Health Service Commissioner : first report for session 1980-81 : selected investigations completed April-September 1980 / Health Service Commissioner.

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Report of the Health Service Commissioner

Selected Investigations completed April-September 1980

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HEALTH SERVICE COMMISSIONER

First Report for Session 1980-81

Selected Investigations completed April-September 1980

Presented to Parliament pursuant to Section 119(4) of the National Health Service Act 1977 and Section 96(5) of the National Health Service (Scotland) Act 1978

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HEALTH SERVICE COMMISSIONER

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Section 119(4) of the National Health Service Act 1977 and Section 96(5) of the National Health Service (Scotland) Act 1978 empower me as Health Service Commissioner for England, for Scotland and for Wales to make such reports to the Secretaries of State with respect to my functions as I think fit.

The Appendix to this Report contains a selection of the individual reports issued during the months April to September 1980. Those for England have the prefix 'W'; those for Scotland the prefix 'SW' and those for Wales the prefix 'WW'.

C M CLOTHIER
Health Service Commissioner

November 1980

APPENDIX

This selection of 27 reports is taken from a total of 53 cases on which full investigations were completed during the period 1 April to 30 September 1980. I issued two of these reports (indicated with prefix 'C') as joint reports in my capacities both as Health Service Commissioner and Parliamentary Commissioner for Administration.

CONTENTS

Case No. W.59/78–79 – Care of patient in psycho-geriatric ward

Background and complaint

1. The complainant's father-in-law, aged 78, was a patient on a male ward (the psycho-geriatric ward) of a hospital (the hospital), in August and September 1977. He went home on weekend leave on 30 September and died there on the evening of 3 October. The complainant said, through her Member of Parliament, that the attitude of the nursing staff towards the patients was lacking in consideration, and that her father-in-law was subject to ill-treatment and neglect. As examples of this she states that:

(*a*) On 2 September his arm was twisted during an attempt to get him to take a hot bath;

(*b*) Teeth belonging to another patient were forced into his mouth, and a relative had to intervene when he began to choke;

(*c*) He was not fed properly – he lost five stones in weight and constantly seemed to be hungry;

(*d*) After he started making complaints to his relatives, he was put under heavy sedation;

(*e*) He received injuries to his face and side which the hospital says were caused by a fall on 21 September, but which a Home Office pathologist stated were not consistent with the fall;

(*f*) He was sent home on 30 September without underclothes; and had bed sores that had not been dressed and which therefore stuck to his clothing; and that

(*g*) The Area Health Authority (the AHA) have failed to provide satisfactory answers to her complaints.

2. There were two other specific incidents brought to the attention of the AHA by the relatives. One was an allegation that he had been held by the throat one night and the other was about a diet sheet found on the psycho-geriatric ward kitchen wall. These matters are referred to in paragraphs 65–69.

Investigation

3. During the investigation my predecessor obtained the comments of the AHA and I examined these and other relevant papers. Two of my officers met the medical, nursing and administrative staff concerned. They also met a private nurse (the private nurse) who was a friend of the family and had previously been employed by them, the three principal family practitioners in the group practice which had been responsible for the care of the complainant's father-in-law, his two sons and two daughters-in-law. Unless it is necessary to be specific, I refer to the sons and daughters-in-law collectively as 'the relatives'.

Police inquiry

4. Almost immediately after the father-in-law's death a Chief Superintendent of the county constabulary conducted an enquiry into the relatives' allegations of ill-treatment by members of the hospital staff. I obtained copies of statements made to the police and the police report. My officers also met the police officer who carried out the enquiry. The Chief Superintendent told me that there was no evidence to substantiate the allegations made.

The inquest

5. After the father-in-law's death on 3 October a post-mortem examination was performed by a Home Office pathologist. An inquest was held at which the pathologist was reported as saying that the condition of the body at death was such that the patient had not been well cared for immediately preceding death; there was also considerable bruising but this had no connection with the deceased's death.

6. At my request the Coroner sent me a copy of the evidence given at the inquest by the Home Office pathologist; it says that the complainant's father-in-law 'suffered from muscular degeneration and also a type of bruising seen in old people and, in his case, clearly identifiable on the backs of both hands and on both feet. The other bruises were not the result of natural disease but played no part in the death'. The Coroner therefore ruled that as the pathologist had said the bruises had not been a cause of death, the solicitors acting for the relatives (the solicitors) could not ask questions about them or other matters not relating to the death.

Possible legal redress

7. Prior to my predecessor agreeing to undertake an investigation, he was given an assurance from the relatives that they had no intention of seeking redress through the courts. They said they were principally concerned with conditions in the hospital and the treatment of patients as well as with the competence and the general attitude of the nursing staff and the consultant psychiatrist (the psychiatrist).

Form of report

8. The evidence given in this report from the relatives, witnesses and members of staff has been gathered from the police inquiry, the inquest, correspondence to the AHA and to me and from interviews by my officers. In the interests of simplifying the narrative, I do not distinguish these sources except where I believe it to be necessary. I begin with the background to the father-in-law's admission to the hospital; then I deal with his general care in the psycho-geriatric ward and examine a number of specific allegations made by the relatives; and then I consider the way that the AHA dealt with the matter. Following this I consider the evidence given at the inquest by the Home Office pathologist. My findings and conclusions on all aspects of the complaint are left to the end of my report.

Background to hospital admission.

9. The relatives said that in June 1977 father-in-law had been extremely depressed. He was worried about his Parkinson's disease and had been found wandering near a railway line where he had said he would attempt suicide. His relatives took this as a plea for help and consulted the family practitioner who suggested that he should have a course of treatment, including drugs, and a short stay in the hospital. The family practitioner told the relatives that he expected the treatment to last around six weeks. He was admitted to the ward (the admission ward) at the hospital on 7 July. The relatives were generally satisfied with his care in this ward and he seemed reasonably happy there.

10. On his first day in the admission ward he expressed his anxiety to the nursing staff that he might be considered 'a right loony' and sent to the main hospital to a long stay ward. He was transferred to the general hospital for surgical treatment on 12 August. He refused to consent to the operation, and a sister there told my officers that a relative had said that he would willingly sign the consent form as his father was not aware of his own actions. He returned to the admission ward on 18 August without having had the operation. On 26 August he was transferred to the psycho-geriatric ward. The psychiatrist who was responsible for both the admission ward and the psycho-geriatric ward said that the transfer was because it was obvious that he needed predominantly nursing care for his physical condition, rather than psychiatric treatment and this assessment was supported by members of the medical and nursing staff on the admission ward.

The general conditions in the psycho-geriatric ward

11. The relatives outlined a general complaint that the staff at the hospital were cruel, violent and grossly neglectful of the patients in their charge. As there were few other visitors to the psycho-geriatric ward, the relatives said they got to know the other patients fairly well. The patients would rush over to talk to them, mostly without making much sense, and ask them for cigarettes etc. One day the relatives did not receive the usual rush of patients and they believed that all the patients had been sedated and placed in high chairs so they could not get down. The nursing staff were gathered around the television set watching a boxing match.

12. The relatives said that they had seen the nursing staff assault other patients. They had seen a charge nurse (charge nurse A) hit one of the patients. The patient fell to the floor when the charge nurse had thrown him into a chair; as he tried to get up charge nurse A kicked him. A relative said that on another occasion she had brought a nurse's attention to the fact that one of the patients was eating soil from a plant pot. The nurse at first ignored her, but when she repeated the complaint the nurse took the patient by the neck and threw him across the room.

13. Another relative said she had seen a patient urinating in a corner and then wiping himself afterwards with the table cloth. Cake for tea was then put on to the same table cloth, and at no time did the nurses wash before handling the patients' food. The relatives felt that these incidents strengthened their view that the attitude of the nursing staff showed a lack of understanding and compassion for the patients. They felt sure that their relation received similar treatment when they were not present.

14. The private nurse said she was not impressed with the general standard of nursing care on the psycho-geriatric ward. She accepted that as a former nursing sister on a coronary care unit she did not have the usual experience of a psycho-geriatric nurse, but in her opinion the nursing care was far below a minimum standard. The ward had at first appeared to be no different from most other psycho-geriatric wards, but she was surprised at the attitude of some of the nursing staff – they tended to watch television and seemed to ignore the patients. She had seen one of the patients eating rubbish and another patient urinating – the nurses just ignored them. She thought the nursing staff did not pay much

attention to the ambulant patients who, without proper supervision, wandered about fairly freely.

15. A consultant pathologist told my officer that as a member of the District Management Team (the DMT) he was extremely dissatisfied with the level of general medical care given to all the patients at the hospital; he thought that some of the consultants were insufficiently concerned about the general medical condition of their patients; the junior medical staff and the nursing staff were not supervised enough, and that the medical staff did not attend the wards to examine patients as often as he thought necessary. He told my officers that there was a need for more general medical care to be given to all the long-term psychiatric patients. He said that the doctors concerned regarded themselves as psychiatrists first and doctors second, paying insufficient attention to the patient's physical condition.

16. The psychiatrist said that he had 300 patients to supervise and their day-to-day care was undertaken by the junior doctors. The District Administrator (the DA) said in a letter to the Area Administrator (the AA) dated 6 February 1978 'the amount of time that the Consultant can spend with one patient when he has 300 others to look after is obviously limited . . . urgent consideration should in my view be given to the Consultant staffing level'. (The AHA have told me that an additional consultant psychiatrist is now in post.) The DA pointed out to my officers that whatever problems there were on the ward were not helped by the upgrading of the toilets which was going on whilst the complainant's father-in-law was a patient. Subsequent to this the DMT had decided that such upgrading should not in future be done whilst there were patients on the ward involved.

17. The psychiatrist told my officers that he had no doubt that if the incidents described by the relatives had happened on the psycho-geriatric ward he would have heard from the staff about them. He knew there were nursing staff on the psycho-geriatric ward who would not tolerate any mistreatment and told my officers that, subsequent to the father-in-law's time as an in-patient, members of the nursing staff had reported an incident (not involving anyone connected with his treatment) and the member of staff involved had been officially warned.

18. A charge nurse (charge nurse B) said that he was quite satisfied with the medical cover given by the doctors to the psycho-geriatric ward. They came when asked to see patients for particular reasons and the clinical assistant to the psychiatrist (the clinical assistant) visited the ward every morning. The psychiatrist visited at least once a week. Charge nurse B said that at no time did he feel that the nursing staff were left without access to medical cover, although there was always a problem with long-term psycho-geriatrics as to how much medical attention to give. He said there had been a difference in approach between himself and charge nurse A. After charge nurse A left, subsequent to the father-in-law's time as an in-patient, there had been a change of policy whereby a regular toileting routine and a more regular pattern of nursing care had helped to lessen the patient's confusion. Charge nurse B said that although he was generally quite happy with the standard of nursing care on the ward there were some female nursing auxiliaries that he would not have employed if he had 'had the chance'. In retrospect he said some of the staff could have been a little more understanding in their dealings with the relatives.

19. A Divisional Nursing Officer (the Div NO), who had conducted the hospital's initial inquiry into the relatives' complaint, told my officers that the conditions on the psycho-geriatric ward were not ideal but in his wide experience of mental nursing they were about average. He said that they had had no complaints from other relatives or patients about any of the medical team involved in looking after the complainant's father-in-law or the nursing staff on the psycho-geriatric ward. He was sure that there were people on the ward who would not hesitate to bring forward complaints if they had seen any incidents of the sort described by the relatives. He added that the impression he had gained from his interviews with members of the staff was that the complaints that the relatives had made were a reaction to the transfer to the psycho-geriatric ward from the admission ward. A domestic who worked on the psycho-geriatric ward said that if she had seen anything like the incidents complained of she would certainly have taken some action herself.

20. The AHA refuted the allegation that on one occasion all the patients were sedated and placed in high chairs, pointing out that the chairs in the ward were of mixed sizes and types. They also said that it was inconceivable that staff would assault patients in front of relatives and if the alleged assaults had been reported immediately there would have been a speedy enquiry.

The father-in-law's general care on the psycho-geriatric ward

21. The relatives said they noticed a difference as soon as their relation was admitted to the psycho-geriatric ward. He constantly asked them to get him out, appeared frightened of the nursing staff and he also lost weight. The staff appeared to be indifferent to the patients and the surroundings appeared to distress him.

22. The private nurse said that she had been asked to go to the hospital because the relatives were worried about the father-in-law's condition. She had gone to the psycho-geriatric ward with a relative on 22 September and had seen charge nurse B. She had talked generally to him about the father-in-law's condition and the sort of attention he was receiving. He was withdrawn and unhappy; he would mumble but was coherent if someone took the trouble to speak to him. She said that he was quite sure he wanted to go home and three weeks before he died the relatives were keen for him to do so. As his wife was unable to cope with him on her own the private nurse had been asked by the relatives to find out if it would be possible to nurse him at home. She had therefore spoken to charge nurse A but she found him unco-operative; his and charge nurse B's assessment of the father-in-law's state of health and mind differed. About a week later she had gone to see the father-in-law again and had found him much worse and drowsier. Charge nurse A had told her that the father-in-law could walk but he was assisted by nursing staff on every occasion she had seen him. She had also seen a female auxiliary nurse, who was smoking, and a male nurse assisting him across the ward when he was clearly unable to walk by himself. His knees buckled and although he did not fall the female nurse tried to straighten his knees by pushing at them with her leg whilst still smoking a cigarette. The private nurse said that she had rushed across the ward to intervene as the auxiliary nurse continued to kick his legs.

23. A staff nurse on the admission ward (staff nurse A) said that the father-in-law seemed to be frightened of the male nurses; he did not seem to understand that the men were nurses. He had a particular fear of the coloured nurses and he did not like them touching him or doing anything at all to him although the coloured nurses themselves went out of their way to be helpful towards him.

24. In the nursing notes for 22 August staff nurse A records 'patient mentally remains very confused and disorientated and has become very demanding and gets very agitated. Says he is frightened of the "blacks" and thinks that they are going to hurt him'.

25. Charge nurse B said that he was aware that the complainant's father-in-law did not like black nurses and would because of his confused state occasionally become agitated, but he had found no evidence of any mistreatment by members of the nursing staff, black or white.

26. The clinical assistant told my officers that when she had first seen the father-in-law he had been very weak and he could walk only if supported by the nursing staff. She described his condition as one of slow deterioration. In her opinion he was no different from any of the other patients on the psycho-geriatric ward. She was generally happy with the standard of nursing care on the psycho-geriatric ward and she had certainly seen no incidents of the sort alleged by the relatives.

27. Charge nurse A said that at no time whilst the father-in-law was on the psycho-geriatric ward at the hospital did he ever see him ill-treated by any member of the staff or by any other patient and he had never heard of any other member of the staff refer to any such ill-treatment.

28. One of the family practitioners had seen the complainant's father-in-law, who was at home on a day visit, the weekend before he had left the hospital and did not think at the time he looked ill-treated. All of them agreed that the condition of muscle degeneration described by the consultant pathologist would be extremely difficult to detect and they had themselves only heard of one other case in twenty years of practice.

29. The relatives said that charge nurse B had told them that they should try to get the father-in-law out of the psycho-geriatric ward as soon as possible as it was no place for him.

30. Charge nurse B told my officers that he felt that it was important that the father-in-law did not become institutionalised and so give up hope. He recalled that one of the sons had asked him if he thought the psycho-geriatric ward was the correct ward for him to be in. Charge nurse B replied that he thought it was whilst his mental and physical condition was as it was. He did however say that 'the sooner we could get him out the better', meaning that the sooner they could get his mental and physical condition improved the sooner they could get him home. At the time he said this, however, there was no doubt in his mind that the psycho-geriatric ward was the right place for him and that there he could receive full nursing care.

31. The relatives said that they asked a consultant surgeon (the surgeon) if he would visit the complainant's father-in-law and advise them on the

practicability of a private operation for his urinary retention problem. This he did on 27 August and they said he advised them to try and get their father home as soon as possible.

32. The surgeon told my officers that when one of the father-in-law's sons had telephoned him the son had said that he was very concerned that his father had been moved to an unsuitable ward and was not getting the best treatment at the hospital. After obtaining the consent of the psychiatrist the surgeon agreed to see him.

33. The surgeon could not remember making any suggestion in his subsequent conversation that the father-in-law should be taken home although he may have suggested it as a hopeful course of events but he certainly did not mean to imply that it was because the treatment and care he was receiving in the hospital was not good enough.

34. I now consider the specific allegations made to my predecessor about incidents directly involving the complainant's father-in-law.

(a) *His arm was twisted during an attempt to get him to take a hot bath*

35. Relatives said that on 3 September they had gone into the psycho-geriatric ward and found that their relative could not straighten his right hand. They told my officer that he said that a black nurse had twisted his arm around his back the previous night to make him take a hot bath. However, in their statements to the police, the relatives did not mention the bath although one of them stated that he had said that his arm had been twisted because he did not walk fast enough.

36. The psychiatrist said he was unable to substantiate this allegation of maltreatment. He thought that the problem, which he described as wrist drop, would have been most unlikely to have resulted from an incident involving arm twisting as had been described to him. The radial nerve of the arm would need to be trapped rather than struck or twisted and he thought a likely explanation was that the father-in-law had slept on his arm. He said that he would have expected some complementary bruising to the arm had there been any arm twisting, but there was none when he had examined him. A note in the nursing records shows that the psychiatrist examined him on 5 September after one of the relatives had telephoned him to complain about this incident. It says that the psychiatrist advised continuation of treatment by means of a cock-up splint that had been applied to the wrist to correct the wrist drop. The psychiatrist said that he approved of this treatment which had been carried out by one of the nurses.

37. My officers interviewed all members of the nursing staff who might have bathed the father-in-law on the day in question, and also asked them whether any other incident that day involving him could have been the source of the complaint. None of the nurses could recall any such incident. Charge nurse A said that although this patient could be aggressive at times he could not remember any specific problem over bathing him. Charge nurse B said that sometimes when they were being dressed or undressed patients became very tense and their arms would be put into uncomfortable positions. A record is supposed to

be kept of when and by whom patients are bathed but on the day in question the nurse who bathed the complainant's father-in-law is not recorded and none of the nurses on duty could remember who bathed him.

(b) *Teeth belonging to another patient were forced into the father-in-law's mouth, and a relative had to intervene when he began to choke*

38. On 29 September a relative visiting said he found a male nurse trying to put someone else's teeth into his father's mouth. He told the nurse that they were not his father's teeth but the nurse nevertheless persisted. When his father began to choke the relative told the nurse to stop, pointing out that the nurse was trying to insert a full set but that his father did not possess and had never worn a bottom set of teeth. The relative said the nurse admitted making a mistake. Although he thought he knew the name of the nurse the name he gave to my officer was of a female, not a male nurse.

