was told that she and her partner did not meet a recently-introduced criterion and that treatment would not therefore be provided by the NHS. I was satisfied that the criterion was introduced to ensure that limited funds were used effectively but I recommended that the decision on the woman's case be reviewed because I found it had been reached without considering properly whether she had been given grounds to believe that she had been offered treatment when, and not if, funding was available. I did not uphold her complaint. Trust to remind medical staff of the need to ensure that patients understand and are kept informed whenever treatment depends on non-clinical factors such as the availability of funding.

The former South Thames Regional Health Authority

E.1140/94 - 95

I upheld a woman's complaint that the London Ambulance Service's investigation of her complaint to them in December 1993 about an ambulance journey was dilatory and that their response lacked sensitivity and included factual inaccuracies. They also failed to provide full explanations or assurances that action had been taken to address the failures which had been identified. London Ambulance Service NHS Trust to monitor their complaints procedures and review instructions on dealing with cases where a death has occurred.

E.439/95 - 96

A woman complained about the way an independent professional review, held in October 1994 under the former NHS clinical complaints procedure, dealt with her complaint about various aspects of her treatment. She believed that a consultant surgeon, who had treated her after the events complained of, should have been interviewed. At one point she had been told that he would be. I found that the procedure did not require the assessors to interview the consultant surgeon. Clinical aspects of the judgment not to interview him were outside my jurisdiction at that time. I did not uphold the complaint.

E.203/95 - 96: South Warwickshire General Hospitals NHS Trust

I upheld a woman's complaint that her father, who was admitted to hospital in April 1995, fell after he was left unattended on a commode. Staff had not followed normal procedures on the positioning of the commode and I recommended that the Trust remind staff of the need for care in the use of commodes. I found that there had been an unacceptable delay in resiting a drip but did not uphold a complaint that her father was not helped to drink during that time. I did not uphold complaints that the man's blood pressure was inadequately monitored or that he was inadequately supervised when his bed was moved to the day room. I upheld the woman's complaint about the Trust's handling of her complaint: a meeting was badly arranged and no record kept; a letter which gave condolences for the death of her father was dated the day before his death - the Trust apologised for this error. Trust to ensure that complainants are made aware of the nature of meetings and who will be present; and that records are kept which are confirmed with the complainant.

S.47/95 - 96: Southern General Hospital NHS Trust, Glasgow

I found that the Trust's reply to a woman's complaint about her mother's care and treatment, made in December 1994, while not intentionally misleading, gave a far more positive assessment of the discharge arrangements made for her mother than could be supported by the available evidence. I also found that the Trust took too long to reply to a further letter from the woman in July 1995 and that their reply did not answer a question she had raised. Staff were reminded of the need to address all the issues raised in a complaint and to keep the complainant informed of what is happening. Trust to write to the woman about the outstanding issue.

St George's NHS Trust, London

E.673/94 - 95

A woman complained about her husband's treatment on the day of his death, in March 1993, at St George's Hospital, Tooting, the lack of support and information she received and poor record-keeping. I upheld her complaints that her husband's nursing and medical records for that day were inadequate which prevented the Trust from giving her a proper explanation of events before his death; that when she telephoned the ward shortly before her husband's death to ask how he was, a staff nurse's manner was tactless (although I did not consider it misleading); and that after her husband's death the staff nurse failed to speak to her about events on that day. I did not uphold complaints that her husband's pain was not monitored effectively; that his diabetes was inadequately managed; that he was left unattended; and that after his cardiac arrest there was a delay before a crash team was called. I noted that the ward's record system at the time, which nurses found complicated, was no longer in use. The nurses

on duty had not received bereavement training despite Health Authority guidance on that. All nurses to receive training and guidance on dealing with the bereaved.

E.1072/95 - 96

A woman was taken to the accident and emergency department in September 1995 and died a few hours later. Her family were not informed and her son found out indirectly three weeks afterwards. I upheld his complaint that the Trust had made inadequate efforts to contact her next of kin. No next of kin details were recorded when she was admitted. There were two sets of notes for the woman - with different first names - one of which did not include next of kin. Trust to improve their written policy about obtaining next of kin details, examine ways of preventing the creation of duplicate records and agree new procedures with the police for contacting relatives where next of kin are not known.

E.1298/96 - 97: St Helens and Knowsley Hospitals NHS Trust

I upheld some aspects of a man's complaint that his request for an independent review in June 1996 had been handled unsatisfactorily by the Trust. I upheld complaints that the request was not passed immediately to the convener, and that the convener sought to resolve the case through her own investigations thereby compromising her role. I did not uphold a complaint about failure to take independent medical advice. Trust to review their procedures for dealing with requests for independent reviews and the convener to reconsider her decision.

St Helier NHS Trust, London

E.981/94 - 95

A woman complained that her father received inadequate nursing care between December 1993 and January 1994 in that he was left unattended on a chair or commode for long periods; his urine bag was not emptied and on one occasion failed to work correctly; commodes provided were too small and not cleaned; his air bed was not disinfected or cleaned before use; his care plan for oral hygiene was not followed; and a suction machine was used roughly. I made no finding on the complaints about the care plan and suction machine. I did not uphold the other complaints.