39. Charge nurse A could not recall any specific incidents involving the complainant's father-in-law and his teeth but remembered that he used to take them out as did a number of the other patients. On one occasion they found that a patient had put someone else's teeth in his pocket. Charge nurse B said that the father-in-law was not too happy with his teeth and he could remember him throwing them behind a radiator on one occasion. He could not remember whether he had a full or a half set of teeth but there were problems with patients' teeth as a number of them took them out. Charge nurse B had changed the routine for collecting and giving out the teeth, collecting them in the evening and putting them into individual pots. They were then given out the next morning.

40. No male or female nurse on the psycho-geriatric ward was able to recall the incident. A nursing note made by a staff nurse (staff nurse B) says against the date 29.9.77 'visited by two sons and daughter-in-law – daughter-in-law complained about his dentures. That he doesn't wear his own but somebody else's. I explained to them that the patient doesn't keep his dentures in, he always tries to take them off.' Staff nurse B said that he told the relatives that the dentures were kept in a container in the father-in-law's locker, and that he showed them the dentures in that locker. I have seen a property list for him completed when he was transferred from the admission ward to the psycho-geriatric ward. It records against 'Dentures', 'Top set'.

(c) *He was not fed properly – he lost five stones in weight and constantly seemed to be hungry*

41. The relatives said that they took their relation food and he ate it as soon as it was given to him; he was constantly complaining that he was not getting enough to eat. They occasionally gave food to other patients who they said appeared to be 'ravenous'. The private nurse said he was losing weight noticeably and yet when she spoke to charge nurse A about this he said that the father-in-law had lost no weight, although he was unable to refer to any occasions when he had been weighed. The private nurse said the weight loss was so noticeable that even someone who was not a nurse would immediately see that the patient's weight was diminishing.

42. In an interview with my officers the family practitioners who looked after the father-in-law said that they had a record of his weight on 2 June 1977 as 11 stones 1 lb.

43. The weight chart in the nursing records has space for one entry a month. There is no entry for July or August. There is an entry for September and this, which from the bath book was made on 23 September, records his weight as 9 stones 3 lbs. I have been unable to find any other record of his weight whilst he was a patient. At the post-mortem examination his weight was recorded as 7 stones 8 lbs.

44. The psychiatrist did not think that the weight loss was great. His appetite had been reasonable and it had not given cause for concern.

45. Charge nurse A said that on a number of occasions the father-in-law was reluctant to eat and the nurses had quite a lot of trouble persuading him to do so. He had 'Complan' added to his diet. He was unable to feed himself. Charge nurse A did not consider it necessary to refer the patient's eating problem to the doctors because he was seen by a doctor once a week as a matter of course and a doctor came to the ward every day. Charge nurse B said that the father-in-law on occasions did not eat his food but he was given 'Complan' if he had insufficient food for any length of time. He said that on occasions it was normal for every patient not to feel like eating but if it became clear that food was not being taken regularly then it would be up to the nursing staff to refer to a doctor. This had not happened in this case, nor had it been necessary. Charge nurse B thought the father-in-law's weight was around nine stones. He had later made arrangements for more regular weighing of the patients on the psycho-geriatric ward but a system of weekly weighing was introduced only after the father-in-law had died.

46. Other nurses remembered that he had to be encouraged to eat but that this was not unusual for a patient on the psycho-geriatric ward and he had not caused them any great alarm. Their estimates of his weight loss whilst he was in the psycho-geriatric ward varied from 'a couple of pounds' to 'about a stone'.

47. The AHA told me that the senior dietician had confirmed that the food was nutritious and adequate. The AHA also told me that they had received no other complaints concerning under-feeding or under-provision of food and that 'patients in psychiatric hospitals do tend to queue up if "goodies" have been brought in [but] this does not imply that they are ravenous'.

(d) *After he started making complaints to his relatives, he was put under heavy sedation*

48. The relatives said that their relation continued to complain to them that the nursing staff had pushed him around, and that he was being forced to take hot baths. The relatives said that on their visits following these complaints, he was sedated when they arrived. He began to ramble in a way he had never done before and exhibited signs of fear when the nurses approached. They said that nurses at first denied administering drugs but one of the charge nurses, charge nurse B, later admitted to a relative that the patient had been sedated.

49. The psychiatrist said that on 5 September, when the first complaint had been received from the relatives, the father-in-law was receiving in the way of

sedation Heminevrin which had been started on 27 August, Haloperidol which had been started on 30 August and Welldorm at night if necessary, started on 1 August. The dose of Heminevrin remained the same until 13 September and from then on it was progressively reduced. The dose of Haloperidol remained the same also until 13 September, was then reduced and from 22 September omitted altogether. The Welldorm at night was given fairly regularly between 21 and 29 July, omitted altogether until 9 September, given regularly until 13 September and then omitted altogether. My officer saw that the drug records confirmed this information.

50. Charge nurse A said that the father-in-law was receiving only the drugs prescribed by the doctors; there was nothing unusual in the medication prescribed for him. He said that he would have remembered any special administration of drugs but there had been none whilst he was on duty on the psycho-geriatric ward. Charge nurse B also said that drugs were given only as prescribed by the doctors. Drugs were always administered by a trained nurse and there were set times for the drug rounds. The father-in-law's reaction to the drugs would however have been affected by his urinary retention problem. If he had been dehydrated they could well have had a greater effect on him. Charge nurse B could not remember exactly what drugs had been given but was quite sure that they would never have been prescribed or administered as a reaction to the complaints from the relatives. He had talked to the father-in-law's relatives about the drugs he was receiving and had tried to reassure them by explaining why he needed particular drugs.

51. None of the nursing staff to whom my officers spoke could recall any special medication given to the father-in-law at any time during his stay on the psycho-geriatric ward. The medication he was receiving was similar to that which other patients were receiving on the ward and was given as prescribed by the doctors.

(e) *He received injuries to his face and side which the hospital says were caused by a fall, but which the Home Office pathologist stated were not consistent with the fall*

52. On or about 21 September a relative visited the complainant's father-in-law and found that he had two black eyes, cuts on his face and a number of bruises on his body. He appeared heavily sedated. When asked what had happened he said 'I fell out of bed'. The relative pressed him and asked him if that was true. He replied 'they said to say I fell out of bed', and although rambling and sometimes incoherent, after further questioning said quite firmly that the nurses had pushed him around. The relative went to see charge nurse A who had laughed and seemed offhand; he said the patient had simply fallen out of bed. The relative said charge nurse A did not seem to care about the patient's condition.

53. The staff nurse who was on duty at the time of the alleged fall (staff nurse C) said that the nursing station was in the middle of the dormitory area. He was talking to the charge nurse (charge nurse C) when he heard a noise from the direction of the father-in-law's bed. He and charge nurse C arrived at the bed at the same time as the auxiliary nurse. They examined the patient to ensure that he had not broken any bones and then the three of them put him back on

to the bed. The bed did not have any cot sides but was a low bed. The staff nurse said that he could see that there was some blood on his right eyebrow and on the bridge of his nose. The wound was cleaned and although there were slight grazes to the eyebrow and the bridge of the nose there were no cuts. He was conscious and staff nurse C asked him if he was hurt – he replied 'No'. An Antibiotic spray was applied to the grazes and the butterfly suture to the eyebrow. He was then moved to a bed with cot sides and positioned in front of the nurses' station so that he would be under constant supervision. The staff nurse said that as far as he was aware there were no other apparent injuries at that time. He recorded the incident in the night report and casualty book and completed the appropriate accident form. Charge nurse C and the nursing auxiliary confirmed staff nurse C's account, as does the accident report form.

54. I have seen from the various nursing records that the complainant's father-in-law fell without sustaining injury on 15 July, on 16 July (twice) and 22 August. This last was a fall out of bed. The only record of a fall at which injury was sustained was that on 21 September, and this was the only fall recorded in the psycho-geriatric ward.

55. A consultant neuropathologist who has seen the tissue specimens from the post-mortem has told me that he found evidence of muscle fibre damage, and in his opinion all the 'damaged' muscle available could have been due to local bruising. He did not think there was evidence of primary muscle fibre disease such as muscular dystrophy, nor of denervation, nor of inflammation. However, he could not exclude the possibility of a general wasting disease, eg carcinomatosis, nor of inanition and wasting secondary to Parkinson's disease. He could not be more specific, but 'knowing from you that this unfortunate patient suffered from Parkinson's disease, I think he would have had a marked tendency to fall and he may well have had problems with swallowing and feeding himself leading to inanition with muscle wasting'.

56. The consultant pathologist discussed with my officers the inquest findings and subsequently wrote to me about them. He said that the pathological evidence indicated to him that this patient was suffering from an active wasting disease which was progressive and would inevitably be associated with the great weakness he had. It was his opinion that the treatment was primarily appropriate for his mental condition, as 'his presenting symptoms appeared to have been mental symptoms' and that where death ensues, a post-mortem examination sometimes reveals a physical illness not hitherto suspected. He believed that this was such a case. He continued 'I believe that the muscle wasting was associated with the physical illness and not merely with lack of nourishment: if there were lack of nourishment that would be an additional factor but not the sole factor to loss of weight. In his condition he would be prone to bruise readily and any injury or grip by the hand would produce a more severe reaction in his state than it would, say, in me in my present state of health and nourishment'. He concluded: '[——'s' illness I think would have only been diagnosed by a high-powered team of physicians'. He told my officers that he did not think that the hidden illness could have been arrested, nor that because it was not discovered until after his death could it be said with any degree of certainty that if it had been discovered earlier his life could have been prolonged to any extent: it would however have made bruising easy and his pressure sores would

not heal properly; he would develop sores quicker and they would stay longer. In a letter dated 16 March 1978 to the DA the consultant pathologist had said 'had the whole truth been ventilated [at the inquest] it is my opinion that the case would now be one of slight rough handling of a patient, or perhaps not such gentle handling as one would have wished, and there would not be allegations of any degree of violence being used. I do not condone any violent treatment of a patient but I am not convinced from the evidence seen that there had been violence as you and I understand the word.' However after seeing the opinion of the consultant neuropathologist, the consultant pathologist said that as the consultant neuropathologist had far greater experience in neuropathology than he had, he must accept that there was no definite evidence of muscle wasting.

57. The psychiatrist told my officers that in his opinion nothing in the nature of intentional mistreatment had ever occurred in this case. The bruising which was said to exist on the father-in-law's body at the time of his death, he thought, could have been the accumulation of a number of falls which were recorded in the medical and nursing notes, as this patient's rate of recovery of skin tissue was much lower than normal.

(*f*) *The patient was discharged without underclothes; and had bed sores which had not been dressed and which therefore stuck to his clothing*

58. About the middle of September the relatives decided that they should take their relation home as soon as possible and arranged for the private nurse to review the situation as described in paragraph 22. The private nurse saw the father-in-law on 22, 25 and 28 September. She was extremely shocked at the deterioration in his condition over this period. Charge nurse A had told her that this was because he had an infection, although when he went home on 30 September no antibiotics were sent with him.

59. When on Friday 30 September the relatives took him home they said they were shocked to find that he had pressure sores over various parts of his body, and they took a number of coloured photographs of the pressure sores which I have seen. They said that on discharge he was dressed in a thick suit and had no underclothes. When he was undressed the suit had stuck to the pressure sores and the flesh came away with it. A relative felt that the pressure sores showed clearly why the complainant's father-in-law objected to taking hot baths.

60. The private nurse said that when the father-in-law arrived home he was not wearing underpants. He had three large weeping ulcerated sores, two on one side and one on the other side of his sacrum. The sores had not been there the week before and they were completely untreated. In her opinion they must have been there for at least a couple of days; he also had two sores on his hips which were like a clean graze and were not ulcerated.

61. Staff nurse B said that at about 6 p.m. on 30 September the complainant's father-in-law's son and the private nurse came to the ward. Staff nurse B said that at this time all the father-in-law's clothing was dry; the pressure sores on his heels had been newly dressed and the one on his hip had been treated with a powder as it was not in the same condition as those on his heels. Staff nurse B told my officers that on occasions patients who had diarrhoea would not be

dressed in underclothes because there was often a shortage of underclothes on the ward, although he was unable to be more specific. He could remember dressing the father-in-law on the last day of his stay at the psycho-geriatric ward and said he was quite sure that he had put underclothes on him. Staff nurse B said that it was usual to check a patient who was being discharged to ensure that he was properly dressed and that he had checked him several times during the day to make sure that he was wearing underclothes. When he checked him for the last time another nurse had been with him but he was unable to remember who this nurse was.

62. The student nurse told my officers that he could remember being involved in dressing patients on the father-in-law's last day but could not remember if he had actually dressed him himself. He and pupil nurse A agreed that there had been problems on the ward with underclothes but they had never seen a patient without underclothes. They would certainly have put underclothes on patients whether they were severely incontinent or not.

63. Pupil nurse B said that sometimes if the patients were incontinent they did not have underwear put on. He said that charge nurse A had told him to leave underclothes off on occasions as there was often a shortage and that on one occasion when there was a shortage he had been told off by charge nurse A for putting underclothes on a severely incontinent patient. He understood that this was the policy for the psycho-geriatric ward. He was unable to recall specifically whether he left underclothes off the complainant's father-in-law at any time.

64. I have seen a copy of the nursing notes covering the father-in-law's stay on both the admission ward and the psycho-geriatric ward. Numerous entries confirm that the nursing staff regularly attended to various red areas, broken areas, and pressure sores about his body, and there is constant reference to the pressure sores on his heels which were deep, and which were frequently redressed.

The 'neck rubbing' incident

65. A relative said that on 27 August, the day after the father-in-law's admission to the psycho-geriatric ward, he complained that two male nurses held him by his neck and throat very tightly one night in bed and he was frightened. The relatives spoke to the staff who initially denied the allegation strongly but when the relatives raised the matter a second time they were told that stroking the patient's neck was a form of treatment often used to relieve the tension and induce sleep. The relatives said that they had made further enquiries since and that this form of treatment appeared to be unheard of by other people in the medical profession. The relatives telephoned the psychiatrist who at first suggested that they were imagining things; during a second telephone conversation he said that the patient had needed to be restrained in bed.

66. The psychiatrist said that a relative had telephoned him and told him that the night staff had been rubbing their relation's neck which had apparently left some mark on it. The psychiatrist said he told her that he had some difficulty in understanding why the night staff should do so but would look into the matter. He made enquiries and discovered that on occasions it was necessary for the night staff to hold the father-in-law down in bed as he became very confused:

he had tried to get out of bed at around four in the morning to embark, as he thought, on his coal round. The psychiatrist said that he had made arrangements to interview the relatives but that they did not keep the appointment.

67. Charge nurse A said that one night he had received a telephone call from one of the relatives who said that the father-in-law was complaining that someone had had hold of his neck. Charge nurse A said he replied that he did not know what they could have been talking about and that he would look into the matter. He said that occasionally the nurses would massage a patient's neck to relax him.

The diet sheet

68. A relative removed part of a diet sheet from the ward kitchen wall which they said had been there for several days. I have a copy of this diet sheet. It lists the names of patients; against two of the names is written the word 'dead' and against a third name 'should be'. The private nurse said that she thought the note was both bad in itself and symbolic of the attitude of the nursing staff. Neither my investigation nor that of the police could determine the author of the note on the diet sheet.

69. The DA recorded that at the meeting with the relatives on 12 April 1978 (see paragraph 71) 'a general apology was tendered to the relatives for the incidence of this type of comment'. It was pointed out that it was not proven that the comments had been written by any member of the staff, and they might even have been made by one of the patients.

(g) *The AHA have failed to provide satisfactory answers to the complaints*

70. On 23 September 1977 the complainant telephoned the hospital to complain about the treatment her father-in-law was receiving. She was asked to put this complaint in writing and did so on the next day. This letter was sent to the AA and acknowledged by him on 27 September. He told her that he had given instructions for the matters she had raised to be thoroughly investigated and for him to be furnished with a report. He said this might take a little time but he would write to her again as soon as possible. The letter was referred to the DA for investigation who obtained reports from nursing administrators and the psychiatrist.

71. Following the inquest (see paragraphs 5 and 6) the AA replied to the complainant on 31 January proposing a meeting. The solicitors wrote on 2 March to the Legal Adviser to the Regional Health Authority (the Legal Adviser) stating that their clients were not satisfied with the treatment which the complainant's father-in-law had received on the psycho-geriatric ward at the hospital. It was decided by the senior officers of the AHA that the relatives should be given an opportunity of discussing their complaints with them and the Chairman of the AHA (the Chairman). This was thought to be more satisfactory than endeavouring to deal with the matter in correspondence. The relatives agreed and a meeting was held at the District Offices on 12 April 1978. The AA said that it had been hoped that this meeting would to some extent satisfy the relatives' complaints, but a letter from the solicitors on 15 May informed the AHA that their clients were most dissatisfied with the manner in which their complaint had been treated. The solicitors said they were instructed to make

arrangements for an independent inquiry. The AA said that it was difficult to know what else could have been done in the circumstances to assuage the relatives' concern.

72. On 20 April the complainant wrote to her Member of Parliament who asked my predecessor to investigate.

73. The DA said that he had first heard of the complaints at the end of September 1977 after her father-in-law had gone home for the weekend leave from which he never returned. On 6 October the police inquiry had commenced and this had to some extent pre-empted the AHA's own inquiry. They were naturally reluctant to start their own enquiries when the police were investigating the same matters.

74. The DA agreed that the general complaint was that the standard of nursing care on the psycho-geriatric ward was not adequate and he thought the father-in-law's transfer from the admission ward to the psycho-geriatric ward had made the relatives cross and disgruntled. After the police enquiry had been completed it was decided there was no point in going further into the matters alleged, particularly as the police had said that there were no grounds to substantiate the allegations. After the meeting with the Chairman he had the impression that the relatives were still dissatisfied, but he thought perhaps less so. He told my officers that he did not think that the AHA could have treated the matter in any different way.

75. The Div NO (see paragraph 19) told my officers that he had difficulty in investigating the complaint because the relevant books and documents were needed by the police for their inquiry. He had interviewed as many of the staff as he could and the impression he had gained was that the complaint was an immediate reaction to the patient's transfer to the psycho-geriatric ward from the admission ward. He agreed the meeting with the Chairman on 12 April 1978 had not gone too well.

76. The Legal Adviser said that a police inquiry had started by the time he became aware of the complaint that had been made. It was therefore very difficult for the AHA to know how and when to reply to the allegations. He thought they certainly could not reply before the police had completed their inquiries, but he said it was not the AHA's intention to frustrate the relatives in their complaint. He and the Chairman thought that a personal interview was the best way to deal with the complaints.

77. The Chairman said that he had decided to attend the meeting on 12 April personally and he had specifically asked for the local staff involved to be present. He said that he had found it very difficult to decide what the complainants wanted. He was quite sure that the meeting had failed to satisfy them and he made this point at the end of the meeting. He promised as a result of the meeting to send a team to look at the hospital, consisting of three or four members of the AHA. When this team reported to him they made a number of recommendations but none was particularly applicable to the psycho-geriatric ward. He said that he was happy that the AHA had done all they could to answer the complaints in the circumstances. He did not believe that any further inquiry by the AHA would help particularly as the nursing staff's morale had already been upset by the number of different inquiries that had been carried out into the allegations.