E.1062/95 - 96

I upheld a complaint that the Trust's handling of a complaint by a woman in December 1994 about aspects of her mother's care and treatment was dilatory and unsatisfactory. The Trust took seven weeks to reply to the woman's initial letter of complaint and almost five months to reply to her second because the papers were lost. Definitive replies were not sent by the chief executive and the woman was incorrectly told that her complaint had been reviewed by the Trust's complaint panel. The clinical aspects of the complaint were not dealt with under the national clinical complaints procedure until the woman specifically asked for that to be done. Trust to provide the woman with a full account of the action taken as a result of her complaint. Trust Board to satisfy themselves that new arrangements for dealing with complaints ensure adequate investigation and full and prompt replies in every case.

E.849/95 - 96: St James's and Seacroft University Hospitals NHS Trust, Leeds

I did not uphold a woman's complaint that, in February 1994, staff failed to monitor her late mother's condition adequately or act on concerns expressed by her family, though I criticised the staff's recording of those concerns. I found that misleading information was given about the source of a request for physiotherapy and that there was a delay in the Trust's replies to the complainant. Trust to make staff aware of the importance of responding to and recording relatives' concerns, to review arrangements for providing continuity of qualified nursing care and to make sure that further complaints are referred promptly to the complaints officer or chief executive.

St Mary's NHS Trust, London

E.1166/94 - 95

The family of a 100-year-old man complained that in March 1994 he waited for nine hours on a patient trolley in the accident and emergency department of St Mary's Hospital, Paddington, before being admitted to a ward. They also complained that during that time requests for pain relief were not answered and he was not offered any food or drink. I found that the man had to wait too long on the trolley. I also found that insufficient attention was given to make sure he was adequately supplied with food and drink. I was unable to make a finding on whether pain relief was given because of poor record-keeping. I upheld both aspects of the complaint. Trust to remind staff of national guidance about recording the administration of medicine.

E.1443/95 - 96

A man complained that when he attended the accident and emergency department at St Mary's Hospital, Paddington, in November 1995 medical staff breached confidentiality by discussing his condition in a telephone conversation with his sister. I was unable to identify the staff member allegedly involved and I made no finding. However, I had doubts about the adequacy of the Trust's investigation of the matter and I considered that they should have explained to the man in more detail their reason for refusing a meeting to discuss his complaint.

E.1115/94 - 95: Sunderland Health Authority

I did not uphold a woman's complaint that in November 1992 the Health Authority had failed in their duty of confidentiality to her by releasing clinical information about her condition to the Department of Health to enable a Minister to reply to a complaint from the woman's Member of Parliament. The Health Authority's chief executive considered it necessary to give some details of the woman's condition to place her complaint in context, but when he sent the information to the Department he had made it clear that it was confidential.

E.1413/95 - 96: Surrey Heartlands NHS Trust

I upheld a woman's complaint that two meetings which had been arranged between her and a consultant psychiatrist at the affective disorders clinic (ADC) at West Park Hospital, Surrey, towards the end of 1995 were unsatisfactory; that was because the consultant psychiatrist was inadequately prepared and did not have her records in his possession. I also upheld her complaint that a further consultation with the consultant psychiatrist in March 1996 could not take place because again the records were not available. Trust to remind staff of the need, whenever practicable, to confirm in writing to all interested parties details of meetings with complainants and also to review arrangements in the ADC and introduce any necessary safeguards.

Swindon and Marlborough NHS Trust

E.723/95 - 96

I upheld a woman's complaint about information provided to her about an operation which she had been told, in May 1995, would take place in a month. It was a year before the operation took place as some of the Trust's operating facilities were closed and the Trust had left it to patients to discover that for themselves. I criticised the Trust for failing to give the woman her Patient's Charter right to receive detailed information on local health services, including waiting times, and for failing to provide other information she required about the operation. Trust to give a guaranteed date by which a patient will be admitted for treatment or, if a date cannot be given, the reasons why.

E.1037/95 - 96

I upheld a woman's complaint about the loss of her father's urine sample, taken in January 1995 while he was a patient receiving respite care at St Margaret's Hospital. I found that no records were kept of samples sent for testing and there was no system for checking whether results had been received. Trust to review the system for recording and monitoring requests for tests including considering the use of computers. I did not uphold a complaint that there had been a failure in nursing care in that the patient was given inadequate assistance to drink.

E.613/96 - 97: Tameside and Glossop Community and Priority Services NHS Trust

I did not uphold a complaint that in March 1996 the Trust failed to make adequate or timeous arrangements for a woman's continuing treatment when the clinical psychologist who had been treating her was made redundant. However I found that the Trust failed to register or treat as a complaint the oral representations she made to them. Trust to make sure that complaints are dealt with in accordance with their complaints policy, and explanations to be given to all the concerns expressed by complainants.

United Bristol Healthcare NHS Trust

E.490/95 - 96

A woman complained about aspects of her care and treatment during the birth of her son in St Michael's Hospital, Bristol in April 1994. I upheld complaints about the loss of her hospital medical records; failures in communication about the use of a pseudonym; that her concerns were dismissed rudely and without adequate explanation; that soiled bed linen was left unchanged; and that she was denied privacy when the lavatory in her amenity room was used by other patients because ward toilets were out of order. I did not consider it a failure that she had to wait while the amenity room was cleaned, and I did not

find made out a complaint that the woman's wishes regarding her chosen birthing method and partner were disregarded. Trust to review procedures for the movement and storage of records, keep a record of action taken to find missing records and remind staff of the importance of safeguarding records. Trust also to produce guidelines for recording and implementing patients' requests to use a pseudonym, remind staff of the need to fully discuss a woman's birth plan with her and review procedures to make sure that the availability of linen and other baby supplies is made known to all patients. Staff dealing with complaints to be reminded of the need to investigate complaints thoroughly.