The attitude adopted by a Home Office pathologist

78. During the course of my investigation I thought it would be helpful to obtain amplification from the Home Office pathologist of the reason for his answer 'No' to the Coroner's question 'Did you have the impression that the deceased was well cared for prior to his death'. For a personal reason not connected with my inquiry into this complaint he expressed himself unable to help me. His reason was quite unacceptable. Had I found myself in the position of not being able to reach a conclusion for lack of this witness's evidence, I would have had no hesitation in exercising my powers under Section 114(2) and paragraph 12 of Schedule 13 of the National Health Service Act 1977. But in the event, I had sufficient evidence from elsewhere to enable me to come to a conclusion on the general standard of care given to the complainant's father-in-law which tended to support the Home Office pathologist's opinion.

Findings

The complaints about the care of the patient

79. It has not proved possible, due to conflicting evidence or the lack of evidence to determine the facts on all aspects of this case. With regard to the specific complaints in paragraphs 1 (a) to (g) and 2 above I find as follows:

(a) Although the complainant's father-in-law may well have been reluctant to take a bath and have resented care by coloured or male nurses, I do not believe that the alleged arm-twisting incident occurred in the manner described by him. I accept the reasons given by the psychiatrist for the wrist drop. I do not uphold this complaint.

(b) I find the complaint about the teeth proved, and consider it reprehensible that so little thought was given to patients' dignity and hygiene that it was possible for the wrong teeth to be forced into a patient's mouth, particularly since the need for individual identification and safe custody of dentures of long-stay patients is well known. I am relieved that the AHA have now ensured that a proper system is routinely in force.

(c) None of the doctors or nursing staff thought the complainant's father-in-law was unduly thin for this type of patient. I have confirmed from the nursing records that he was being encouraged to eat and given 'Complan' if needed. The medical opinion given to me was that in view of his Parkinson's disease he might well have had difficulty in swallowing leading to inanition and muscle wasting. It is regrettable that his weight was not regularly recorded. There is no doubt that this total weight loss from June to October was 3 stones 7 lbs, of which 1 stone 9 lbs was lost in the last ten days of his life, but I cannot come to any firm conclusion why this was so. The AHA have assured me that a proper and more regular weighing routine for all patients is now in force.

(d) The medical and nursing staff assure me that medication was administered as clinically prescribed and I have seen from the drug record that drugs were progressively reduced as described by the psychiatrist in paragraph 49. This action stems solely from the exercise of clinical judgement and accordingly is not for me to question. I do not uphold this complaint.

(e) It is not disputed that some of the injuries to the father-in-law's face and side were due to the fall on 21 September. I find there are also records of earlier falls. In explanation of the bruises present at the time of the Home Office pathologist's examination evidence given to me has suggested that these could well be due to the Parkinson's disease from which he was suffering. I cannot come to a definite conclusion on this.

(f) I am in no doubt that he was sent home without underclothes, and I uphold this complaint. I have been assured by the AHA that their policy is that patients should be dressed properly and that staff are now fully aware of this. I am satisfied from inspection of the nursing records that the bed sores on his heels had been dressed and one on his hip had been treated with powder.

The 'neck rubbing' incident

80. The explanation given by charge nurse A was unfortunate and I prefer to accept that given by the psychiatrist in paragraph 66. I am satisfied that there was nothing sinister in the incident.

The diet sheet

81. I find this incident deplorable. Although it has not proved possible to determine the author of the note, the fact that it was left on the ward kitchen wall for several days and that any member of the staff could have reported or removed it, cannot but reflect adversely on all of them.

The handling of the complaint by the AHA

82. An investigation into the relatives' complaints by the AHA was delayed by the police inquiry and the subsequent inquest, and I can appreciate that the AHA would wish to wait until after the inquest before offering to meet the relatives. I can also understand their decision to meet the relatives to discuss their complaints, but when the outcome of that meeting was so obviously unacceptable to the relatives, and bearing in mind statements made at the inquest, there was in my predecessor's view no alternative but to hold an independent inquiry and for this reason, with the agreement of the AHA, he decided to investigate. I do not therefore criticise the AHA for not themselves arranging an independent inquiry under the terms of circular HM(66) 15 paragraph 7 (iii) (b). The team of AHA members which visited the hospital did make recommendations for improvements to the ward environment which have been carried out but did not apparently report adversely on any of those deficiencies revealed in my own investigation. To that extent the AHA could have done more in the handling of this complaint.

General conclusion

83. The evidence given to me supports the allegation that, at the time, the general standard of care and supervision in the psycho-geriatric ward was unacceptably low. Many of those responsible for or working on the psycho-geriatric ward expressed unease about it. My own enquiries have also revealed deficiencies. The disturbing assessments given by the private nurse and by the consultant pathologist, who was also a member of the DMT, about the general conditions on the ward, seem credible to me. Although I do not believe that the

complainant's father-in-law was ill-treated, I consider that he did suffer from lack of proper care. In this I regret to have to record my impression that his care was of the same inadequate standard as that of the other patients on the psycho-geriatric ward; the principal difference being that he had relatives who visited and were able to complain. The responsibility of the ward staff is that much greater when patients' dependence on them is almost absolute. The AHA have asked me to convey their apologies to the relatives for the shortcomings in care revealed in my report and I gladly do so. They have also assured me that the standard of care of patients has been further improved since the events about which I am reporting. I hope that the relatives, whose concern was also to achieve improvements in the care given to other patients, will gain some satisfaction from that assurance.

Case Nos. W.140/78–79, W.461/79–80 and C.1110/78 – Failure to provide psycho-geriatric bed

Complaint and background

1. The complainants say that their mother was admitted as an emergency to a private nursing home after a partner (the FP) of her family practitioner had tried unsuccessfully to obtain a psycho-geriatric bed for her in a National Health Service (NHS) hospital. They complain also that the Area Health Authority (the AHA) refused to reimburse the substantial private nursing home fees incurred by the patient and that the Department of Health and Social Security (the Department) endorsed the AHA's decision; and that there was an unreasonable delay in transferring the patient from the home to a NHS hospital near to where one of the complainants lives (the other lived abroad).

Jurisdiction

2. The law does not allow me to investigate the actions of family practitioners in connection with the service they provide under contract with Family Practitioner Committees. In this report I have mentioned at some length the part that family practitioners played since this is essential to an understanding of the events complained of.

Investigation

3. During the investigation the written comments of the Department and the two Health Authorities were obtained and I examined the relevant correspondence. One of my officers interviewed the complainants and the administrative staff and doctors concerned in the complaint.

The complaint that the AHA failed to make adequate arrangements for the patient's treatment

4. The Member of Parliament who represented the patient explained to my predecessor that on 31 December 1975 the patient was admitted as an emergency case to a private nursing home, after the residential home she was in had refused to keep her because she was suffering from senile dementia and the FP had urgently tried, but failed, to get her admitted to a NHS psychiatric hospital. A firm of chartered accountants (the accountants) acting on behalf of the patient's daughters had told the Member that when the FP had got in touch with the younger daughter about the dilemma, she had agreed that her mother should be

admitted to a private nursing home. The accountants maintained that she did the only thing she could have done in such an emergency and that her agreement was given only on the understanding that it was a strictly temporary arrangement. The FP told my officer that when the younger daughter agreed that her mother should go to the private nursing home she had told the younger daughter that they would see if her condition improved and a transfer either to the daughter's home or to a hospital near to her could then be considered. The FP said in a letter to the District Administrator on 3 August 1977 that at the time of the patient's admission to the private nursing home this was considered to be a temporary measure and that the daughter hoped to find a place for her mother nearby.

5. The FP gave my officer the information recorded in this and the following three paragraphs. She said that she had been called to the residential home by the matron on 29 December 1975 as the patient was confused and was not eating. She had prescribed a mild sedative. On 31 December the matron had got in touch with her again as the patient had been trying to climb out of a third storey window. She visited her and found her to be more confused than before but not violent or a danger to anyone else. However, the residential home was an old Victorian house with a number of stairs and it was therefore not suitable for the confused type of patient. The matron was very alarmed about her and told the FP that she did not have enough staff to provide the amount of supervision the patient needed and could not keep her.

6. It was the FP's view that had the patient been living with relatives, they could have looked after her because all she really needed was permanent supervision, and so she decided to telephone the patient's family. She was given the younger daughter's telephone number by the matron of the residential home and when she spoke to her she told her that her mother would have to leave the home and invited her to see her mother. The daughter explained that she could not do this because she went out to work and had too many commitments. (In contrast she told my officer that the FP had said there was no point in her going at that stage.) The FP then told her about her mother's condition and said she would try to have her admitted to a psychiatric hospital.

7. The FP then approached one of the consultant psychiatrists responsible for psycho-geriatric beds at two hospitals, but he told her that there were no beds available. She told my officer that she could not remember if the consultant had offered to make a domiciliary visit. But in a letter written on 3 August 1977, when her memory would have been fresher, she recorded that the consultant had offered a domiciliary visit but said that he had no psycho-geriatric beds available at either hospital. As she had been given a categoric statement that there was no bed available she said she thought a visit would have been a waste of the consultant's time. However, at his suggestion she had tried to get in touch with the other consultant psychiatrist but he was not available. She spoke, instead, to the sister on the ward where he had beds and was again told there were no beds available. She therefore telephoned the younger daughter again and said she could not get her mother into a NHS bed locally and asked her if she could approach her own family practitioner to enquire about a bed in her own area, but the daughter did not seem to be 'very enthusiastic about this'. She also asked her if she or any other relatives could take the patient but

the daughter said that they could not. The FP then mentioned the possibility of the private nursing home, explaining that it would be expensive; and the daughter gave her agreement to transfer her mother there. The patient was admitted to the nursing home on 1 January 1976 as an emergency under Section 29 of the Mental Health Act 1959. The FP told my officer that she made this Order under Section 29 because she considered the patient was an emergency, in that her life would be in danger if she were not supervised and in order to cover the problem of consent to treatment, since the patient was not capable of giving it and her relatives were too far away. (The Order was in fact allowed to lapse after the expiry of the 72-hour statutory period.)

8. The FP had not been in touch with any of the consultant geriatricians in the area to obtain a bed because she did not think that the complainant's mother was an appropriate case for them. She also knew that there was an acute shortage of geriatric beds in that area at this time.

9. My officer spoke to the consultant geriatrician who had been longest in the district and he explained that if the FP had contacted him about the patient he would possibly have made a domiciliary visit; but he would not have been able to give her an assurance that he could have found her a bed straight away. He also went on to say that they did not admit patients with senile dementia and disturbed behaviour patterns, nor could they offer to take psycho-geriatric patients as emergency admissions. He added, however, if there had been a spare bed in one of their long-stay hospitals 'they would have tried to help', but vacancies were rare. He did not have the records of bed occupancy for these hospitals, but the District Administrator later supplied the information that for the quarter ended 31 December 1975 percentage occupancy at each hospital was 99·8. Although it was not possible to establish the precise occupancy on 31 December 1975 and 1 January 1976, the evidence points to the likelihood that all beds were occupied.

10. The consultant psychiatrists who had beds at the two hospitals told my officer that at the time in question their combined waiting lists contained the names of over one hundred patients. They explained that although these lists were 'fictitious' to the extent that, by the time it was possible to offer a patient a bed, in many cases he or she had died, the lists demonstrated the serious shortage of psycho-geriatric facilities. Both psychiatrists said that as soon as a bed became free, usually as a result of a death, it was re-occupied almost immediately.

Findings

11. While I recognise that the patient's transfer to the private nursing home was the start of a chain of events (which I deal with in the next section of my report) that caused her to incur considerable costs, I am concerned in this part of the complaint simply to decide whether or not the AHA failed to provide a service which they should have provided.

12. Although the patient was eventually admitted to the private nursing home under the terms of an Order under Section 29 of the Mental Health Act 1959 I can find no evidence that the AHA were made aware by the FP, at the time when she was seeking her admission to a NHS bed, of the priority of her admission. The FP spoke to one of the consultants in psychiatry but did not arrange for

him to make a domiciliary visit to the patient. She did not manage to speak to the other consultant but rested on the word of the ward sister concerned that no beds were available. She did not get in touch with the consultant geriatrician, who told my officer that, although he would not have been hopeful of success, he would have tried to help.

13. The Minister of State for Health, in correspondence with the Member, explained that a decision to admit is not governed by the availability of a bed of a particular type and that, in the absence of a psychiatric bed, a geriatric assessment bed might well prove a suitable alternative for the purpose of a joint geriatric/psychiatric assessment; a number of elderly patients with severe mental infirmity were admitted, by transfer, to psychiatric beds in precisely this way. And I believe this to be so.

14. I can well understand that the FP, faced with the problem that neither the residential home nor the patient's relatives were prepared to look after her and with the evidence she had obtained about the state of the local psychiatric beds, should have suggested to the younger sister that her mother might be transferred to the private nursing home for what was hoped would be only a temporary stay. But the fact remains that, although it would no doubt have been difficult to find a bed for her, the ability of the AHA to provide a service for her was not fully tested. In these circumstances, I do not consider that they can be said to have failed to provide a service which it was their duty to provide; and I do not therefore uphold the complaint. Had a responsible hospital doctor seen the patient, considered that she should be admitted immediately as an emergency, and failed to obtain a bed for her, I would have taken a different view.

The complaint about the delay in transferring the patient to the hospital

15. As early as February 1976 the elder daughter was worried about the high expense of her mother remaining at the private nursing home and wrote to the Medical Director there to enquire about the possibility of a transfer. Her concern about the rapid erosion of her mother's capital was shared by the accountants who wrote to both daughters on 2 April 1976 to make them aware of their own concern and to offer to make enquiries about the possibility of having their mother transferred to a NHS establishment. On 14 April, the accountants wrote to the patient's own former family practitioner to ask if he could arrange to have her transferred. They also wrote to the Medical Director at the private nursing home to inform him that she could not afford the fees and that they had therefore asked her former family practitioner whether he could arrange a transfer to cheaper accommodation. The accountants were subsequently informed by telephone by her own family practitioner (not the FP) that she was no longer within their province, having transferred. On 11 May 1976 the social worker from the private nursing home wrote to the consultant psychiatrist at another hospital saying that the younger daughter would like to have her mother near her and requesting a bed for her. Following this application the patient's name was placed on the waiting list for the hospital on 19 May 1976, and on 16 June 1976 the consultant psychiatrist there wrote to the Medical Director of the private nursing home asking for a medical report on the patient's physical and mental condition (which was supplied in a letter dated 18 June), but saying that until the patient secured admission their social worker was going to investigate the possibility of getting her into an old people's home.

16. The consultant psychiatrist at the hospital was then informed in a memorandum dated 23 June 1976 from the Principal Social Worker for the area that the Social Work Department could not be responsible for obtaining accommodation for a patient from a private hospital which was in any case outside their catchment area. The consultant psychiatrist passed this information on to the Medical Director of the private nursing home in a letter dated 23 July 1976 in which he said he would have to withdraw his offer to help but that the solution of the problem rested with the younger daughter, who resided in the area, and that if the patient were living with her the solution would have been straightforward.

17. The younger daughter told my officer that she had been informed by both the AHA and the consultant psychiatrist at the hospital that if her mother were registered with a local family practitioner it would be easier to obtain a bed for her at the hospital. Eventually the younger daughter managed to get her mother registered with her own family practitioner who wrote on 31 January 1977 to the consultant psychiatrist at the hospital requesting that the patient be given a bed there. The consultant psychiatrist replied to him on 11 February 1977 explaining the problems of admitting someone from outside his catchment area, and pointing out that the chances would be greatly increased if the patient were to come and live at her daughter's home. However, on 1 April 1977 the Medical Director of the private nursing home wrote once more to the consultant psychiatrist at the hospital who replied on 5 May 1977 enclosing a copy of his letter of the same date to the younger daughter's family practitioner which said that a vacancy had now arisen at the hospital. She was finally admitted to the hospital on 18 May 1977.

Findings

18. The patient's name was on the waiting list for a place at the hospital for almost exactly a year. The problems of arranging a transfer of a patient to a hospital when she lives outside (in this case, well outside) their catchment area are always considerable. I have seen evidence that the transfer was considered as clinically non-urgent; and Authorities in these circumstances, naturally, and in my view properly, regard it as their first duty to serve patients in their own area and I do not therefore consider that there was an unreasonable delay in arranging the transfer. Indeed, I think the consultant psychiatrist at the hospital went out of his way to try to be helpful to the patient and her family. I do not uphold this part of the complaint.

The complaint that the AHA and the Department refused a request for the cost of the stay in the private nursing home to be refunded.

19. On 23 June 1977 the accountants, who hold Power of Attorney for the patient and were acting on behalf of her two daughters, wrote to the local office of the Department about a refund of the fees incurred during the sixteen and a half months' stay at the private nursing home. This letter was passed to the District Administrator of the Health District who replied on 9 August 1977 giving a general explanation that he could see no way in which either the AHA or the Department could refund such fees because there was no guarantee that any patient would receive treatment in a hospital on demand and this was borne out by the high waiting lists which are prevalent throughout the country. The

accountants then approached the patient's Member of Parliament who wrote to the then Secretary of State for Social Services on 30 August 1977. The then Minister of State for Health replied on 4 November 1977 pointing out that it did not appear, on the facts, that no accommodation could have been found within the NHS because the FP had not explored all the avenues open to her – ie she had not accepted the offer of a domiciliary visit from the consultant psychiatrist; nor had she contacted any consultant geriatricians.

20. On 15 November 1977 the Member replied to the Minister of State pointing out that, on the evidence of two approaches by the FP, there were no beds available at the hospital and that the fact that a geriatrician could have arranged an assessment ignored the fact that the case was an emergency one. Furthermore, the FP did not contact a geriatrician because in her view the patient was a psycho-geriatric case. The Minister of State replied to the Member on 6 February 1978 saying that he remained convinced that, for the reasons I have quoted in paragraph 13, it had not been established that no accommodation could have been found within the NHS for the patient had a responsible hospital doctor decided, on examining her, that admission was the appropriate course to have taken.

21. The AHA told my predecessor that they acknowledged that they had no psychiatric facilities in the area but took the view that if the NHS were under a legal obligation to provide treatment *on demand,* with the alternative of meeting the private fees incurred, this would result in a 'bonanza' for the private sector which would progressively cripple the NHS. The Department also remained firm in their view and, in a letter to my predecessor on 4 December 1978, said that if the FP had taken up the offer of the consultant psychiatrist to make a domiciliary visit and had he then decided that immediate admission to hospital was necessary, a NHS bed would have been found in some hospital.

Findings

22. The AHA's decision was based on the premise that, as a general principle, there is no guarantee that any patient can receive treatment in a hospital *on demand* and therefore they could not re-imburse the fees that had been incurred at the private nursing home. I believe that in principle this is right. What I have to decide is whether this particular case exhibits features that make it an exception to that principle and, if so, whether there was maladministration by the AHA or the Department.

23. There are two aspects to this. The first is whether the AHA failed in their duty when they did not provide a NHS hospital bed for the patient on 31 December 1975/1 January 1976; the second is whether there was dilatoriness afterwards on the part of the AHA in making arrangements for her transfer to a NHS bed.

24. On the first point, I have found (paragraph 12) that the AHA did not fail to provide a service they should have provided because the proper, full procedure for requesting the service was not carried out. It follows from this that I cannot recommend any *ex-gratia* payment and therefore I uphold the decisions by the AHA and the Department.

25. On the second point, I have found (paragraph 16) that, once the decision had been made to attempt to transfer the patient, commendable efforts were

made by the consultant concerned to effect the transfer. This leaves open the question whether the AHA (from whom an *ex-gratia* payment was claimed) had been guilty of any maladministration. I can find no evidence that this was so. Indeed, the District Administrator said, and the papers confirm this, that he only knew of the problem when he received a copy of the accountants' letter of 23 June 1977 (paragraph 17) from the local office of the Department; and by this time the transfer had already been effected. I can see no ground for recommending that the AHA should be held financially responsible for a situation which had not been brought to their attention and accordingly I again support the decisions of the AHA and the Department.

Conclusion

26. I can understand the sense of grievance that the daughters have at the considerable expense incurred by their mother while she was at the private nursing home and I think it likely that ways could have been found to transfer her sooner into NHS accommodation had the AHA been aware of the problem. But, as I have explained, I find no evidence of maladministration on the part of either the AHA or the Department in reaching their decision not to support an *ex-gratia* payment and I cannot therefore uphold the complaint.

Case No. W.194/78–79 – Refusal of NHS treatment after private consultation
Complaint

1. The complainant alleged that she was refused physiotherapy under the National Health Service (NHS) when she attended a hospital (the hospital) after a consultation with an orthopaedic consultant (the consultant), arranged privately.

Investigation

2. I have seen the comments made by the Area Health Authority (the AHA) on the complaint and also the relevant correspondence and the medical notes. Enquiries have been made of the Department of Health and Social Security (the DHSS) and one of my officers discussed the case with the medical, physiotherapy, nursing and administrative staff concerned and with the complainant. From this information I set out the main sequence of events in paragraphs 3 and 4.

3. In March 1978 the complainant fell and injured her ankle. After seeing her family practitioner she arranged to see the consultant in his private consulting room because of the length of the waiting list for NHS out-patients at the hospital. The medical notes record that the consultation took place on 31 March. An x-ray was taken and the consultant decided that physiotherapy treatment was appropriate. On 27 April he referred the complainant to the Physiotherapy Department of the hospital. The District Physiotherapist concluded (even though the referral form did not specifically say so) that the complainant was a private patient because the form was dated on a Thursday whereas the NHS clinic was held on Fridays. As is her practice the District Physiotherapist telephoned the complainant early in May to warn her that the waiting list for treatment was long – private patients had to take their turn – but in the course of their conversation, the complainant made it clear that the consultant had indicated to her that she was to get NHS treatment, even though

the consultation had been a private one. On 2 June the Physiotherapy Department invited the complainant to attend for treatment on 6 June; a standard letter setting out the charges was enclosed. The complainant telephoned the Assistant Sector Administrator (whose name appeared at the bottom of this letter) maintaining that she wanted NHS treatment. She did not attend on 6 June. A follow-up appointment for 8 June was sent routinely, but again the complainant did not attend.

4. Meanwhile the complainant got in touch with the consultant again and explained her difficulty. The consultant prepared a letter addressed to the registrar in his firm at the hospital (the registrar) and on 9 June, some time after 5 pm, the complainant took the envelope to the clinic. She thought she handed it to the receptionist but was sure that on that occasion she saw neither doctor nor physiotherapist. The envelope contained a note to the registrar and a referral form bearing the complainant's name. The registrar filled in those parts of the form marked 'Diagnosis' and 'Aims of Treatment' and the medical notes were annotated 'Seen by . . . (the registrar). Needs Physio'. When the Physiotherapy Department received the completed referral form they again asked the complainant to attend the department – this time on 15 June. There was no indication that she was to be treated privately and she therefore attended for her appointment. But when she was asked for her appointment card which would have been given to her when she attended the clinic on 9 June, she explained that she had not seen a doctor or a physiotherapist then and had done no more than hand in the consultant's letter. The Senior Physiotherapist told the complainant that in these circumstances she would still have to be regarded as a private patient. This was because it was necessary for a patient who had had a private consultation to be seen in a NHS clinic by a NHS doctor before he or she could be given NHS treatment. The complainant was upset by this and saw the Sector Administrator (the SA). He confirmed the position to the complainant and she complained that she was the victim of local rules. The SA explained that they were following 'Regulations made by the DHSS' and he confirmed the position to the complainant in a letter the same day. The complainant then complained to my Office that, despite paying National Health Insurance Contributions for the previous 20 years, she had been denied NHS treatment.

The complainant's entitlement to NHS treatment

5. The DHSS have told me that there is nothing to stop a person seeing a consultant privately and then being referred to the out-patient department of a hospital for treatment under the NHS. Private patients have as much right of access to NHS services in a capacity as NHS patients as anyone else but arrangements for such access to NHS hospitals must be fair. Many private patients move in and out of private care for different parts of a medical episode, but DHSS recognise that difficulty can arise in deciding at what stages in any one medical episode a patient can 'opt' back into the NHS and what the arrangements should be when he or she does so. DHSS have told me however that they take the view that it would be inequitable to allow a patient who attends for a private out-patient consultation to revert to NHS status for tests and treatment connected with that consultation without going through the usual procedures for 'admission' as an NHS out-patient. The arrangements for the 'admission' of NHS out-patients are the responsibility of the Area Health

Authority and it is for them to determine procedures to be followed. The DHSS added that it was for the AHA to decide whether the manner in which the complainant was referred, constituted a proper NHS out-patient 'admission' entitling her to physiotherapy under the NHS.

6. In the course of the investigation the AHA confirmed that the Physiotherapy Department was an open department as were the diagnostic Radiology and Pathology Departments. An open department is one to which access is not dependent upon referral by way of a consultant's clinic. DHSS told me that the extent to which open access is provided and the policy governing it, is a matter for local health authorities but in the view of DHSS open access is intended for general practitioners and their NHS patients only. DHSS are aware that it is sometimes used by general practitioners and consultants working outside NHS hospital premises for the reference of private patients and where this is allowed by the health authority it may be possible for a private consultation outside NHS premises to lead *directly* to open access use of NHS treatment services as an NHS patient. However in this case the Area Administrator has told my officers that it was, and had been for more than twenty years, the normal practice of the AHA to require a patient who had had a private consultation to be seen by a NHS doctor on NHS premises before NHS treatment could be given.

7. I have seen evidence that the District Administrator reminded all consultant staff in the District in 1975 that a patient who, after being seen privately at a Consultant's Room, elects to be treated as a NHS patient for subsequent treatment, must have an appointment booked to attend a Consultant's Out-patients' Clinic at the hospital and be registered there before he or she can receive treatment. I have also seen that the complainant's consultant was personally reminded in August 1977 that he should make it clear to his private patients that they may not have physiotherapy as NHS patients until they have been seen at the NHS clinic.

8. My officer therefore asked the complainant what the consultant had told her. She explained that he had not specifically said that the x-ray and subsequent treatment were to be free but that she had thought this implicit from her conversation with him and her subsequent discussions with his secretary. After the complainant received appointments on a private basis to attend the Physiotherapy Department on 6 and 8 June, the consultant's secretary told her she would have to visit the NHS clinic – and she therefore took the letter prepared by the consultant there on 9 June.

The consultant's letter and the action taken on it

9. When my officer discussed the complaint with the complainant she explained that she had been told that she did not need to wait when she took the letter to the NHS clinic on 9 June. She could not be sure whether it was the consultant or a nurse at the clinic who had said this. The consultant had no recollection of making this comment and remarked that it was his intention that his registrar should see the complainant on 9 June. The complainant was sure that she had not seen the sister in charge of the orthopaedic clinic that day although the latter recalled that the complainant handed her a letter in an enveloped addressed to the registrar and marked 'Private'. She asked the

complainant to wait but the complainant replied that she had been told there was no need to do so.

10. The sister told my officer that the registrar was very busy at that time and although the envelope was marked 'Private', she thought she might assist by finding out what was required. She discovered the envelope contained a request by the consultant for the registrar to refer the complainant for physiotherapy treatment. The sister alleged that the consultant indicated in the letter that there was no need to see the patient but that an entry should be made in the case notes. She added that the consultant further indicated that the letter should be destroyed when action had been taken on it. A referral form was with the letter but the sister said that, because it was late and the information given on it did not include the complainant's Christian names, address or hospital number, there was no chance of tracing her notes there and then. She gave the letter to the registrar who filled in those parts of the referral form marked 'Diagnosis' and 'Aims of Treatment', and signed it. On 12 June the sister herself filled in the personal details as required on the form.

11. The registrar confirmed to my officer, first, that he had not seen the complainant on 9 June, second, that he had signed the (undated) referral form and third, that he knew it was wrong to refer patients for treatment without having seen them. He could not recall what the consultant had said in his letter but he must have given the diagnosis of the complainant's condition and details of the treatment she should have.

12. A medical secretary told my officer that on 12 June she had to get the case notes from the Physiotherapy Department in order to type the note which the registrar had recorded on tape for inclusion in the case notes. The medical secretary recalled that the notes were not with those for other patients the registrar had seen on 9 June, and she had felt very reluctant to type '9.6.78 Seen by . . . [the Registrar]. Needs Physio.', because she knew from the location of the notes and from a conversation with the sister in charge of the orthopaedic clinic that the statement was untrue.

13. When my officer discussed this point with the consultant, the latter could only suggest that the registrar was thinking of another patient when filling in the referral note and making the entry in the case notes. The registrar accepted that he must have dictated the note but could offer no explanation for the entry in the case notes.

14. When the referral note signed by the registrar was received in the Physiotherapy Department, a further appointment was sent to the complainant inviting her to attend on 15 June. When she arrived the complainant was asked some routine questions and in the course of conversation it became clear that she had not seen the registrar despite the entry in the clinical notes. The Senior Physiotherapist and the SA had to explain that in these circumstances the complainant would still have to be regarded as a private patient. She left without treatment.

Events after the complaint was referred to my Office

15. When the SA wrote on 15 June confirming what he had told the complainant earlier that day – that she would have to be regarded as a private patient

– the SA said he was sending a copy of his letter to the consultant who could arrange to see the complainant himself or arrange for another doctor to do so in a NHS clinic. On 14 August 1978 the AHA confirmed to my predecessor that the consultant had offered to arrange a further appointment and if necessary order physiotherapy in 'the recognised manner'. On 1 September the complainant wrote to my Office to say that she had received a card informing her that arrangements had been made for her to be seen on 8 September at the clinic – she did not know why, because she was waiting for treatment in the Physiotherapy Department. She did not attend on 8 September and subsequently explained to my officer that as the consultant had already referred her to the Registrar and 'nothing had come of that', she could not continue to take time off work when it was to no purpose.

16. Meanwhile the consultant's action had angered the Physiotherapy Department who sent a letter in July 1978 to the District Community Physician referring to the problems that arise when the Department are obliged to tell a patient that he or she has to pay charges because the consultant has not explained this or made it clear that the alternative is a referral through the NHS clinic. The letter mentioned the complainant's case and the writer thought it quite unreasonable that, because a patient was not fully informed of the position before he or she arrived in the Department, the Department should be accused of refusing treatment. The AHA have told me that the letter in July 1978 to the District Community Physician was the subject of discussion between the latter and the then District Administrator but was not considered by the District Management Team.

17. I pursued the wider implications of the complaint as it related to the open access Physiotherapy Department. The procedure adopted in the Area does not require *all* patients to attend a NHS Clinic before physiotherapy commences – patients who are prepared to be treated as private out-patients in the Physiotherapy Department and pay the appropriate charges are not required to attend a consultative clinic. And a family practitioner may refer a patient direct to the Physiotherapy Department for NHS treatment. But, as I have already explained (paragraph 6) when a consultant has seen a patient privately there must first be contact with a consultant or his registrar at a NHS out-patient clinic before the physiotherapist can provide NHS treatment. In this type of case the referral form has now been amended to indicate the status of the patient but it was only as a result of my further enquiries that the AHA explained that the referral form used by a general practitioner does not at present indicate the status of the patient. It is their intention to amend this form when it is next reprinted.

Findings

18. The DHSS have said that 'the question of whether patients may revert to NHS status following a private consultation is a contentious area but . . . DHSS have generally taken the line that all NHS entitled patients have the right to NHS treatment regardless of whether it is required as a consequence of a NHS or private consultation'. However they have expressed the view that in the circumstances of this case a private patient cannot move directly from private status to NHS, while at the same time recognising that it is for the AHA to decide whether the patient was properly referred for the purposes of obtaining NHS treatment. The Physiotherapy Department and Sector Administrator

decided that the complainant was not properly referred and I am satisfied that in doing so they applied the normal criteria used by the AHA in such cases.

19. The difficulties the complainant experienced undoubtedly stemmed from the disagreement between the consultant and the AHA about the reasonableness of insisting that a patient who has previously had a private consultation has to be seen by a NHS doctor on NHS premises before NHS treatment can be given. This is a difficult question and it is not for me to resolve it. However I make the following comments on the practice as it affected the complainant. There was a waiting list for a consultation under the NHS and the complainant elected, as she was entitled to, to have that consultation privately. By paying she gained an earlier consultation. As will be seen, she gained nothing else. The consultant decided that she needed physiotherapy and after the Department first refused to accept her for NHS treatment, he wrote a note to the registrar at the hospital giving his diagnosis and he told my officer he expected the registrar to see the complainant on 9 June (paragraph 9). Had the registrar done so the likelihood is that the complainant would have received her treatment earlier, by virtue of her private consultation, than would have been the case had she elected to have a consultation under the NHS. But the registrar did not see the complainant and, on 15 June, the Department again refused to treat her under the NHS. She elected not to attend the clinic on 8 September and has still not received that treatment, although the consultant expressed the view when he met my officer that it was necessary and for that reason the arrangement was made to see her on 8 September (paragraph 15).

20. In the past, patients (and the consultant) have been told incorrectly that the practice the AHA follow has been dictated by DHSS Regulations. The AHA now accept that this is not the case and I find that they were at fault in this respect. But I believe that the complainant's grievance arises directly from the consultant's letter which she took to the NHS Clinic on 9 June. The consultant has said that it was his intention that the registrar should see her but the evidence does not seem to me to support this claim. I have been unable to trace the letter and if, as the sister recollects, the registrar was instructed to destroy it, that is inexcusable not least because the letter was the only support for the registrar's request for treatment. It is not disputed that the registrar did not see the complainant on 9 June despite a record in the complainant's notes indicating the contrary. It seems to me that these improper actions may have been taken in an attempt to circumvent the practice adopted by the AHA but, in the event, they were all to no avail. The complainant did not get her physiotherapy and in my opinion has been the victim not of local rules (paragraph 4) but of tactics which were unnecessarily devious. It is true that after the complainant made her complaint to this Office, offers were made to resolve the situation but she decided understandably that she did not wish to return to the Physiotherapy Department although it appears that she still needed treatment.

Conclusions

21. It is unreasonable that the Physiotherapy Department should be accused of refusing treatment when they were merely carrying out recognised practice, and I make no criticism of the staff who did so. I am satisfied that before 15 June the complainant did not fully understand that she had to be seen by a NHS doctor on NHS premises before she could use the physiotherapy facilities

at the hospital under NHS arrangements. The consultant did not accept the practice but I believe that it was for him to have made it quite clear to the complainant at the outset that NHS treatment was conditional upon the patient seeing the registrar in the NHS Clinic. Had he done so, the complainant would have been in a better position to decide her status, either as a private or NHS patient, for the treatment. I can well understand that she thought it unnecessary that she should be obliged to have a second consultation when the consultant had already prescribed physiotherapy. The position arises from the flexible arrangements under which the complainant elected to have a private consultation but NHS treatment. Under the practice adopted in the Area, had the *family practitioner* decided to refer his patient for an x-ray and physiotherapy a second consultation would not have been required.

22. There is no doubt that anomalies remain and I have seen that the complaint was not an isolated one and that there have been other similar cases in the Area which occurred both before and after this one was referred to this Office. I am pleased to report therefore that DHSS have told me that they are considering issuing further guidance on what is generally recognised to be a very difficult subject. I also hope that when the complainant receives the explanation in this report she will consider returning to the NHS Clinic and the Physiotherapy Department if she feels that treatment would still be beneficial to her. I am in no doubt that the complainant would have been given treatment as a private *or* NHS patient and I must conclude that, at least until the time of her complaint to this Office, she was denied treatment to which she was entitled. I believe the consultant's actions were primarily responsible and I therefore invited him to express his sincere regret for the avoidable distress the complainant undoubtedly suffered. But it was only after four letters and two telephone calls to his secretary and a delay of some six months that he responded. He said it did not seem fair to him to be asked to express regret to a patient on whose behalf he went to a great deal of trouble including arranging for her to attend a hospital clinic. But I am not satisfied that these arrangements were in accordance with hospital procedures and I believe that the complainant's problems continued as a result. I conclude that the complaint is justified and remains unremedied.

Case No. W240/78–79 – Care and treatment prior to discharge from hospital
Complaint and background

1. The complainant's father who was 92 and lived alone, despite being almost blind, deaf and disabled, was admitted to hospital on 19 October 1977 because a leg ulcer, which had formed after a fall, had become infected.

2. The ulcer improved with treatment and the hospital decided to discharge him home. The complainant was unhappy about this decision and arranged instead for him to enter a private nursing home. He was discharged from the hospital to the home where he died three days later, on 29 October 1977.

3. The complainant says, through her Member of Parliament, that:

(a) when she brought her father to the hospital's casualty department she was separated from him for two hours and her requests to rejoin him were ignored by the nursing staff;

(b) the nursing care he received was inadequate and, in particular, he was given food he could not eat; and he was once found sitting in a chair soaking wet;

(c) She, as next-of-kin, was not told promptly of a deterioration in his health or of the hospital's decision to discharge him;

(d) a doctor was unhelpful towards her when she eventually learnt of and queried the decision to discharge her father, and told her that she could not see the consultant; and

(e) although he was still ill the hospital transferred her father to the nursing home in a 'sitting' ambulance; they refused to give the home a discharge note; and, after his death, wrote to his family doctor to say that he had been discharged into his care.