E.515/95 - 96

I made no finding on a complaint that a man should have been told that his mother could stay in hospital following a stroke (although that would have been contrary to medical advice), rather than be discharged to a private nursing home in December 1990, where the cost of her care was met from the sale of her home and statutory benefits. The complaint did not reach me until August 1995, but I considered that there were circumstances to merit waiving the usual time limit. The evidence of the complainant varied greatly from that of the hospital staff and I was unable to resolve those differences.

University College London Hospitals NHS Trust

E.965/94 - 95

In July 1994 the Trust neglected to contact the daughter of an elderly man when his condition deteriorated and he subsequently died, despite having specifically been told to contact her at any time if his condition changed. When the daughter went to see her father's body the following day the viewing was delayed unnecessarily as the arrangements were left to an inexperienced student nurse to organise unaided. The daughter complained to the Trust about the lack of contact and the delay in seeing her father's body. Apart from an initial acknowledgement letter the complaint was not investigated thoroughly and she never received a final reply. I upheld the complaints about the events surrounding the death and about the Trust's handling of the woman's complaint to them.

E.1472/94 - 95

A man complained that between October 1994 and October 1995 the National Hospital for Neurology and Neurosurgery failed to arrange a meeting between him and his consultant. I upheld the complaint to the extent that there were significant delays in arranging the meeting which was then cancelled without explanation. I also upheld his complaint that the hospital failed to implement the second stage of the clinical complaints procedure in operation at the time. No further action was taken to resolve the complaint once my investigation began. Trust to pay special attention to its complaint handling procedures and to contact the complainant, and take appropriate action, to resolve outstanding concerns.

E.664/95 - 96

I upheld a man's complaint, made in September 1995, that a consultant at the National Hospital for Neurology and Neurosurgery had not replied to his letter of complaint of 3 November 1991. The consultant could find no trace of the original letter. A draft for the general manager's signature had been prepared in response to a copy of the original letter provided by the local community health council but it had never been sent. The general manager accepted responsibility for that omission although he had still not replied to the complaint. I criticised him for taking the view that a reply was no longer necessary. The Hospital's complaints procedures to be reviewed by the Trust's non-executive directors and applied and monitored properly in the future.

E.734/95 - 96

I upheld a complaint that the Trust failed to give a satisfactory explanation to a woman in late 1994 about why her medical records were not available at several outpatient clinic appointments which she attended, that the problem continued to occur and that her complaint was not put to the Trust's complaints panel as she had asked. Trust to review arrangements for the removal of records from record libraries, follow-up action when records go missing and training of temporary staff in record retrieval.

E.512/95 - 96: University Hospital Birmingham NHS Trust

I partly upheld a woman's complaint that her husband, who had recently had two major operations, was transferred from the Midland Centre for Neurosurgery and Neurology to Hereford County Hospital in April 1995 in an unsuitable vehicle. The man was transferred in a non-emergency seated ambulance which the ward sister had ordered in accordance with long-established practice. I found that the sister, who was unaware of relevant guidance, was unduly influenced by the man's ability to walk and care for himself. Greater consideration should have been given to the man's comfort during the two-hour journey. Trust to review their guidance and make sure that all staff concerned are aware of it and of relevant national guidance.

Walsgrave Hospitals NHS Trust

E.1105/94 - 95

A man who required 24 hour nursing care was admitted to a hospital outside his health authority's area. His wife complained that when he was discharged in February 1993 no arrangements were made for his continuing care under the NHS and she was given no advice or information about the provision of such care. She felt under pressure to make her own arrangements and as a result she had to pay for her husband's care in a private nursing home which caused financial hardship. I was not persuaded that the hospital staff withheld help from the woman or put pressure on her to find alternative accommodation for her husband. I was satisfied that the Trust made an attempt to arrange continuing care, but the woman was deprived of the main channels through which discharge planning normally takes place by her refusal to allow nurses or a social worker to become involved. I upheld the complaint to the extent that there were some communication failures on the part of the Trust, and Department of Health guidance was not followed. Trust to make sure that all staff involved in the discharge of patients are familiar with Department of Health guidance and that they review their discharge policy to ensure that it reflects that guidance and deals adequately with the situation when a patient comes from outside the local area.

E.327/95 - 96

In March 1994, an elderly woman patient in Coventry and Warwickshire Hospital fell three times from her chair. I found that nurses had given inadequate consideration to her continued use of the chair. Trust to remind staff that the circumstances of accidents should be considered fully to prevent them recurring. I found no fault with nurses' management of the woman's incontinence, but they failed to inform her daughter adequately about the care and treatment of pressure sores. Replies to the daughter's complaint were delayed and inaccurate.

E.1218/95 - 96

I upheld some aspects of a woman's complaint about her father's nursing care and treatment in Walsgrave Hospital between September 1994 and July 1995. I found failures in record-keeping, communication, provision of meals and a delay in a referral to a second consultant. I found that the Trust had failed to send holding letters to the family telling them of the progress of their enquiries into the complaint. I did not uphold complaints about access to a call bell, checking and cleaning a wound and checking and emptying a urine bag. Trust to remind staff of the need for accurate completion of nursing notes and to monitor the introduction of new referral procedures.

4. CASE SUMMARIES AND REMEDIES - V - Z

E.1144/95 - 96: Warwickshire Health Authority

I upheld a complaint that the Authority did not make sure that their policy about informing local residents was followed when a voluntary organisation purchased a house intended for supported accommodation for mentally ill residents. They expected the voluntary organisation to inform the residents but the organisation was neither aware of that nor of the policy. I criticised the Authority because this case arose only months after the report of my investigation into a similar case at the Authority. I also upheld a complaint that the Authority's replies to the complainant were inadequate and misleading. The Authority revised their policy and its promulgation to the voluntary sector.

E.879/95 - 96: Weald of Kent Community NHS Trust

I found that a complainant was unable to produce sufficient evidence to support a complaint that a woman was put under undue pressure to agree to be discharged from hospital to a nursing home in December 1994. I did not uphold a complaint that she was transferred without her family's agreement and contrary to what had been agreed with the consultant treating her. However I criticised the discharge procedures in the ward, particularly a failure to tell the family when the transfer was to take place. Trust to audit the implementation of new discharge procedures.

E.560/94 - 95: West Hertfordshire Health Authority (successor to North West Hertfordshire Health Authority)

A woman whose husband was admitted to Hemel Hempstead General Hospital in December 1993 after suffering a stroke complained that his medical records had been poorly maintained and that he was often left in an undignified, semi-naked state in a mixed sex ward. I did not uphold the complaint about the medical records. The man had been confused, restless and incontinent and nurses made plans to deal with those problems. However, they faced particular difficulties because at that time the hospital was not always able to maintain adequate supplies of clean clothes to wards. I upheld the complaint to that extent.

E.1446/95 - 96: West Middlesex University Hospital NHS Trust

A woman wrote to the Trust in June 1995 complaining about her treatment when she had attended West Middlesex Hospital the previous month with a suspected heart attack. She wrote again in August but despite intervention by both her MP and the NHS Executive she did not receive a substantive reply until February 1996. She considered that reply to be inadequate. I upheld the woman's complaint that the Trust's handling of her complaint was dilatory and did not comply with the standards set out in the Trust's complaints procedure. I noted with approval the action which the Trust had since taken to improve their handling of complaints. The Trust's reply failed to deal explicitly with the woman's concerns and had been signed on behalf of the chief executive without being checked against the original complaint. I considered it unacceptable that the reply was signed on behalf of the chief executive when he had not approved the draft. Trust to remind staff that in line with the Patient's Charter replies to complaints should be sent by the chief executive; Trust to monitor closely the effectiveness of their new complaints procedure.

E.525/96 - 97: West Pennine Health Authority

I upheld a complaint that the Authority's convener did not follow the NHS complaints procedures in deciding in July 1996 not to grant an independent review of the complainant's grievances about a locum general practitioner's refusal to provide treatment for an eye infection in January 1996. The convener refused an independent review because he formed the clear view that the complainant had an explicit intention to take legal action. I considered that the convener might have applied an interpretation which was not intended. I also noted contradictory drafting in the national guidance on the test to be applied in judging whether legal action is intended. The convener failed to set out in writing to the complainant the reason for his decision, instead leaving that to the complaints manager. I criticised the Authority's chief executive for failing to provide me with all the Authority's internal documents on the case. Authority to review the convener's decision in the light of the requirements of the new complaints procedures and to make sure that relevant staff and conveners follow the national guidance.

E.578/94 - 95: West Sussex Health Authority (successor to Mid-Downs Health Authority)

In October 1992 a woman was discharged from Princess Royal Hospital, Haywards Heath, to a private nursing home where she

died in July 1994. In February 1994 her husband complained to the health authority that her long-term care should have been funded by the NHS and that their rights had not been explained to them. The health authority replied that the decision to move the woman to a nursing home had been made with his agreement. The woman's husband then complained to me. I found that he had the necessary general information about the arrangements for his wife's care and although he was not told in writing (as required by national guidance) who would pay the nursing home fees he was not caused any hardship or injustice by that failure. I found no evidence to establish that in 1992 the woman had a right to long-term care funded by the NHS but I criticised deficiencies in the response which her husband received from the health authority in 1994. The health authority apologised and agreed to remind their provider units about giving information to patients and relatives.

E.506/95 - 96: Whittington Hospital NHS Trust, London

A woman complained that, in September 1994, when her husband had a psychotic reaction to chemotherapy, he was treated roughly by security officers who were returning him to his bed. She said that, during the investigation of her complaint, the Trust were unreasonable and failed to demonstrate impartiality in refusing to allow her to meet the officers or to see their written statements about the incident. There were conflicts in evidence and I did not find the complaint about the officers' behaviour made out. Although I criticised the Trust for failing to take statements at the time of the initial complaint, I did not uphold the woman's complaint about the Trust's handling of her complaint.

E.106/95 - 96: Wigan and Leigh Health Services NHS Trust

A woman was admitted to Leigh Infirmary in February 1994. She complained that a senior house officer (SHO) refused to attend her, that on two occasions he was rude and aggressive towards her, and that on the second occasion a nurse failed to follow proper chaperone procedures. The woman and her husband said that the handling of their complaint was inadequate. I found that the allegation that the SHO refused to attend was not made out and I made no finding on the first complaint about his attitude. I upheld the complaint about the second incident to the extent that the SHO's actions could have been seen as aggressive but I did not uphold the complaint about chaperone procedures. I partly upheld the complaint about the handling of the couple's complaint.