Investigation

4. During the investigation the written comments of the Area Health Authority (the AHA) were obtained and I have seen these and other relevant papers. My officers interviewed members of the medical and nursing staff as well as seeing the complainant and her husband. They did not see the deceased's private nurse who, the complainant said, had actually originated the complaints about the care. The complainant was aware that the nurse did not want to become involved and so this proved when my officer made two unsuccessful approaches to her seeking an interview. Apart from being the initiator of some of the complaints, she was also a material witness to most of them. Although I have the power to obtain evidence from anyone who, in my opinion, is able to give me information relevant to an investigation I decided to leave the choice to the complainant and she informed me, through her Member of Parliament, that she wanted my investigation to go ahead without the benefit of the evidence of the private nurse. My investigation is therefore necessarily not as complete as I would wish.

(a) *The complaint that the complainant was separated from her father*

5. In a letter dated 5 December 1977 to the hospital, the complainant said that her father was taken to the Casualty Department (casualty) when he arrived at the hospital. He had been in great pain in the ambulance but his private nurse and the complainant were 'waved away' and left to sit for two hours in a passage where they could hear her father shouting. She said she tried to speak to the sister on duty in casualty (the casualty sister) but she was busy and the complainant was 'brushed away'. Neither medical nor nursing staff came to ask the complainant about her father and she eventually asked his private nurse to go to his side. The complainant told my officer that she was worried about her father but the casualty sister had been in too much of a hurry to speak civilly to her. In a letter dated 6 February 1978 to her Member of Parliament, the complainant described her father's reception at the hospital as 'cold and frightening'.

6. The casualty sister told my officer that she had only vague recollections of the patient but remembered that he had been accompanied on arrival in casualty. She said it was quite possible for patients to spend two hours in casualty, waiting for doctors to attend them and waiting for the results of tests. I have seen from the hospital notes that the complainant's father underwent routine

examinations in casualty – temperature, pulse rate and blood pressure, for example. I have also seen that wound swabs of both legs were taken on the day of admission but I am unable to say whether these were taken while the patient was in casualty or after he had been transferred to the ward. The casualty sister told my officer that, in this particular case, there would have been an extra delay of about thirty minutes because, in view of the infectious nature of the leg ulcers, it was decided to admit him to a room on an isolation ward (the ward), and it would have taken that length of time for staff to ensure that the room was sterile for the incoming patient.

7. She told my officer that relatives or anybody else accompanying a patient are asked to sit in the waiting area in casualty. She said that she would normally try to keep the relatives informed of progress and explain any delays; it was not always possible to let relatives sit with the patient as, at that time, there were only curtain partitions between each bed and this gave very little privacy. She added that the casualty facilities have been improved since then and the partitions are now more substantial. She told my officer also that they were short-staffed and it was generally a busy department; but she had no recollection of any 'brushing away' incidents. And she said that they would always try to transfer a patient to the ward as quickly as possible. She felt she would have remembered if there had been any complaints at the time; but to the best of her memory everything went smoothly as regards the complainant's father.

8. The senior nursing officer told my officer that the recognised establishment for casualty was three sisters, three staff nurses and one state enrolled nurse. The actual complement at the time had been one sister, one staff nurse and two student nurses.

Findings

9. I have been unable to resolve the conflicting accounts given by the complainant and the casualty sister. What is quite clear, however, is that the casualty department was under-staffed at the time and one immediate effect of this would be that those on duty would have had little time to deal with relatives. Indeed, the complainant herself said that the sister was busy. I have little doubt that the complainant did not receive the attention she would otherwise have had and, to that extent, I uphold her complaint, though I do not think the staff were to blame. It was unfortunate that the complainant could not sit with him for at least some of the time he was in casualty. But this was partly because of inadequate partitioning and I am pleased to learn that the facilities have now been improved.

(b) *The complaint about the nursing care*

10. In her letter of 5 December 1977 to the hospital, the complainant said that, when her father was admitted to the ward, she explained to a staff nurse there that her father was punctilious about personal hygiene and that they should let him use the commode whenever he wanted; she explained also that his food should be very finely minced. As she lived some way away, she sought permission for the private nurse to come to the ward each day so that her father would not feel abandoned and was told that this would be a great help.

11. In her letter the complainant also said she visited her father on the following Sunday (23 October) and she was horrified to find him so changed that she did not recognise him. She said that he was slumped in a chair, could move only in jerks, could not speak properly, and did not recognise her. Whilst the complainant and her husband were waiting to see a doctor, the complainant's father became very agitated and she realised that his bell was on the floor. She rang the bell and a nurse came and simply left him a bottle – which later fell to the ground and spilled the contents on the floor. The complainant said, both in the letter and to my officer, that the private nurse had reported to her that, on the first occasion she had visited, she had found the complainant's father sitting in a chair soaking wet and and that he had been given food he could not have eaten. The complainant's husband told my officer that on the one occasion when he saw a meal his father-in-law had been given it was an 'ordinary meal'.

12. On 24 January 1978 in a reply to the complainant the Sector Administrator (the SA) at the hospital told her that it was unfortunate that her father had had to be nursed in an isolation ward. His confused state and his high dependency on nursing staff were factors which suggested that he would have been better placed elsewhere but the infectious nature of his ulcers necessitated the use of an isolation ward. The SA's letter went on to explain that he was a difficult patient to nurse, often being aggressive to the nursing staff. However, considerable attention was paid to his comfort and to ensuring that he always had a bottle nearby and a bell, which, in fact, he used very frequently.

13. My officer spoke to the sister in charge of the ward (the ward sister) who had previously made a statement to the senior nursing officer during the hospital's investigation of these complaints. She said that the complainant's father was confused and very aggressive. When a member of the nursing staff tried to help him he started shouting and hitting out at them. The ward sister remembered that the patient hit several of the night staff and she herself remembered being kicked. She said that the nursing staff were continually tending him, sitting him up and making sure that he had a bottle near him and a bell. She described him as difficult and unco-operative and she said that he had as much attention as could be given considering the ward was busy and short-staffed. The nursing notes describe the patient at various times as 'disorientated', 'noisy', 'restless', 'rather aggressive' and on one occasion record – 'nursing care given with difficulty!'

14. The ward sister told my officer that the patient was indeed incontinent but he was receiving two-hourly treatment for pressure sores (although this is not recorded in the nursing notes) and this would be therefore the maximum length of time he could have been left in his chair soaking wet. The nursing notes carry an entry on 20 October 1977 'Incontinent of urine'; and the Fluid Balance Summary indicates that on five days during the period of admission it was not possible to measure accurately the patient's fluid output. As regards the complaint about the food, the ward sister told my officer that the complainant's father was on a soft diet. She could not remember any complaints about the diet being made at the time. However, the consultant surgeon (the consultant) in charge of the patient's care told my officer that the complainant's father was not put on any special diet and the nursing notes carry an entry under the heading 'Diet' which reads 'Normal Hycal' (normal diet supplemented by a high-calorie drink).

Findings

15. The evidence is that the complainant's father was a difficult and demanding patient, no doubt because of his age and considerable infirmities. And because of his infectious ulcers he had to be placed on a busy and short-staffed ward to which he would not otherwise have been suited. However, I have no reason to believe he did not receive the best nursing care possible in the circumstances. The evidence is that he was on a normal diet together with a high-calorie drink; and that would have been a professional decision, made in the light of his condition, and is not for me to question. He may well have been found in a chair soaking wet but, such a situation must at times be inevitable when a patient is incontinent and liable to spill the contents of his bottles. While unfortunate, this does not necessarily indicate lack of nursing care. I have not found such evidence as to enable me to uphold this complaint.

(c) *The complaint that the complainant was not told of the deterioration in he father's health or of the decision to discharge him*

16. In her letter of 5 December 1977 to the hospital, the complainant said that on Saturday 22 October her father's private nurse had telephoned her to say that he was to be discharged and to ask if the complainant could collect him by car at 9 am on the following Monday. She said she was annoyed and had telephoned the hospital to arrange to see the doctor, or anybody else who could help, on the Sunday. When she arrived at the hospital she did not recognise her father because he had changed so much. The doctor told her that he had discharged her father and that he must go at 9 am the following morning.

17. In a letter of 5 February 1978 to the SA, the complainant's husband specifically asked why his wife had not been told that her father's health had deteriorated and that it was intended to discharge him. He also explained the difficulties his wife had experienced in having her father adequately cared for at his home – which made it impossible for him to be discharged at short notice. The complainant told my officer that her father's condition had deteriorated within two or three days of his admission and he had become a 'vegetable'. She could not understand why the hospital had not told her about this. Also, she could not understand why her father's private nurse was told of the decision to discharge him before she was told.

18. The consultant told my officer that while the complainant's father was in hospital his general physical condition had improved. He said he had seen the patient on the day after his admission and on one other occasion (which the nursing notes record as 22 October) when he discussed the question of discharging him. He said that he had been unable to discuss the matter with the patient himself; because of his age and general disorientation he was unable to understand the simplest of matters. In ideal circumstances, he would have been transferred to geriatric care but, unfortunately, no such places were available. Knowing that the patient had a private nurse and having established that the home circumstances were satisfactory, he decided that to discharge him would be in his best interests. But the date of discharge had been postponed for two days when the family expressed their intention of trying to get him into a private home.

19. My officer also interviewed one of the House Officers (the first HO), who remembered the patient as demented and generally very difficult to manage. He told my officer that apart from the ulcers the complainant's father was in reasonable physical condition for a man of 92 but that his dementia got worse during his admission. When his ulcers had reached the stage where they could be treated at home and because his mental condition was getting worse while he was in hospital, it was decided, in the patient's best interests, to discharge him to his home. Another House Officer (the second HO) confirmed that the complainant's father grew steadily more confused whilst his ulcers improved. He added that it was not uncommon for elderly patients to become confused in hospital.

20. The ward sister, in her written statement made during the AHA's investigation of the complaints, stated that, when the decision to discharge was made, she had tried to telephone the complainant but had been unable to get in touch with her. She had therefore telephoned the private nurse and told her. She told my officer that she believed she had tried twice to speak to the complainant but the line had been engaged on the first occasion and there had been no reply on the second. She could not remember whether she had asked the private nurse to tell the complainant but felt sure she would have explained the difficulties she herself had had in contacting her.

Findings

21. There is no doubt that the patient's mental condition deteriorated and that this was a major factor in the decision to discharge him on 24 October. I have no reason to doubt that efforts were made to contact the complainant on 22 October to tell her of the decision. But I do not think it was reasonable to regard the private nurse as a substitute. I think the hospital should have made absolutely sure that the complainant and her husband had reasonable notice, at first hand, of the decision, should have explained why they considered that the complainant's father, frail though he was, would be better off at home and was to be discharged so soon, and have given them an opportunity to say their say. As it was, there is little doubt that when they learned, at second hand, they felt they were being faced with an ultimatum. I think there was an error of judgement in the way the discharge arrangements were handled.

(d) *The complaint that a doctor was unhelpful*

22. In her letter dated 5 December 1977 to the hospital the complainant said that, when she went with her husband on Sunday 23 October to the hospital to see a doctor about the decision to discharge her father the following day, they had to wait for about an hour to see him. When he finally appeared he was completely unhelpful and unsympathetic. He repeated that the patient was being discharged and, in the face of their protestations that they would be unable to arrange for proper care at such short notice, he asked how they had managed as regards nursing care for him before his admission. The complainant said in the letter that the doctor had said, 'To me, the patient is just an ulcer. I am not interested in his welfare'. She went on to say that she asked to see the consultant but was told by the doctor that he was interviewing students and that she could not see him for a week. She asked to see the 'Matron or the almoner' but was told

that this was not possible. The ward sister finally appeared and said she would keep the complainant's father until Wednesday 26 October, but no longer. The sister had said that in the meantime she would try to find him a suitable place in a nursing home.

23. The doctor who saw the complainant and her husband was the second HO and he told my officer that they had explained to him that they did not want the complainant's father to be discharged to his home by himself, that they had had difficulties in securing suitable private nursing staff to look after him and that this was an expensive proposition. He remembered that the complainant had said that her father would be unhappy to stay with her and she herself could not get him into a home. When the complainant had asked to see the consultant the doctor had explained that the consultant was not then available. He told my officer that he thought he probably did not tell them when the consultant would be available. He said that the discussion lasted for about half to three-quarters of an hour and that the complainant had become rather irate during the course of the meeting. He attributed this to her distressed condition and worry about her father. He said he had tried to answer the questions put by the relatives but accepted that they might not have been happy with the answers he gave. He said that during the interview he, the complainant and her husband became less and less happy with its progress and, although they had thought him rude, he did not believe he was; and he said he could not imagine saying anything like the statement attributed to him.

24. The ward sister told my officer that she had been present during some of the conversation and she remembers the second HO telling the complainant that there was no further treatment they could give the patient, that he would be better off at home and that she (the ward sister) would explain how to dress the ulcers.

25. The consultant said he had a regular time for seeing relatives – just before his weekly clinic – and that this was well known to the staff. He emphasised that he considered it part of his job to see relatives but he agreed that he was not available at the time in question.

Findings

26. I dare say that the second HO could have been rather more helpful to the complainant and her husband – for example by telling them when they could see the consultant or, if necessary, trying to arrange an early consultation – but I suspect that the main reason the complainant considers the second HO to have been unhelpful is that she disagreed with the decision to discharge – a decision not taken by him, but by the consultant. The fact that he spent so long with the complainant and her husband is not, to my mind, indicative of a deliberately unhelpful attitude, but I uphold the complaint that the communications were not as good as they could, or should, have been. This aspect of the affair seems to me to stem largely from the events upon which I have commented in paragraph 21.

(e) *The complaint about the ambulance and the discharge notes*

27. In her letter dated 5 December 1977 to the hospital the complainant said that she was appalled to learn that her father had been sent to the nursing home

in a sitting ambulance. She said also that the doctor had been too busy to write a note to the nursing home at the time of her father's discharge and that, some time after her father had died, his family doctor received a note saying that the complainants' father had been discharged into his care. She told my officer that, on the transfer, her father had been accompanied by her husband and the private nurse. The complainant's husband confirmed that it was a sitting ambulance with bench-type seats. He said that the nursing home wanted a certificate of discharge from the hospital but when he went to the hospital to ask for one he was told by the ward sister that the doctor was 'scrubbing up' and in the operating theatre and therefore could not write it. She had suggested that the family doctor could do it. The complainant thought that the hospital had had plenty of opportunity to arrange for this procedure to be completed, especially as they had originally intended to discharge her father two days previously. As regards the note sent to her father's family doctor, the complainant told my officer that she *believed* the private nurse had informed the hospital of her father's death and that the family doctor had received a note from the hospital much later, having heard nothing at all from them prior to this.

28. The consultant told my officer that he thought a sitting ambulance was perfectly suitable for the complainant's father who had been 'sitting out' whilst in the hospital. He added that patients with a chronic cardiac condition (which this patient had) were often better off sitting up.

29. In her written statement during the AHA's investigation, the ward sister said that the complainant's husband came to the ward to say that he wanted the doctor to fill in a form to be presented at the nursing home on his father-in-law's admission. The ward sister telephoned the doctor but he was 'scrubbed' and in the operating theatre and he advised her to ask the complainant's husband to get the family doctor to fill in the form. The ward sister said that the complainant's husband was not very happy about this. She went on to say that she had sent a letter with the patient to the nursing home, suggesting that they telephone her (the sister) if they required further information. They did not telephone. I have seen a copy of this letter, the main purpose of which was to explain the patient's condition and treatment so far.

30. I have seen also a copy of the discharge note addressed to the patient's family doctor and this clearly indicates that the patient was discharged on 26 October 1977 to a nursing home. The first HO, who had signed the discharge note, told my officer that this would probably have been despatched on the day of discharge and I have confirmed from the hospital copy that it is dated 26 October 1977. The consultant told my officer that, in all cases, no matter where the patient is discharged to, a discharge note should be sent to the family doctor and, where the patient is being sent to a nursing home, as in this case, the ward sister or house officer would normally write to the home.

31. The first HO said that a 'Registrar's Abstract' (a copy of which I have seen and which is undated) would have followed the discharge note. This expands on the discharge note. The Registrar's Abstract relating to the complainant's father includes the phrase 'discharged to his doctor's care'.

Findings

32. I find that the patient was indeed transported to the nursing home in a sitting ambulance but there is medical evidence that this was appropriate in his condition. I find also that a doctor was unable to send a discharge note to the nursing home because he was 'scrubbed' and in the operating theatre. I think the advice that the family doctor should do this when he had been in no way responsible for the patient's immediate past care was absurd. However, the ward sister sent a note to the nursing home with an offer of further information if necessary. This proved to be quite sufficient and, indeed, the consultant said this was common practice. But it is clear that there was a muddle and I am not surprised that the complainant and her husband were upset about it.

33. Finally I find that the family doctor received a copy of the Registrar's Abstract carrying the phrase 'discharged to his doctor's care'. This, in fact, was not so; but since it was preceded by the discharge note, explaining that the patient had been sent to a nursing home the mistake was of no great significance. Whether it was sent before or after the hospital learnt of his death is problematic since it is not known when or if the private nurse notified the hospital, and the abstract is anyway undated. I think, nonetheless, it would be helpful if such abstracts did bear a date.

Conclusions

34. I have explained my findings on the complaints in paragraphs 9, 15, 21, 26, 32 and 33 above. The AHA have asked me to convey to the complainant and her husband their apologies for the weaknesses in communication set out in paragraphs 21, 26 and 32 and this I gladly do.

Case Nos. W.249/78–79, W.106/80–81 and W.107/80–81 – Failure in communication between hospitals on transfer of patient

Complaint

1. The complainant's son, aged eight months, was admitted to hospital (hospital A) on 16 May 1976 for investigation of pyrexia of unknown origin (PUO). His condition deteriorated and on 31 May he was transferred to another hospital (hospital B) where he died on 1 June, the cause of death being given as infantile polyarteritis. The complainant says that:

(*a*) there was a lack of communication between the two hospitals and that his son's medical notes (the notes) were not transferred in time for him to be given the appropriate treatment;

(*b*) his son did not have satisfactory medical and nursing supervision at hospital B;

(*c*) the replies by the Regional Health Authority (the RHA) and by the Area Health Authority (Teaching) (the AHA(T)) to his complaints were unsatisfactory.

Background

2. The complainant's son was admitted to hospital A on 16 May 1976, following his referral by his family practitioner, for investigation of PUO. He received treatment and investigations were carried out to identify the cause of the pyrexia but on 31 May his condition deteriorated and he was transferred to

hospital B. He died on 1 June and the report on the autopsy conducted on the instructions of HM Coroner gave the cause of death as infantile polyarteritis. The complainant was concerned about aspects of his son's treatment at hospital B and instructed solicitors (the solicitors) who wrote to the RHA on 14 July asking for the notes to be made available to them. The RHA declined to release them to the solicitors but on 15 December sent the notes to an independent consultant paediatrician (the independent consultant) nominated by the complainant. The solicitors wrote to the RHA on 28 February 1977 enclosing a copy of the independent consultant's report and said that there were a number of points in the report which caused the complainant grave concern – in particular the arrangements for transfer from hospital A to hospital B – and they asked for a hospital enquiry. On 20 July the RHA replied giving an explanation of the transfer procedure and an account of what had happened when the complainant's son was transferred. The RHA did not consider a hospital enquiry would serve any purpose other than to establish known facts. The complainant took advice from his Community Health Council and on 20 September wrote to the AHA(T) detailing his complaints and asking for an investigation. The complainant was not satisfied with the AHA(T)'s reply of 13 February 1978. He therefore wrote to my predecessor and he agreed to investigate his complaints.