E.726/95 - 96: Wigan and Bolton Health Authority; Wigan and Leigh Health Services NHS Trust

A man suffered a brain haemorrhage in 1991 which left him with memory impairment. From October 1992 until June 1993 the health authority (HA) funded his attendance at a transitional rehabilitation unit. I upheld a complaint that there were then significant delays by the HA in arranging a further rehabilitation programme for the man. I did not find that the Trust had contributed to those delays, although I upheld a complaint that they should have provided cover for an assistant psychologist employed by them to work with the man or explained that occasional missed days would not be detrimental to his care. The HA to remind staff that, where there is a need for continuity of care, arrangements are made to provide it.

E.98/95 - 96: Wirral Community Healthcare NHS Trust

A woman complained that in November 1994 a health visitor from a clinic managed by Wirral Community Healthcare Trust breached confidence by discussing her child with a child minder. I did not consider that the health visitor could have ignored the childminder's concern but she merited criticism for passing on information, which was effectively part of the medical records, that the child had not had a 15 month check and I upheld that aspect of the complaint. Trust to consider ways to inform parents of their policy on health visitor contacts and to review their systems for supervision of health visitors, and for making sure that visits are made at appropriate times.

Wirral Hospital NHS Trust

E.70/95 - 96

A woman complained about the care her late mother received in Arrowe Park Hospital in September 1994. Because of poor record-keeping and conflicts in evidence I was unable to reach a finding on the cause of bruising suffered by the patient. The woman also complained that her mother was given radiotherapy treatment against the family's wishes. I was satisfied that the woman had consented to treatment but I criticised the poor communication with the family. I upheld the complaint that there were serious deficiencies in the Trust's investigation of the complaint. Trust to remind all staff of the need to treat patients with dignity and compassion, to review record keeping and communication, and to make sure that allegations of rough handling are investigated speedily and rigorously.

E.682/95 - 96

On 27 May 1995 a woman's mother was admitted to Arrowe Park Hospital. On 27 June the woman complained about the loss of

her mother's hearing aid. The woman could not remember whether she told staff that the hearing aid had been brought to the hospital. The records showed that staff took adequate steps to check and record her mother's property. I did not uphold that aspect of the complaint. When her mother was discharged the woman was not told that there was a drainage bag over the wound site or that a district nurse would be calling. The documentary evidence showed that there was some discussion of the mother's discharge arrangements but records were not completed as fully as they should have been and some entries were unsigned and undated. A staff nurse should have taken remedial action once she realised her omission to explain about the bag. I upheld the complaint about those shortcomings. I found that the Trust's handling of the woman's complaints was unsatisfactory and the Trust did not follow its complaints procedure or comply with the patient's charter.

E.1326/95 - 96: Worthing and Southlands Hospitals NHS Trust

In July 1995 a woman complained to the Trust that she had had to wait three and a half years for an operation to her wrist. I upheld her complaint that the Trust's reply was inaccurate and failed satisfactorily to explain the delay. Trust to remind staff dealing with complaints of the need to obtain all relevant documents and to make sure that replies are factually correct and cover all the issues raised. I invited the Trust to consider arranging a meeting with the woman and to deal with a claim for compensation which she had made.

York Health Services NHS Trust

E.150/95 - 96

I did not uphold a man's complaint that a health visitor had breached confidentiality in disclosing to his former partner in February 1995 his concerns about the safety of their son. I upheld his complaint that the Trust had made inadequate responses to the issues he had raised. Trust to remind staff of the importance of providing full replies to complaints.

E.724/95 - 96

I did not uphold a woman's complaint that while her husband was a patient in York District Hospital in April 1995, he fell over because he was given inadequate nursing care and that staff failed to give her a prompt or satisfactory explanation for his fall. I upheld in part her complaint that the Trust's handling of the complaint was unsatisfactory.

5. COMPLAINTS UNDER THE NEW NHS PROCEDURE

5.1 This Chapter describes the experience of my Office so far in dealing with complaints under the new NHS complaints procedure described in Chapter 1. Detailed guidance on the new procedure was issued by the three national NHS Executives [``Complaints: Listening....Acting....Improving''] in March 1996.

5.2 All complaints must first be considered through `local resolution'. In NHS Trusts, Authorities or Boards local resolution of written complaints must be ended by a letter from the Chief Executive; in the family health services, local resolution is concluded by a letter from the practice concerned after the complaint has been considered through the practice-based procedure that all practitioners are now required to have.

5.3 Complainants have to be told at that stage that if they are not satisfied with the response they have received they may ask for an independent review panel to be set up by the relevant Trust, Health Authority or Board. Such requests have to be made to the `convener'. Each Trust, Authority or Board is required to appoint one of its non-executive directors as convener, though other persons may also be appointed. The role of the convener is central to the new procedure. Conveners decide whether to establish an independent review panel, or to refer the complainant back for further attempts at local resolution, or that there is nothing further that can be done to resolve the complaint. All those appointed as conveners in 1996 were necessarily new to the task, as it had no equivalent in the old complaints procedure and some had no previous experience of the NHS. The national guidance requires them to act impartially, and to seek advice from a lay person drawn from lists of persons regarded as suitable to chair independent review panels. If clinical issues are involved conveners have to seek appropriate professional advice from someone not associated with the handling of the complaint up to that stage. The guidance also requires conveners to give as full an explanation as possible to the complainant if they decide not to set up a panel.

5.4 If conveners decide against setting up a panel they are required to tell the complainant of his or her right to complain to the Health Service Commissioner about that decision.

5.5 Some commentators forecast that the new complaints procedure would run into difficulties through the workload placed on conveners or through NHS bodies having to run an unmanageable number of panels. Others warned that my Office would be inundated by complaints from those whose requests for panels had been turned down. So far, these forecasts have not proved right. [Figures from the NHS Executive for England show that in the first year of the new procedures 362 panels were held or were in the process of being set up. The NHS Executive for England received some 2,446 requests to nominate lay chairman either to advise conveners on whether to set up a panel or to chair a panel. These figures suggest that there were about the same number of requests to conveners for panels from people dissatisfied after local resolution, though that may be an underestimate.] The number of complaints going through local resolution in 1996 - 97 is not known, but on historic trends was probably well over 100,000.

5.6 Over the first year of the new procedure my Office received 353 complaints from people complaining about conveners' decisions, or asking me to investigate the issues about which they had originally complained, or both. By the end of March 1997 I had completed 21 investigations of complaints about conveners' decisions. The average length of time of these investigations was 19 weeks. A further 25 were in progress.

5.7 Such complaints began to reach my Office in the autumn. My predecessor took the view that it was in the interests of complainants and the NHS that those dissatisfied by the services they had received should have their complaints dealt with fully and fairly within the local complaints procedure without having recourse to this Office. He accordingly regarded it as an important part of his responsibilities, at the outset of the new complaints procedure, to investigate whether, in reaching their decisions, conveners were acting in accordance with the directions and guidance issued by the NHS Executives. He took the view, which I share, that complainants had a right to expect that their complaints would be dealt with in accordance with the new procedure, and that failure in this respect could of itself be regarded as maladministration causing injustice.

5.8 In law, conveners are acting for their Trust, Authority or Board when they decide whether or not to convene a panel, and their decisions are decisions made by the bodies in whose name they act. When I investigate complaints about decisions of this

kind which are within the discretion of the NHS body concerned I have no power to recommend a different decision. However, if I consider that the decision was in some respect maladministrative I may, if appropriate, invite the body concerned, through their convener, to consider the decision afresh, putting right whatever maladministration I have identified. All such invitations have been accepted. Once a convener has decided whether or not to convene a panel, he or she cannot lawfully change that decision unless I have recommended that the decision should be reconsidered. The convener cannot alter the decision, for example, because of further representations from the complainant, unless, exceptionally, wholly fresh evidence is brought forward and the nature of the complaint is changed.

5.9 When I recommend that a decision should be considered afresh, that carries no implication that the NHS body should reach a different decision. I know that in a good number of instances the convener has reached the same decision, so that my intervention has not been of direct value to the complainant. However, it is important that complainants should feel confident that, under the new procedure, their concerns will be properly and fairly considered at each stage, whatever the outcome. The procedure is designed to achieve that. Failures to follow it undermine that confidence. However, in deciding whether to investigate conveners' decisions my predecessor and I have generally had regard to whether the apparent shortcomings might have affected the decision, or might reasonably be thought by the complainant to have done so.

5.10 Some investigations were also undertaken with a view to illustrating, by examples, what this Office considered to be a reasonable response by conveners to complainants, having regard to the national guidance and directions. It is not for my Office to change the national guidance or to create any new and separate requirements. However, in order to do justice to those who complain to me I have to decide whether the guidance is being properly followed; and this necessarily involves some interpretation. I regard it as important, both to complainants and to those in the NHS who respond to complaints, to be as open as possible about such matters. This is particularly so at present, when the new complaints procedure is bedding down, so as to promote a common view of what is good practice. My investigations may also help to establish issues where the NHS Executives may need to consider amending, clarifying, or adding to their guidance.

5.11 Among the issues which have led me or my predecessor to investigate a convener's decision I draw attention to failings in three specific areas where it is particularly important, in my view, for the conveners to get things right. Underlying all three is one theme - that of confidence. Complainants need to have confidence that conveners, and those who give them clinical advice, are taking a truly independent and impartial view of their complaint. Conveners should remember, particularly if they are a member of the body against which the complaint is made, that however objective they may be in considering the issues they may not be perceived as such. They should therefore avoid language which appears to identify them with the body complained against. They should remember also that even if they themselves are satisfied that the NHS body concerned has conducted an adequate investigation these may still sometimes be advantage in referring the complaint to a panel because it is seen to be independent.

Failure to obtain appropriate clinical advice

5.12 If clinical issues are involved the convener is required to obtain appropriate clinical advice from someone who has not already been associated with the complaint. Conveners are invited to look in medical cases to the medical director in the first instance, and in other cases to other professional heads. They may seek advice from an independent assessor from the lists maintained by the NHS Executive in England, the Welsh Office in Wales, or in Scotland by Health Boards; if a clinical complaint is against a family health service practitioner they must seek such advice. My investigations have included cases where, despite evident clinical issues, such advice was not sought at all; or it was obtained from people who had been involved earlier or whose impartiality might be doubted, for example the responsible clinical director or the medical adviser employed by the Health Authority. If it appears from what the complainant puts to me that there may have been failings in getting appropriate clinical advice I will almost always investigate as there is inevitably a question whether the convener can have reached a properly considered decision. However, if there appears to be no doubt, even before investigation, that there has been such a failure, I may simply invite the NHS body to have the decision reconsidered. If they accept, that puts consideration of the complaint back on the right track with the minimum of delay.