Jurisdiction

3. The Act which defines my powers specifically excludes me from investigating actions taken by doctors which, in my opinion, are taken solely in the exercise of their clinical judgement. The complainant was told that my predecessor could not comment directly or indirectly on the adequacy of a patient's medical care. In this report I refer to the medical aspects of the case only in order to place the complaints in their context.

Investigation

4. During the investigation one of my officers visited the complainant and his wife. The comments of the RHA, the AHA(T) and the Area Health Authority (the AHA) were obtained; medical, nursing and administrative staff of the health authorities concerned were interviewed. I have examined relevant documents and records. For convenience I deal with the evidence on complaints (a) and (b) together.

(a) and (b) *The complaints about the lack of communication and the unsatisfactory care*

5. The complainant and his wife's account of the events as given in their letters and in their interview with my officer is summarised in this and the following four paragraphs. They said that when they arrived at hospital A during the afternoon of 31 May 1976 they were told that their son's condition had deteriorated and that arrangements had been made to transfer him to hospital B. His mother noticed that an intravenous infusion (IV drip) had been set up; this worried her and she spoke to the hospital A paediatric registrar (the hospital A registrar) who told her that her son's condition was satisfactory for the journey. Her son was placed on a trolley and as he was leaving the ward with his mother and a nurse (the escort nurse) who was to accompany him in the ambulance,

the complainant's wife heard the ward sister (the hospital A sister) say 'don't forget these' and a large brown envelope was placed on the trolley.

6. On his arrival at hospital B at about 4 pm the complainant's son was taken straight to a ward (the ward). The ward sister (the ward sister) was not present on the ward and the escort nurse waited to speak to her before returning to hospital A. Shortly afterwards the hospital B paediatric registrar (the hospital B registrar), accompanied by a female doctor and the ward sister, examined the complainant's son and the IV drip was taken down. The complainant's wife said they asked the hospital B registrar why their son had become cyanosed that morning when feeding and he said that it could have been caused by mucus but that their son appeared to have cleared it himself. The complainant and his wife asked the hospital B registrar what he intended to do and he told them that he was stopping the antibiotics which had been ineffective and that he would probably order tests which had not been carried out at hospital A but, however, their son's notes which he needed had not come with the ambulance and arrangements had been made by telephone for them to be sent. The complainant's wife said that her son was very restless and noisy and that she had to comfort him so that they could continue their conversation. They told the hospital B registrar that their son had been given sedatives at hospital A to settle him. He replied that he did not wish to prescribe sedatives as their son appeared to have a respiratory problem.

7. The complainant's wife stayed almost continually with her son until about 11 pm, by which time he had settled and she spent the night of 31 May at hospital B. While she was with her son no medication was given. Before she went to bed she asked a nurse (who had come on duty since her son's admission and was sitting in the ward sister's office) if the notes had arrived from hospital A. The nurse told her that they had arrived and pointed to some files on a desk.

8. The complainant and his wife said they accepted that it was unlikely their son's death could have been prevented at that stage but they were very concerned that nothing appeared to be done for him. He was in pain or great discomfort for the last hours of his life; antibiotics which he had been receiving were stopped and the IV drip taken down; he should have had continuous medical and nursing care but he 'was left to get on with it'. They also could not understand why the health authorities had been unable to tell them whether or not the notes, which the hospital B registrar had said he needed to see before ordering tests, had arrived from hospital A.

9. The complainant's wife said that the nurse (who was the Night Nursing Officer (the NO) see paragraph 26) who took her to the ward at about 7.30 am on 1 June after her son collapsed told her that her son's condition had been satisfactory when she had last seen him about an hour earlier. When the complainant's wife arrived on the ward her son had died and she asked the hospital B registrar what had caused his death. He replied that possibly her son had choked. As the NO had told her that she had not seen the child for an hour before his death the complainant's wife asked the hospital B registrar why her son had been left unattended. He had not replied.

10. The independent consultant's report to the complainant said 'As far as can be ascertained from the notes [the son] had not been seen by medical and

nursing staff between 6.00 am and 7.30 am' and later in the report he wrote: 'My own interpretation of the policy adopted by the medical and nursing staff, based on a careful reading of the notes, is that they judged the child's condition to be not critical. He was thought to have a respiratory infection and the cyanotic episode which precipitated his transfer from hospital A was attributed to an excess of mucus in the respiratory passages. This seems to have been cleared by the child's own efforts. Individual nursing was not, therefore, felt to be necessary. In retrospect this appeared to have been an error of judgement. There can be no doubt, however, from the post mortem findings that the baby was suffering from infantile polyarteritis and this condition is invariably fatal. It cannot be said, therefore, that this error of judgement was in any way responsible for the child's death. Death was almost certainly the result of an acute cardiac arrhythmia due to myocardial infarction. Even if a nurse had been constantly in attendance at the cot-side his death could not have been prevented.'

11. The consultant paediatrician at hospital A responsible for the complainant's son's care was away on 31 May 1976 and another consultant paediatrician had made the decision to transfer the child to hospital B. These consultant paediatricians explained to my officer that when a doctor at hospital A wanted to transfer a patient to another hospital he would speak to a doctor at the other hospital and obtain his agreement to the transfer; a full discussion would take place about the patient's condition and the treatment already given. A referral letter, usually typed, containing a summary of the relevant sections of the hospital notes would be sent to the doctor accepting the patient. It was not the usual practice to send notes with transferred patients and this would only be done at the specific request of the admitting hospital. They assumed in this case that such a request had been made as the hospital A registrar's referral letter of 31 May concluded 'I am sending his notes and x-rays and shall be grateful for your help'. The consultants could not recall which doctor had arranged the transfer. Although they believed that the x-rays were sent they did not know whether or not his notes had been forwarded to hospital B.

12. The hospital A registrar told my officer that he could not remember if he made the arrangements for the transfer or whether he had asked the nursing staff to send the notes with the patient. He confirmed that the notes would not have been sent unless requested and said that in view of his referral letter he must have intended the notes to be sent to the second hospital. But the hospital A registrar clearly recalled that he had arranged later on the day of the transfer for the notes to be delivered as initially he had difficulty in obtaining transport. However, he had insisted that it was an urgent matter and the notes were delivered.

13. The hospital A sister, who told my officer she had been on the children's unit there for about ten years, said that although x-rays were often sent it was unusual for notes to accompany children transferred to other hospitals; she could recall few instances when this had happened and a doctor would have to give specific instructions to the senior nurse present when the transfer was arranged. She said that when she came on duty at 12.30 pm on 31 May she was told about the complainant's son's transfer but there had been no mention of his notes. The hospital A sister said that a nursing referral letter in hospital B records was signed by the escort nurse. The letter gave a brief summary of his

treatment, current diet and medication. The sister said that she thought she had received a telephone call from hospital B about the notes but as she had no power to release notes or authorise a journey she would have had to inform a doctor.

14. The escort nurse was at the time a staff nurse on the children's unit and she left hospital A shortly afterwards. She told my officer that she clearly remembered escorting the complainant's son to hospital B because she was worried about him. There had been a problem about his notes and hospital B had taken some action to obtain them. She could not recall discussing the transfer with a doctor on the morning of 31 May or receiving any instructions that the notes were to accompany the child: if she had, she was sure she would have taken them.

15. My officer obtained a hospital A transport log sheet covering journeys on 31 May 1976: it shows that a vehicle left hospital A at 18.05 for '[a city] Hospital' and returned to hospital A at 21.25; the 'goods' were described as 'urgent notes'. The driver of this vehicle told my officer that on 31 May he was asked to take a set of notes to hospital B: he was told that the notes should have gone with an ambulance and that they were urgently required. He thought he arrived at hospital B about 19.15 and he handed the notes to a female member of staff who told him that she had been waiting for them. (I have established that the complainant's son was the only patient transferred by ambulance from hospital A to hospital B that day.)

16. Hospital B keep records of the return of notes and x-rays to other hospitals and these show that the notes were returned to hospital A on 2 June and his x-rays on 3 June 1976.

17. The consultant paediatrician at hospital B (the hospital B consultant) responsible for the complainant's son told my officer that he did not see him nor was he consulted by his registrar about him. He had been available if required. It was the usual practice for his registrars to decide on an investigation plan for a patient which he would be shown when he saw the patient on his ward round next day and this was what would have happened in this case. The hospital B consultant said that it appeared from the hospital B registrar's notes that although the complainant's son was clearly a sick child on admission his condition had not caused concern. The hospital B consultant considered the decisions to stop the antibiotics and to wait for the hospital A notes before making the investigation plan reasonable. The hospital B consultant felt that as the hospital B registrar decided not to reinstate the IV drip (which had come out of the child's vein during the journey from hospital A) he must have been satisfied that such supportive measures were not required. In cases where a doctor did not know a child well it was, the hospital B consultant said, a practice not to prescribe sedatives if it was thought that the patient had respiratory difficulties.

18. The hospital B consultant said that hospital B medical staff regularly carried out investigations on children with PUO for hospitals throughout the region. This death had been totally unexpected and the cause of death, infantile polyarteritis, was an unusual condition and he had seen few cases in his career; in his opinion it would have been unlikely that the thrombosis that led to the

complainant's son's death would have been prevented even if the planned tests had been carried out and drugs prescribed as a result, because the drugs would have required time to take effect.

19. The hospital B registrar was unavailable during my investigation as he was in the Far East but I have seen his clinical notes which appear comprehensive and provide a clear account of his assessment of the complainant's son's condition, the matters which concerned him and of his intentions. His notes include a detailed description of the child's medical history at hospital A which I must assume he could only have obtained from the referral letter and a telephone discussion when the transfer was arranged. He noted on examination the presence of oedema which he thought might be due to a fluid overload from the IV drip although he qualified this entry with the comment that the complainant's wife had told him that her son had been like this since he was admitted to hospital A; that the child's pyrexia had not responded to the antibiotics (which he detailed) administered at hospital A; and he instructed their discontinuation to allow the situation to clarify. The hospital B registrar also recorded that no notes had arrived with the child and they were needed before proceeding further. He noted that the results of the hospital A investigations were required before he could plan his own investigation as he needed to know what the tests had excluded, and then he wrote 'meanwhile 1) normal feeding; 2) regular suction and physiotherapy; 3) no antibiotics; 4) plan investigations when [hospital A] notes arrive'.

20. The house physician on duty at hospital B during the evening and night of 31 May 1976 told my officer that she remembered looking at hospital A's notes and discussing them with the hospital B registrar during the evening before the complainant's son's death. She was sure that it was as a result of their discussions that she ordered a series of tests for the child to be carried out on the morning of 1 June and the clinical notes support her recollection.

21. Apart from these a special laboratory test was carried out that night. As Monday 31 May was a bank holiday an 'on-call' system was in operation for pathology requests and the senior chief medical laboratory scientific officer was on duty. A record is kept of calls and this shows that he came in to perform this special test for the complainant's son at 6 pm on 31 May and left at 6.25 pm. Although he cannot recall the incident this officer said that he was sure he would have telephoned the result to the requesting doctor before leaving the hospital. The information about the test is confirmed by the hospital B notes.

22. The night staff nurse in charge of the ward (the staff nurse) made a statement on 4 June 1976 in accordance with hospital B's procedure when an unexpected death occurred. In it and to my officer she said that at about 21.30 she gave the complainant's wife her child's feed for her to give him. When she returned the complainant's wife had asked her when the doctors would see her son the following morning and she had replied that she was not able to say with certainty as the time of the ward round varied. The complainant's wife had left the ward to go to bed at about 22.30 and the staff nurse tried to feed the child as he had taken little of his feed. A little later his temperature was found to have risen and fan therapy was commenced. The staff nurse said that at about 24.00 a rash had appeared on the child's body; she informed the house physician who asked to be told if the rash worsened but it faded and the complainant's son went to

sleep between 00.30 and 01.00. At about 01.30 he was awake and crying; he refused to be fed orally and the staff nurse passed a naso-gastric tube (an NGT) so that he could be fed.

23. The staff nurse told my officer that the complainant's son was seen frequently during the night by the NO, the night sister and herself. He was awake and crying when at about 06.00 the staff nurse was feeding the baby who shared the cubicle with him. When she finished feeding the other baby, at about 06.30, she tried to feed the complainant's son orally but he again refused and he was fed by NGT. The staff nurse explained to my officer that feeding a baby orally normally took about twenty minutes but by NGT it took longer, about thirty minutes; she thought that she probably completed his feed at about 07.00. His temperature at that time was 37·5°C and fan therapy was discontinued. The staff nurse said that when she left the complainant's son to write up the night duty report his condition was unchanged, but that at about 07.30 the night sister found he had collapsed and the resuscitation team was called.

24. The staff nurse showed my officer when he visited the ward that the glass partitioning in the ward and positioning of the cots made it possible generally for a nurse whilst feeding one baby to observe three other babies. As nurses spent much of the night feeding the children they were therefore almost continually observing them.

25. The night sister in a statement made on 3 June 1976 and when interviewed by my officer said that she spoke to the complainant's wife at about 22.45 on 31 May. They discussed the doctors' visit next day. The complainant's wife then left the ward and shortly afterwards the night sister saw the complainant's son. She found him asleep on top of his cot and she noticed that he was pyrexial and that a fan was in operation. She discussed the details of his condition and his care with the staff nurse. The night sister said she saw him again at approximately 24.00 and at 03.00 and 05.30 on 1 June and on each occasion he had been asleep but he remained pyrexial. On her 03.00 visit she had noted that an NGT was *in situ* and that his feed chart showed he had been tube fed at 02.00. When she next visited him at 07.30 she found he was not breathing and she had been unable to find a pulse beat. The resuscitation equipment was brought into the cubicle and shortly afterwards the resuscitation team arrived.

26. The NO in her statement made on 3 June 1976 said that she saw the complainant's wife and her son at 22.30 on 31 May. The complainant's son was well nourished and although he was rather sleepy did not appear to be a particularly sick child. The complainant's wife asked her if he could have a blanket but the NO said he would be better left uncovered as he was running a high temperature. The NO told the staff nurse about her conversation with the complainant's wife and discussed the difficulties in feeding him. The NO next saw him between about 05.45 and 06.00 on 1 June. Apart from his raised temperature his general condition appeared unchanged. When the call for the resuscitation team was made at about 07.30 she went to the ward and after the medical staff had arrived she left the ward to find the complainant's wife to tell her what had occurred. The complainant's wife appeared a little critical of her son's management and said that his treatment should have been started the previous evening. The NO explained to her that her son had been kept under observation during the night and the doctors would have reviewed his case that

morning. She told my officer that during this conversation it was quite possible that she told the complainant's wife that she herself had last seen the child at about 06.00.

27. The Senior Nursing Officer (the SNO) at hospital B told my officer that there were four nurses on duty in the ward (including the ward sister who was not available for interview by my officer as she was in Canada) until 21.15 on 31 May, one of whom remained until 22.30. Three other nurses, including the staff nurse, were on night duty from 21.00: a fourth nurse should have been on duty but she was sick. The SNO said that the administrative report for that night showed that extra help was sent to the ward at 22.00 to help with feeding the babies. No further request for help was made that night and the staff nurse, who was a most conscientious and well qualified nurse and who had since been promoted sister, could have requested further assistance from the night sister if there had been any difficulty. The ward had twenty cots but on the night of 31 May only seventeen were occupied and the SNO considered that the number of staff on the ward was adequate.

28. The SNO told my officer that it was not unusual to feed sick babies by NGT and it did not indicate that a child was particularly ill because sick children were often disinclined to feed and as it was necessary that they received regular nourishment, NGT's were used. The medical notes did not indicate that the complainant's son required continuous observation and although a doctor would usually order 'specialing' it was also the responsibility of the senior nurse to arrange it if she considered that the condition of a patient warranted it: the SNO said that in her opinion and experience the child's temperature of 39°C when fan therapy was introduced did not necessitate 'specialing' or the summoning of a doctor.

Findings

29. As to complaint (a), I have found that communication between hospital A and hospital B about the child's transfer on 31 May took several forms. There was an initial telephone conversation between doctors of the two hospitals; there were referral letters from a doctor and a nurse; and the escort nurse spoke to the sister of the ward. I found that the child's x-rays went in the ambulance with him and that it was the intention that his notes should also have gone then but I have been unable to establish why they did not. However, both hospitals acted promptly when the error was realised and it was remedied expeditiously. There is evidence that on receipt of the notes the medical staff of hospital B planned their investigation into the child's PUO and ordered tests to be carried out the following morning although no change in his immediate treatment seems to have been made. I am satisfied therefore that there was no failure which affected consideration of the child's treatment in communication between the doctors and nurses of the two hospitals nor in the transfer of the notes and I do not uphold this complaint.

30. As to complaint (b), the nursing care which the complainant's son received during the night of 31 May followed the instructions of the hospital B registrar and the ward sister. Their decisions, which have been fully supported by senior colleagues, were in my opinion taken solely in the exercise of clinical and professional judgement and I cannot comment on them. The independent

consultant's report which I have quoted in paragraph 10, the misinterpretation of the meaning of the NO's comments when she fetched the complainant's wife on 1 June and the failure of the RHA and AHA(T) to tell the complainant categorically that the hospital A notes had been received at hospital B, naturally caused the complainant and his wife grave concern. My investigation has convinced me that the arrangements for the nursing care of the complainant's son were conscientiously followed and that medical advice was available to the nursing staff whenever they felt they needed it and I am fully satisfied that the complainant's son had satisfactory medical and nursing supervision.

(c) *The complaint that the RHA and the AHA(T) provided unsatisfactory replies to the complaints*

31. The solicitors wrote to the RHA on 14 July 1976 requesting the child's hospital notes. The RHA Legal Adviser (the legal adviser) would not release them to the solicitors but offered to send them to an independent consultant nominated by the complainant and his wife and they were sent on 15 December. On 28 February 1977 the solicitors sent a copy of the independent consultant's report to the RHA and advised that there were a number of points which caused their clients grave concern, in particular the transfer arrangements, and they asked for a hospital enquiry.