5.13 It is important that when conveners seek clinical advice they should not exceed their role, which is not to investigate the complaint or resolve the complaint themselves but to consider whether, through further local resolution or an independent review panel, it may be resolved. Clinical advice to the convener should be directed primarily at whether the complainant has had a full and satisfactory response on clinical issues in the local resolution stage - whether the answers cover the specific concerns and whether they stand up to independent scrutiny. If the adviser has doubts on that score the convener will need advice on whether matters are best taken further by referral back to local resolution or by establishing a panel with independent clinical assessors. To give that advice may require a review of the clinical aspects of the complaint and the patient's treatment; but it remains the role of the adviser to help the convener reach a decision, not to pre-empt the role of an independent panel and their assessors. This is a difficult area; but cases do come to me where the line has been crossed and, having taken clinical

advice, the convener has, in effect, rejected a complaint which had not been fully or adequately dealt with in local resolution but without reference back or setting up a panel.

Failure to provide adequate reasons for decisions

5.14 The national guidance requires that complainants should be given as full an explanation as possible by the convener of his or her reasons for a decision, so that they can understand it and so that, should they wish to complain to my Office, they can make clear what their points of dissatisfaction are.

5.15 In some complaints put to this Office conveners have simply stated that they consider that the complaint has already been fully and fairly addressed in local resolution and that a panel would achieve nothing of value. Such a response is hardly likely to reconcile the complainant to the decision and fails to meet the requirements of the national guidance. In one case of this kind which I investigated I made clear that I saw such a response as no more than a conclusion, for which no reason had been given. In other cases I have made it clear that complainants have a right to have each of their concerns specifically addressed. Now that some experience has built up I am less disposed to investigate simply because of failure to give reasons for a decision. But I do regard absence of adequate reasons addressing specific concerns as prima facie evidence of maladministration. If I do not have other concerns, I now more often invite the convener to write again to the complainant explaining his or her reasons. I hope in future to see fewer complaints about conveners failing to give adequate reasons.

Investigating and resolving the complaint, showing partiality

5.16 The national guidance makes it clear that the convener must not investigate the complaint with a view to resolving it, must distance himself or herself from those involved earlier in the complaint, and must not show partiality. In some complaints which I have investigated the convener appeared to have conducted, in effect, his or her own investigation, and to have gone well beyond what was necessary to understand the details and circumstances of the complaint. The outcome may, in any particular case, have been just; but the result was that the complainant was prevented from putting his case to a fully independent body if a panel was warranted. This was not what was intended under the new procedure. In these cases conveners often also failed to distance themselves from those involved earlier in the complaint.

5.17 On the evidence of the complaints I have seen so far, the temptation for conveners to become involved in their own investigation seems to be especially strong with complaints involving family health service practitioners. This may be because it can be, or appears to be, more difficult to refer such complaints back into local resolution if the practitioner or the complainant, or both, do not wish it, and do not agree to conciliation. It may also be because `local resolution' conducted through a practice-based complaints procedure does not always produce as much information about the complaint as the convener wants. Certainly there is generally much less information than with complaints about hospital services. However, there is a risk that efforts by conveners in these circumstances to understand the complaint take them over the line into investigation and resolution. Conveners must be more willing to refer back to the practice for more local resolution; and practitioners must be willing to consider taking complaints further in practice-based procedures. Co-operation with the new complaints procedure is now one of the NHS terms of service for practitioners; conveners will sometimes need to remind practitioners of this statutory obligation.

5.18 I now turn to some other concerns about how the procedure is working to which I would like to draw attention.

5.19 The new procedure emphasises the scope for pursuing conciliation, especially as a part of local resolution in complaints about family practitioners. In the complaints made to my Office conciliation has quite often been offered or attempted even though it has not resolved the complaint. I welcome the wider use of conciliation. However, the national guidance draws a clear distinction in respect of complaints about practitioners between, on the one hand, the role of the Health Authority or board in acting for the complainant by seeking the views of the practitioner on the complaint and, on the other, conciliation in which the parties can engage in private `without prejudice' discussions with the conciliator. I have found that this distinction is not always clear to complainant or practitioner; this can give rise to damaging misunderstanding. Health Authority or board staff and conveners need to make sure that they understand and observe the difference.

5.20 In a number of cases complainants have indicated that they do not consider the convener to be impartial, given that he or she is a non-executive director of the Trust against which they are complaining. I have told them that they must address their concerns to the relevant NHS Executive. However, conveners need to be sensitive to these concerns, for example by signing their own letters to complainants and being careful in the language they use to distance themselves and their role from those who have handled the complaint in local resolution.

5.21 Others complaining to me have pointed to failures to keep within the time limits in the guidance. Only if the failings have been gross and my intervention seemed unlikely to divert efforts from dealing with the complaint have I investigated. However, the time limits for local resolution are, in my experience, generally not being met often by a wide margin. Sometimes this appears to be due to repeated attempts to resolve matters through local resolution. This is understandable, and in some cases may be appropriate. Meetings with complainants now seem more common and can be very helpful even though they take time. However, I am concerned that delays in local resolution sometimes occur because complainants are not told early enough of their right to seek an independent review, or through failure by chief executives explicitly to bring local resolution to a timely end. One of the aims of the new procedure was to prevent complaint handling from being drawn out or inconclusive, as it sometimes was under the old arrangements. More effort is needed to keep closer to time limits.

5.22 Complaints put to me have also revealed other examples of the new procedure not being followed carefully enough either by conveners or by chief executives and their staff. These failings may not have affected the outcome; and I have not always included them in my investigations. In a few cases they have arisen because of ambiguities or inconsistencies within the guidance or between the guidance and the directions. I know that the NHS Executives are aware of these inconsistencies; and I hope that they will act soon to reconcile them.

5.23 I recognise that, when conveners consider that further action is needed, it is a challenging task to decide whether they should refer back to local resolution or set up a panel. This may be an area where, as experience increases, the NHS Executives may feel able to expand on the guidance presently available to conveners. But the decision to set up a panel is likely to remain a matter for judgment, taking account of all the circumstances of the case, rather than the application of rules.

5.24 The experience of my Office so far suggests that conveners should give weight not only to the relative seriousness or complexity of the complaint but also to whether the complainant's experience of the handling of his or her complaint may reasonably have caused him or her to lose confidence in getting an answer he can believe from any further local resolution. A panel may also be appropriate if an independent scrutiny may not only help a complainant but may also recommend action to prevent similar difficulties in future. Conveners should also not lose sight of the fact that a panel may satisfy a complainant by conducting an independent enquiry, even though it finds against him or her. In some cases conveners have, in my view, applied an inappropriate test in deciding against convening a panel by indicating that it would be unlikely to resolve a complaint to the satisfaction of both the complainant and those complained against. It is not the role of a panel to mediate a resolution acceptable to all but to decide, where necessary on the balance of probabilities, whether to uphold the complaint.

5.25 I have spent some time on the convener role because it is central to the new procedure and also because it is the part of the procedure where the experience of my Office so far is greatest. I am now receiving a growing number of complaints after panels have been held - 45 by the end of March. It is too soon yet to form any clear conclusion from them. There are however some straws in the wind.

5.26 Lack of detailed national guidance on the conduct of panels may well have reflected a wish by the NHS Executives to keep the panels informal and user-friendly. However, to judge from the complaints I have seen there is considerable variability in how they are conducted and in the style and structure of reports. Panels need to be careful to follow the basic requirements of natural justice, such as even-handedness in hearing both parties. Panels should also observe the requirements in the statutory directions about what should be included in their reports. The directions are more explicit than the guidance; but not all panels seem to be aware of them. They should be. I reproduce them here. All reports must include:

(a) findings of fact relevant to the complaint;

(b) the opinion of the panel on the complaint having regard to the findings of fact;

(c) the reasons for the panel's opinion;

(d) the report of any assessors; and

(e) where the panel disagrees with any matter included in the report of the assessors, the reason for its disagreement.

Reports may include recommendations, for example, to improve services or to offer some satisfaction to the complainant, but that is not mandatory.

5.27 It is still early days but it may be that with more experience it will be possible to issue further guidance about how panels should be conducted and their reports prepared, without prejudicing the objectives of informality and a non-adversarial style. It is not the role of my Office to provide that guidance. However, I hope that reports of my investigations of the conduct of panels will help through issues which might be covered.

6. OPENNESS IN THE NHS

6.1 In his Annual Report for 1995 - 96 my predecessor referred to the extension of his remit from June 1995 to cover complaints from members of the public that their requests for information under the Code of Practice on Openness in the NHS had been refused by the responsible NHS body. He described his experience in dealing with complaints of that kind. In November 1996 he published his first report [2]of selected investigations of complaints made under the Code.

6.2 Over the period of this annual report I have received only nine requests to investigate complaints relating to the Code. My staff have also dealt with a small number of written and telephone enquiries. I have not begun an investigation of a complaint under the Codes during the period of this report; but action by my Office short of investigation has helped the complainant in three cases.

6.3 My predecessor noted that NHS staff had sometimes not recognised that requests for information should be considered as requests under the Code. In those cases refusals to disclose had as a result not been linked to the Code. When considered again, as they should have been in the first instance, by reference to the Code, information has been provided. The Code have now been in force for two years. Any licence for NHS staff failing to consider requests for information against the disclosure requirements of the Code, or to draw the Code to the attention of those seeking information, has long expired. NHS bodies need to be sure that they have adequate arrangements to ensure that staff are aware of the Code, and that the Code is adequately publicised. In that connection I was glad to note that, in writing to NHS bodies in England about my predecessor's report, the Chief Executive of the NHS Executive issued a reminder about section 4 of the Code which makes clear that the NHS should:

> `help the public to know what information is available so that they can decide what they wish to see and whom they should ask' and
>
> `ensure that there are clear and effective arrangements to deal with complaints and concerns about local services and access to information, and that these arrangements are widely publicised and effectively monitored'

and that he also emphasised that staff must realise that any refusal to disclose information can only be justified by application of one of the exemptions in the Code. I understand similar messages were passed to the NHS in Scotland and Wales.

6.4 In his evidence last December to the Select Committee on the Parliamentary Commissioner for Administration the Chief Executive of the NHS Executive for England said that an external review of the workings of the Code was being commissioned and that its results would be published. The Select Committee have recommended that the review, and any comparable actions in Scotland and Wales, should examine how statistics on the working of the Codes might be collated and published at both local and national levels. They also recommended that the NHS Code should be revised to ensure that there is as great a scope for disclosure in the public interest as there is under the Government Code of Practice on Access to Information held by Government Departments. My predecessor had, in his published report, drawn attention to discrepancies in that area. The Government's response is awaited.

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2 [Report of the Health Service Commissioner. Selected Investigations -- Access to Official Information in the NHS HMSO, November 1996] Back