32. The legal adviser sent a copy of the report to the AHA on 10 March who told him on 26 April that the hospital A paediatric consultants had no observations on it. Subsequently the legal adviser asked the AHA for information about the circumstances of the transfer. The AHA's reply to the legal adviser said that the normal procedure was for a preliminary telephone call to be made and that this was followed by a typed letter, case notes and other relevant documents. On this occasion a handwritten letter had been sent because, as it was a bank holiday, there was no typing service; and that the consultant paediatrician was sure that the x-rays were despatched but could not determine whether or not the case notes went. The legal adviser wrote to the solicitors on 20 July:

> 'It appears that this child's transfer took place on a Bank Holiday Monday. The normal procedure is for a preliminary telephone call to be made and this is followed by a typed letter, x-rays and case notes and other relevant documents. It is not clear whether on this occasion a written letter was sent. It is clear from a study of the case notes that the case notes did not go with the patient. Clearly this was a breakdown in the system although it should be pointed out that the medical staff at hospital B had been notified by telephone by the medical staff at hospital A. In these circumstances it is not considered that a hospital enquiry would serve any useful purpose except to establish these facts.'

33. The complainant was not satisfied with the RHA's reply and after taking advice from his Community Health Council he wrote to the AHA(T) on 20 September 1977 setting out his complaints. The AHA(T) referred the complaints to the Health District (the district) responsible for the day to day management of hospital B which in accordance with their usual practice asked the sector administrator (the sector administrator) to carry out the investigation.

34. Early in January 1978 the AHA(T) became concerned at the delay in replying to the complainant and the sector administrator told them that the

investigation had not yet been completed due to an oversight for which he apologised; a letter of apology for the delay was sent to the complainant. On 30 January the district wrote to the AHA(T) enclosing information from hospital B but said that in their view it was insufficient to provide a comprehensive reply and that further information had been requested. The AHA(T) apologised again to the complainant on 31 January and also wrote to the district detailing the information they considered was still required. Finally on 13 February the reply was sent to the complainant.

35. The former deputy sector administrator (the deputy) at hospital B told my officer that when the complaint was received by the then sector administrator the investigation had been divided between them; he had looked into the medical matters and the sector administrator had dealt with the nursing aspects. Shortly after they had started their investigation they found that they needed the child's notes which were with the legal adviser. The notes were obtained but unfortunately no immediate action was taken on their receipt and this had caused a delay in replying to the district. He told my officer that he became acting sector administrator in January 1978 and had been responsible for completing the investigation but that he had been hindered by not being responsible for all aspects of the investigation from the outset and also the fact that the hospital B registrar who had admitted the complainant's son was not available as he was working abroad. He said that he had spoken to hospital A and the information he was given led him to believe that their notes had never left the hospital.

36. The AHA told me that they only became aware of hospital A's involvement in the complaint in March 1977 when the independent consultant's report was sent to them. In July, following telephone enquiries from the legal adviser, they had provided details of their transfer procedure (see paragraph 32) but as it was then some fourteen or fifteen months after the transfer it had been impossible to determine whether or not the notes had been sent. The AHA said that later when the AHA(T) were conducting their investigation and had asked whether the x-rays and notes had been sent they had given the same reply that they had given to the legal adviser. The AHA told me that the consultant paediatricians had pointed out that it was *not* always the practice to send notes and that it would depend on the telephone communication between the hospitals and the referral letter. If the letter contained adequate information then the notes may not be sent as a routine procedure.

37. In their reply of 13 February 1977 to the complainants (paragraph 34) the AHA(T) detailed the treatment prescribed for the complainant's son by the hospital B registrar and said he made a plan for the investigation of the child's condition and further tests had to wait until the hospital A notes had been seen. They told the complainant that notes and x-rays were usually sent by hospital A with the transferred patient but on this occasion no notes or x-rays accompanied the child. Enquiries to hospital A to see if there was a record of the time or date when the notes and x-rays were sent had been unsuccessful and neither had they been able to find out why the notes did not accompany the child on transfer in the usual manner. The AHA(T) wrote 'As you will no doubt appreciate, very searching enquiries have now been completed by reference to nursing, medical and administrative staff involved in this case and I sincerely hope that you will find the foregoing commentary has attempted to answer your specific questions,

even though it is recognised that there are one or two points where, in the circumstances, it has only been proved possible to offer somewhat less than definitive observations', and concluded with an expression of deep regret for the distress caused to the complainant and his wife.

Findings

38. My investigation has established from evidence in contemporary records and from the very clear recollections of staff that the notes were sent from hospital A to hospital B. The RHA and the AHA(T) could have replied to the complainant more accurately and informatively, for example:

(i) the AHA did not obtain information from the hospital A registrar (paragraph 12); or from the vehicle driver or examine the vehicle log sheets (paragraph 15);

(ii) the AHA(T) could not interview the hospital B registrar but they did not obtain information from the house physician (paragraph 20) which would have confirmed that the tests were ordered after receipt and consideration of the notes; and they did not examine their own records (see paragraph 16); and

(iii) the RHA stated erroneously that it was normal procedure to send the notes and that it was not clear whether a written note was sent; they did not explain what was done to get the notes to hospital B after the complainant's son had left hospital A without them; and they did not seek any information from the AHA(T) apart from obtaining and perusing the child's hospital B case notes.

39. I therefore criticise the authorities for the lack of care and application in their replies, particularly because these shortcomings reflected unfairly on the professional care that the complainant's son actually received at both hospitals and the successful efforts made to transfer his case notes. I am also concerned that on their superficial consideration of a very serious complaint about the standard of medical and nursing care given to the complainant's son the RHA decided that no further inquiry was necessary. A health authority ought not to reply in such categorical terms unless they have made a thorough investigation.

Conclusion

40. I have not upheld the complaints about the failure in communication between the two hospitals or the lack of medical and nursing supervision given. I have however upheld the complaint that the responses by the RHA and the AHA(T) to the complainant and his solicitor were unsatisfactory and criticised the authorities for failing to carry out adequate investigations. This is all the more serious in that they added to the complainant and his wife's distress when a proper investigation could have helped to alleviate their natural grief and worry. The RHA, the AHA(T) and the AHA have asked me to convey their apologies to the complainant and his wife on their behalf which I am pleased to do.

Case No. W.281/78–79 – Care and treatment of mentally ill patient

Background and complaint

1. The complainants' son, aged 22, was admitted to hospital (the hospital) on 7 February 1978 under Section 25 of the Mental Health Act 1959, suffering from schizophrenia. On 20 February he fell and an x-ray taken on 10 March at a different hospital (the second hospital) showed that he had sustained a fracture of the right femur. The following day he had an operation at a further hospital (the third hospital) and two weeks later he had to go back there for the removal of a haematoma. On 3 April his mother met a senior nursing officer and shortly afterwards the Community Health Council, on the parents' behalf, wrote a letter of complaint to the Area Health Authority (the AHA). The complainants were not satisfied with the response they received and complained that:

(*a*) after their son had been in hospital for only a short time he was sent home on 18 February on week-end leave despite the reservations of his parents and the difficulty there would be in persuading him to return to the hospital;

(*b*) there was a delay of 19 days between their son's fall on 20 February and his x-ray on 10 March and his appointment for it was postponed on several occasions without satisfactory explanation;

(*c*) in the period between the fall and the diagnosis of the fracture their son was treated as a malingerer, provided with insufficient food and moved to a first floor room with access by way of two flights of stairs;

(*d*) when his father complained that his son's drug regime seemed inappropriate the complainants were told by the consultant that they must leave treatment to the hospital or their son would be sent home;

(*e*) their son was allowed home on leave only one week after his operation which the complainants believed was premature and contributed to the haematoma; and

(*f*) the reply they received to their complaints was inadequate.

Investigation

2. During the investigation comments were obtained from the AHA and I have seen the relevant correspondence and medical and nursing notes. My officer interviewed members of the medical, nursing and administrative staff concerned. He also met the complainants and a social worker involved in the case.

(a) *The week-end leave*

3. In the correspondence and in discussion with my officer the complainants said that when they visited the hospital on the evening of Saturday 18 February they were informed that their son could be taken home for the remainder of the week-end. The parents were unhappy at this decision because their son had been admitted to the hospital only on 7 February and was still rather distressed. They felt that he had been in hospital for too short a time to be allowed a visit home.

The son's mother said that they knew from past experience that they would have considerable difficulty in persuading their son to return to the hospital when his week-end leave was over. They were asked by a staff nurse, in their son's presence, if they would be prepared to take him home with them and it had been impossible for them to refuse. The son's mother told my officer that she objected to this 'blackmailing' technique. In the event it had been very difficult to persuade their son to return to the hospital.

4. The staff nurse (staff nurse A) who spoke to the parents on that occasion told my officer that he conveyed to them the view of the consultant psychiatrist in whose care the complainants' son was (the consultant), that the son was well enough to go home for week-end leave. Staff nurse A recalled that the complainants' son himself had been very keen to go home and he said that at the discussion with the parents, at which the son had been present, they were initially reluctant to accept the idea because they did not believe that he had been in hospital long enough. But they eventually agreed to have him. He did not accept that having the complainants' son present at the discussion put undue pressure on the parents and thought it necessary because the son's opinion was also relevant and needed to be taken into account. The consultant confirmed to my officer that it had been his view that the complainants' son was fit enough to go home but he was critical of the procedure of having him present when week-end leave was discussed with his parents. The sister and one of the other staff nurses, but not the charge nurse, conceded that his presence put unfair pressure on the parents.

5. The nursing notes for the period covering admission on 7 February until week-end leave on 18 February show that the complainants' son was extremely anxious to go home and expressed this desire on many occasions; indeed on 8 February he absconded from the hospital and only returned with the assistance of the police. The entry in the nursing notes for 18 February, written by staff nurse A, confirms his statement in paragraph 4.

Findings

6. Whether or not the complainants' son was fit to go on week-end leave is clearly a matter of clinical judgment and not for me to comment on. It is not disputed that staff nurse A spoke to the complainants on 18 February in their son's presence about his week-end leave and, while I think it was overstating the position to describe it as a blackmailing technique, it clearly put the parents in a position which would have made it very difficult for them to decline taking him home despite their strong reservations. To this extent I uphold this part of the complaint. While accepting there might be clinical reasons in certain cases for the patient to be present, I believe it would have been better for the parents' views to have been obtained out of their son's hearing – it is quite clear from the entries in the nursing notes what his wishes were. Even though there may have been practical difficulties in keeping the complainants' son away from his parents when they wished, I believe the discussion about week-end leave should not have been in his presence.

(b) *The delay before the x-ray was taken*

7. In correspondence and in their conversation with my officer the complainants gave the following account. The son's mother first heard of her son's

fall when she visited the hospital on 22 February. The nurse in charge of the ward at that time (the charge nurse) told her that her son had fallen outside the ward on 20 February, that he had been examined by two doctors and although no damage other than a graze on the hand had been discovered, an x-ray had been arranged for the next day (23 February) as the complainants' son was complaining of a pain in his leg. On the evening of 22 February the son's mother helped her son to bed. During the following week-end the complainants spoke to staff nurse A and the charge nurse but were told that there was nothing to worry about, the complainants' son was 'putting on an act' and that the x-ray was arranged for the following Thursday, 2 March. The son's mother said that a social worker assigned to the case had also given her this date for the x-ray and it was further confirmed at a meeting with the consultant attended by the son's father on 27 February. But when the son's mother telephoned the hospital on 2 March to find out the result, she was told that it had been postponed because the x-ray department was 'presumably too busy'. The son's mother said that the social worker attended the weekly case conference on 7 March when he was told that arrangements had been made for the x-ray to be taken on 9 March. The son's mother again telephoned the hospital that day to ascertain the result but she was very disturbed to be told then that the x-ray had been arranged for 10 March. Late in the evening of 10 March the consultant telephoned the complainants to say that their son had had his x-ray and that it showed he had fractured his pelvis; later the same night he telephoned again to say that this was an error and that their son had fractured his femur. The complainants were most concerned that it took so long for their son to be x-rayed when he had repeatedly complained of pain in his leg and they complained that they had been frequently given wrong information about the date of the x-ray.

8. The charge nurse told my officer that he had been on duty and in charge of the ward when the complainants' son fell. He examined him and found only a superficial injury to his hand. The nursing notes for that day and evening indicate that he also complained of a pain in his leg, but the charge nurse told my officer that he saw no reason to call a doctor at the time. The senior nursing officer (SNO) confirmed to my officer that a nurse has discretion to decide whether or not to call a doctor when an accident occurs. The charge nurse prepared an accident report which reads 'slipped in the snow outside . . . ward front door'. The report indicates that the accident was not witnessed and occurred at 2.30 pm on 20 February. The charge nurse also indicated that abrasions had been cleaned and no dressing was required.

9. The registrar who examined the complainants' son on 21 February and requested the x-ray told my officer that he had seen the complainants' son the day after his fall because he had been told that he was complaining of pain. But when he examined his hip and thigh he made no such complaint and his examination revealed no indication of a fracture. The clinical note for 21 February reads 'fell in the snow and complaining of pain in R hip region on examination no pain or external injury. R hip joint movement is full, x-ray to be done'. The registrar had not thought a fracture had occurred because of the patient's age and absence of any signs but in order to make quite sure he requested an x-ray. I have seen that there was no indication of urgency on the request form sent to the second hospital on 21 February. The registrar considered the x-ray important but not vitally urgent and he said he would have expected to have had the result

within a few days. He said that once he had signed the form requesting the x-ray, arrangements for it would have been left to the nurse in charge of the ward. The registrar said that he received reports from the nursing staff after his examination on 21 February which did not give any indication of the complainants' son being in pain or experiencing difficulty in walking. On one occasion he had himself seen the complainants' son walking normally and had he suspected that there was an injury, he would have tried to expedite the x-ray examination. He had seen no reason to examine him again. The consultant told my officer that at the time he had been aware that his registrar had examined the complainants' son after his fall but had found no evidence of injury although he had ordered an x-ray to be absolutely sure. The consultant supported this action but expressed the view that appointments for x-rays for patients following trauma should not be treated as routine x-rays and should be done as soon as possible. He was also critical of the paucity of information included in the clinical notes, particularly the entry relating to the fall, and the registrar himself admitted that his entry for 21 February had not been made at the time.

10. The charge nurse told my officer that he might well have told the son's mother on 22 February that her son had been seen by two doctors; he had been aware that the registrar had seen him the previous day and believed at that time that the consultant had also done so but realised later that this was incorrect. But the charge nurse was quite sure that he had not told the son's mother that her son was to be x-rayed 'the next day' because he knew it would take at least three or four days to arrange a routine x-ray.

11. My officer spoke to the sister in charge of the ward and to several members of the nursing staff who had been on duty during the period after the son's fall. One of the staff nurses (staff nurse B) told my officer that she recalled taking a telephone message on 23 February from the x-ray department at the second hospital. She was told that they would take the x-ray on 28 February. She said she entered this in the ward communications book and had been about to make a similar entry in the ward diary when she had to deal with a fracas on the ward. When she returned to the desk the pages in the diary must have been turned because, later, she discovered that she had entered the appointment for 7 March, not 28 February. Another staff nurse (staff nurse C) told my officer that she had taken a telephone call from the x-ray department on 1 March, the day after the son's original appointment. They had wanted to know why he had not presented himself the previous day. It was then that the error had been discovered. Staff nurse C recalled that she had asked for an early appointment but the best the x-ray department could offer was one for 10 March. The registrar had gone on extended leave on 1 March and was unaware at that time that the x-ray had still not been taken. But the mistake was not conveyed to any ward doctor.

12. The form requesting the x-ray was received at the second hospital on 22 February and the departmental records there confirm that an appointment was made initially for 28 February and later for 10 March. There is an entry in the ward communications book indicating an x-ray examination for 28 February but in the ward diary the x-ray is listed for 7 March. The nursing notes record on 3 March an appointment for 10 March but there are two entries in the ward communications book showing that the examination was to be carried out on 9 and 10 March. The minutes of the case conferences held on 28 February and

7 March show that the son's x-ray appointment was for 2 and 9 March respectively. The social worker who attended these weekly conferences on the ward gave information to the complainants on the basis of that indicated at the case conferences.

13. The consultant explained that it had been necessary to telephone the complainants twice on the evening of 10 March because he had been misinformed by the duty doctor. He had visited the complainants at home on 12 March and found them to be distressed by the events and he admitted that this had not surprised him. But he told my officer that he had been very surprised to see the result of the x-ray. He had not considered at the time that the son's behaviour stemmed from a physical injury; he and the other members of the staff had attributed it to his mental condition. The consultant accepted, in retrospect, that the complainants' son should have been x-rayed soon after the fall. Since the incident he had taken steps to try to prevent a recurrence by examining patients himself. On the other hand, both the medical assistant who carried out the operation and the Area Medical Officer, expressed themselves surprised that no one had considered that the complainants' son had a physical injury and was in genuine pain. The Area Medical Officer, while recognising that it was for the examining doctor to decide whether he thought an x-ray was needed urgently or not, expressed the view that the x-ray ought to have been carried out at once if there was any suspicion that there might be something wrong.

Findings

14. The registrar did not indicate any degree of urgency when requesting the x-ray. I have noted the comments of the consultant in this respect in paragraph 9 and the Area Medical Officer in paragraph 13 but this is a matter of clinical judgement on which I myself may not comment. But once the x-ray had been requested and an appointment offered by the x-ray department an appalling muddle ensued on the ward. The original mistake was a human error – although a very unfortunate one in the circumstances. But I cannot understand why, once the original mistake was recognised, the confusion about the new x-ray date was perpetuated. The parents, who were understandably very distressed, continued to be given incorrect information about the date despite the weekly ward conferences where the nursing staff discussed the case specifically. I am not in the least surprised that the son's mother should have described herself as eventually 'beyond words'. I have seen that on different occasions the appointments were noted variously in the nursing records, the ward diary and the ward communications book. It seems to me that there would be merit in recording such appointments consistently.

(c) *The treatment by the hospital staff while awaiting the x-ray*

15. The complainants said they were distressed by the way the staff treated their son after his fall; despite his complaints of pain and his inability to walk properly he was treated as a malingerer. They knew that their son's repeated requests to be allowed home annoyed the staff and said they were told that he was 'a naughty boy' and 'putting on an act'. Because of his refusal to attend the dining room they believed that he was inadequately fed and they were asked on

one occasion to refrain from visiting him in order to encourage him to go to the dining room. They were also concerned when they discovered that he had been moved from the ground floor of the ward to a room on the first floor thus necessitating his using two flights of stairs.

16. When he saw my officer, the consultant said that he did not think the complainants' son had been treated as a malingerer. He believed that the intermittent symptoms the son showed stemmed from his mental rather than his physical condition and pointed out that in the past, and previous to the fall, he displayed similar behaviour patterns. He saw the son's refusal to eat as a recurring symptom – he had not eaten for three days prior to his admission to hospital on this occasion. The consultant confirmed that the suggestion that the parents should refrain from visiting their son till he agreed to go to the dining room was in line with the 'reward system' used to encourage good behaviour.

17. The ward sister told my officer that the complainants' son behaved oddly both before and after his fall. She and the other nurses believed his behaviour to relate to his mental condition. She said it was true he had shown difficulty in walking sometimes but on other occasions he had been seen to walk and climb the stairs normally. The ward sister told my officer that she did not consider the complainants' son to be a malingerer although he was an attention seeker and liked to be noticed. She confirmed that he often failed to go to the dining room but on such occasions patients would take him food (although the nurses would not). His parents brought in provisions for him and she told my officer that he had been known to take food from the ward refrigerator. The suggestion that the parents should cease to visit him until he attended the dining room had been made in accordance with the treatment policy but she explained that it had been a suggestion only. She told my officer that the reason the complainants' son had been moved to the first floor was that his bed on the ground floor had been required for a patient who was considered to be in need of close nursing attention. The unit administrator later confirmed to my officer that a new patient had been admitted to the ward on 25 February.

18. The charge nurse separately gave my officer a similar account to that of the sister. He said that it was he who had made the suggestion about encouraging the complainants' son to visit the dining room to the complainants but he believed he had done so with tact and in response to a question from the parents as to how they could encourage their son to eat normally. He told my officer that the complainants' son had been extremely reluctant to eat and had believed his food to be poisoned. Although he considered him to be manipulative he had not thought he was a malingerer. The other nurses seen by my officer confirmed these impressions.

19. I have seen from the nursing notes there are numerous references to the complainants' son showing difficulty in walking. But on two occasions there are references to his shuffling along the corridor and walking normally upstairs; on another to his shouting for help to get upstairs but when his tablets were mentioned to him 'quickly' disappearing. The medical notes indicate that when he was seen at home prior to admission he had eaten nothing for three days and there are references in the nursing notes to him refusing food thereafter. The nursing notes also record that he was moved to the first floor on 25 February and was distressed by the move.

Findings

20. It is clear that the complainants' son was reluctant to eat and that this was a symptom of his mental illness. As to the ways of encouraging him to eat in the dining room and his transfer to the first floor I see no grounds for criticising the staff because they were acting in the light of the knowledge available to them at the time. The medical and nursing staff did not believe the complainants' son when he complained of pain and difficulty in walking. They concluded that the symptoms he displayed stemmed from his mental illness and their disbelief is to some extent supported by the inconsistencies recorded in the nursing notes. Although attitudes must have been coloured by this view I have found no evidence to support the contention that he was treated as a malingerer in the sense that he was a healthy person pretending to be a sick one. However I am pleased to record that the Area Nursing Officer told my officer that she had reminded nursing staff of the importance of bearing in mind the possibility of physical as well as psychiatric causes for unusual patterns of behaviour.

(d) *The disagreement about drug therapy*

21. The complainants said that when their son was admitted to the hospital he was prescribed drug therapy. At the time of his first visit home on 18 February they considered that the treatment was not fully effective and that his behaviour was adversely affected. Later they considered that the drug might have contributed to the fall on 20 February as one of its side effects might have caused him to collapse in the cold weather. On 27 February his father visited the hospital and discussed his son's medication with the consultant expressing concern about the side effects of the treatment. The consultant indicated that he must be allowed to continue to treat the complainants' son as he wished without interference or the complainants would have to take their son home.

22. The consultant told my officer that he diagnosed the complainants' son as a paranoid schizophrenic and explained that his condition was one that could be controlled by medication. He indicated that during the son's previous admission in 1977, he had been treated with a different drug to which the parents had then objected because of its side effects. Later in 1977 the parents had stopped giving their son his medication although the risks entailed in doing so had been explained to them. Moreover the parents had not obtained an alternative drug which he had prescribed. When the complainants' son was admitted to hospital in February 1978 he had received no medication since 9 August 1977. The consultant told my officer there had been long-standing disagreement between the parents and himself about the drugs, principally in connection with the side effects. He agreed he had suggested to the parents that they might wish to take their son elsewhere for treatment if they were not satisfied and he had also said that they could have a second opinion if they wanted it. He did not think he had approached the parents aggressively and said that, despite their disagreements, he thought he had a good relationship with them. I have seen from the nursing notes an entry which refers to the father's meeting with the consultant on 27 February and his concern about the medication. It states that the consultant told him that he could, if he wished, ask for a second opinion about the treatment.

Findings

23. The complainants had strong reservations about the effect of the medication prescribed for their son but in my view the consultant was entitled to explain to them that if they did not have confidence in his treatment they could seek a second opinion. I do not uphold this complaint.

(e) *Leave following the operation*

24. The complainants told my officer that when the result of the x-ray became known, arrangements were made for him to be operated on at the third hospital the following morning. The operation was carried out and he was taken back to the hospital the same day, 11 March. On 17 March they were informed by staff nurse A that their son was well enough to go home for a day. They had reservations about this as they believed it was far too early for him to be going home but nonetheless agreed to have their son home on 18 March. He returned to the hospital after the day at home and his mother recalled that he found considerable difficulty in moving about. Within a week he had to be taken back to the third hospital because, they later learnt, a haematoma had formed under the scar. The complainants told my officer that they believed this had been a direct result of their son's visit home the previous weekend. They spoke to the doctor who had operated on him and who had also treated him on the second occasion and he expressed great surprise when they told him that their son had been allowed to go home so soon.

25. My officer discussed this complaint with the doctor who had operated on the complainants' son (the medical assistant) and I have also seen a written statement prepared by him. The medical assistant said he had known nothing of the case until the evening of 10 March when he was telephoned by the duty officer at the hospital and told the results of the x-ray. He had also been told that the complainants' son was not a suitable patient for nursing in a general ward. The medical assistant operated the following day. There had been no difficulties with the operation and the complainants' son returned immediately to the hospital. The medical assistant told my officer that the kind of injury was unusual for someone of that age and that, before the operation, the complainants' son would have been able to move about although he would have been in a certain amount of pain. He recalled that he met the complainants after the operation and indicated that their son must have suffered in the period before the operation. The medical assistant retained responsibility for the post-operative care of the fracture and subsequently visited him at the hospital twice. He was confident that the nursing staff had the ability to cope with the injury and discussed the treatment with them. He also left instructions in the medical notes for 11 March as to how the patient should be cared for. These read 'Pin and plate inserted – very little blood loss, so transfusion not set up. Should get up tomorrow and sit in chair for a short while (one hour) and then progressively longer every day – could be mobilised on crutches or a frame under supervision from physiotherapist from third day. Sutures out in 14 days . . .' There is a reference to the drugs to be given for the first three days and to the possiblity of an increase in temperature on the third day. Apart from a brief entry by the consultant on the same day which refers mainly to the son's mental state, there is no further entry in the medical notes until 19 March. The medical assistant said that he had not

specified any particular regime because he assumed the staff at the first hospital would carry out normal practices – other patients with similar operations had been treated there. He agreed that he was surprised when the son's mother told him her son went home on the first weekend after the operation and that he may have shown it since it was not in line with what he thought was normal practice at the hospital.

26. The medical assistant told my officer that he had not been asked about the son's proposed visit on 18 March but said he would have advised against it had he been asked. He said that it ought to have been discussed with him and he had not been able to discover who had given permission for it. He agreed that the case demonstrated the need for closer communication between the two hospitals in such circumstances. The medical assistant told my officer that he thought it likely that the son's unsupervised activity at home could have contributed to the condition from which he suffered later. On the other hand, the duty officer thought it highly unlikely that the haematoma was caused by the day at home because there had been bleeding from the wound from the start. The consultant told my officer that he had been on leave at the time when the complainants' son was sent home and his duties were covered by a locum. He had later made enquiries of this locum who had told him that he had not been consulted about the son's leave.

27. Staff nurse C told my officer that she had been closely involved with treating the complainants' son's leg, partly because of her general (as opposed to psychiatric) nursing background. She did not find any difficulty in nursing him and confirmed that the instructions as she understood them were that the son should be mobilised. She told my officer that the medical assistant had told her that the son could go home for the day; she stressed that she would not have authorised this without the permission of a doctor. Other members of the nursing staff who had been on duty during the relevant period told my officer that they understood that the medical assistant had given his approval for the leave. The SNO accepted that it was not clear who had given authority for the visit home six days after the operation but was insistent that none of the nursing staff would have taken the initiative for this without the concurrence of a member of the medical staff.

28. I have examined the written evidence and noted from the nursing notes that although the complainants' son had not used crutches by 15 March he was 'coping quite well' with them by 17 March. In the nursing notes for that day it is recorded that he asked whether he could have a day's leave. The ward communications book refers to a visit by the medical assistant on 13 March and another on 16 March. The entry for the latter date reads 'seen by . . ., everything satisfactory, will come again Tuesday'. An entry for 17 March in the ward communications book reads 'Going home for the day on Sat. if you have no objection. Please ring and confirm with parents, then they will collect him about 11 am.' Although this entry is unsigned (as are all entries in the communications book) staff nurse A told my officer that it was he who had made it; he believed that medical authorisation had been given for this leave and the entry was intended for staff nurse C who was in charge of the ward on 18 March. He said that he too had been under the impression that the medical assistant had approved the leave.

Findings

29. Different opinions have been expressed to me about whether or not the haematoma was a result of the visit home but in any event this is a matter of clinical judgement on which I cannot comment. However, in his evidence to me, the medical assistant indicated that the complainants' son should not have been allowed to go home when he did. There is a direct conflict of evidence, which I cannot now resolve, about whether or not the medical assistant gave oral authorisation to staff nurse C for the patient to go home. I can only conclude that there must have been a misunderstanding between them. That was most regrettable. The Area Medical Officer has acknowledged that in this case post-operative management might have been different had there been better communication between the two hospitals and has suggested that a standard routine of advice is followed in regard to transfer of patients back to the hospital in order to minimise the difficulties which occurred in this case.

(f) *The AHA's response to the complaints*

30. The Community Health Council put the complaints to the AHA in a letter dated 4 April. They highlighted the failure to diagnose the fracture and the post-operative care including the premature home leave on 18 March but enclosed a statement prepared by the parents in the form of a diary setting out the circumstances surrounding the complaints which also provided me with the basis for this, my investigation. The Area Administrator discussed how best they might proceed with the Area Nursing Officer and Area Medical Officer. The Unit Administrator at the hospital was made aware of the complaints and the ANO and AMO obtained written statements from the senior nursing officer, the consultant, the registrar and the medical assistant. The Area Administrator had thought the complaints sufficiently serious to warrant writing to the Regional Adminstrator about the possibility of carrying out a Regional inquiry. The Region did not support the suggestion but, in turn, suggested that the Area might itself carry out the inquiry. By 19 May it had been decided to send a letter of apology to the parents. On the basis of the statements requested by the ANO and AMO the legal adviser to the Authority prepared a draft letter to the complainants. After consultation, the Area Administrator signed the letter to the parents on 25 July.

31. I have seen a copy of this letter; it accepts that there was a delay between the fall and the x-ray and ascribes it to the error I have described in paragraph 10 and to the breakdown of x-ray equipment. The AHA apologised for any additional pain and discomfort caused by the delay. As for the week-end leave, on 18 March, the Area Administrator said that 'with the benefit of hindsight, we would now agree that it might have been better if his first post-operative week-end leave had been delayed until the following week-end. However, the suggestion that he should go home on 18 March was made in [the son's] own interest in that his post-operative treatment required that he should be mobilised as soon as possible and patients often benefit from a period of leave in their own home environment.' The Area Administrator added that the haematoma could well have occurred in any event.

Findings

32. I am not surprised that the complainants were dissatisfied with this response. As regards the delayed x-ray no mention is made of the inaccurate information given to them by members of the nursing staff, a point stressed in the note of events submitted by the Community Health Council and, despite my questions, I have received no evidence to support the statement that there was any equipment failure in the x-ray department at the material time. As regards the week-end leave I have seen from the medical assistant's statement submitted to the Area Administrator before the letter was sent the following passage 'I still think it is strange that he should have been allowed home so early, and not in keeping with what I always thought to be the normal [hospital] practice'. In view of the fact that this statement was available to the AHA at the time they sent the letter, I consider their comment to the parents about the benefit of home environment to be misleading. And there is no mention in the AHA's reply of the other important matters raised in the parents' statement and discussed in this report.

33. In my view the AHA's response to these serious complaints was incomplete and inadequate. I do not accept the argument that in a single district Area, the AHA is put in an invidious position by being prosecutor, judge and jury in its own cause, nor do I consider that that affords a ground for not responding adequately to complaints. It is clear that the Area Administrator was mindful that the case could be referred to me but I believe that health authorities should attempt to provide fully comprehensive replies even if a complainant can later bring his case to me.

Conclusions

34. I have not upheld the complaints set out in subparagraphs (*c*) and (*d*) of paragraph 1, but for the rest, I have found that the complainants were fully justified in complaining. The response by the AHA was not sufficiently comprehensive and I believe the complainants were put in an impossible position when the question of their son's first leave was discussed in his presence. The AHA have admitted that the second leave was granted prematurely and a failure in communication was responsible for this. And I do not believe that the clinical notes were as full as they might have been; I am pleased to record that the Area Medical Officer prepared a note reminding medical staff of the importance of full notes.

35. The medical and nursing staff were surprised that the complainants' son had suffered a fractured femur and the case shows the importance of obtaining x-rays urgently when patients complain of pain resulting from unwitnessed falls. There was serious delay in getting the x-ray. First, no urgency was indicated on the form requesting it and the error in entering the first appointment on the wrong page of the ward diary extended the delay. I think it was particularly regrettable that this error was not brought to the notice of the medical staff who may well, at that stage, have decided that the x-ray was required urgently and the further delay of ten days could have been significantly reduced. I think it quite inexcusable that after this error was discovered incorrect information about the date of the x-ray should continue to be included in documents and

passed on to the parents. The SNO expressed concern that the delay and the fact that the x-ray did disclose a fracture was not brought to his notice at the time and I must conclude that the management of the ward was at fault here. I consider that the case entitles me to invite the Health Authority to implement a review of procedures in order to prevent a recurrence of the inefficiency that this case has displayed. I am pleased to record that the Health Authority have agreed to this review. I hope that my investigation and report will be of some consolation to the complainants in that their complaint should ensure that the serious deficiencies revealed should not be repeated.

Case No. W.323/78–79 – Care and treatment in psychiatric unit

Background and complaints

1. The complainant's former wife aged 51, was admitted to the psychiatric unit at a hospital (the hospital) on 15 May 1978. On 26 May she went on weekend leave until 29 May, when she was readmitted to the psychiatric unit. She was transferred to a medical ward in the hospital on 31 May and she died there on 5 June.

2. The complainant says that:

(*a*) during the night of 21 May his former wife was unable to sleep and sought help from the night staff; she was accused of smoking and forcibly escorted to her bedroom where her locker and handbag were searched; her cigarettes and indigestion tablets were confiscated and during the incident she sustained heavy bruising on her right wrist; both the ward sister (the psychiatric ward day sister) and later the consultant physician (the medical consultant) ignored this complaint when it was put to them;

(*b*) on the evening of 22 May she was woken up and made to go downstairs to receive her medication although she was very weak;

(*c*) additional drugs were prescribed on 24 May but she did not receive them;

(*d*) on 29 May she was moved to a very hot side ward and made to sleep on a mattress on the floor;

(*e*) she was not given food which she could eat and no attention was paid to her weight loss;

(*f*) on 1 June the medical consultant, in the company of a number of hospital staff including medical students, told him in an objectionable manner that his wife was dying; her sister was excluded from this interview by the ward sister (the medical ward day sister);

(*g*) her temple was first noticed to be badly bruised on 1 June but no explanation was given to him;

(*h*) although it was known that she was dying she was left in the open ward and visiting was restricted to normal visiting times; and

(*i*) the reply of 15 August by the Area Health Authority (the AHA) to his Member of Parliament (the MP) was unsatisfactory.

Investigation

3. During the investigation my predecessor and I obtained the AHA's written comments, copies of medical and nursing notes and correspondence connected with the complaints. My officers interviewed medical and nursing staff involved. They also saw the complainant with his former wife's sister and his son separately. The complainant made his complaints in a letter sent through his MP to the hospital and in an interview with my officers. The initial paragraphs in each of the following sections summarise both sources.

(a) *The complaint about the incidents during the night of 21 May*

4. The complainant said his former wife had told him that during the night of 21 May she went to the ward staff room because she was in pain. Four nurses were on duty and they dragged her back to bed, where she was falsely accused of smoking; her locker and the contents of her handbag were searched, and her cigarettes and indigestion tablets were taken. The complainant said that on 26 May he saw four big black bruises on her wrist and he thought they had been caused when staff had gripped her tightly during the incident on 21 May. He also said that next day the cigarettes and indigestion tablets were returned and that in his presence his former wife complained to the psychiatric ward day sister about the incident but she made no comment. He complained to the medical consultant on 1 June but this complaint was also ignored.

5. The reply from the Sector Administrator of the hospital (the SA) to the MP said that they had no confirmation of the bruising to the arm, and in their comments to me about this complaint the AHA stated that there was no record in the nursing notes of the alleged forcible return of the complainant's former wife to her room, although it was recorded that she repeatedly smoked in bed and that her cigarettes and some tablets were removed for her protection and that of other patients. I have seen this record which also says that she became quite abusive with nursing staff.

6. The complainant's son told my officer that his mother had bruises on both arms as if she had been held down. He did not think they were bad enough to require medical treatment.

7. My officer interviewed five members of the nursing staff who were on night duty on 21 May, a sister (the night sister) a staff nurse, a state enrolled nurse (the first SEN) and two nursing assistants (the first NA and the second NA). The staff nurse and the second NA did not witness the alleged incidents.

8. The night sister told my officer that at about 03.00 hours on 22 May the first NA told her that the complainant's former wife was smoking in bed and had been rude when asked to go outside to smoke. The first SEN had gone to see her, but she had been abusive and noisy. The night sister had then joined the other two nurses and had told the complainant's former wife that she should go outside because of the fire risks of smoking in bed. She had refused to stop smoking, so the night sister had told her that she would have to take her cigarettes and matches for safety, but they would be returned in the morning.

9. The night sister said that she was about to leave when the complainant's former wife started talking about taking tablets, and as the night sister thought

she was threatening to take an overdose she told her that they would search her handbag. Four or five bottles of tablets, which the first SEN and the first NA said included proprietary painkillers were found and these had been taken away. The night sister said she told the complainant's former wife, who was crying, that she was sorry she had to do this. The complainant's former wife had been in bed throughout the incident and had not required to be restrained. The first SEN and the first NA confirmed this account.

10. The first NA said that the complainant's former wife had got out of bed after this incident and had sat in the office chatting to her. She had been given a cup of tea and she had definitely not been forcibly returned to bed or restrained at any time. She and the first SEN confirmed that the cigarettes and handbag were returned the following morning.

11. The medical consultant told my officer that at their meeting on 1 June the complainant had complained generally about his former wife's care in the psychiatric unit and had said that she had been assaulted there and that she had sustained bruises to her arm. He said he did not recall seeing these bruises but they had not sounded very bad from the description. He said he had allowed the complainant to relate all his complaints in the hope that he would calm down. He had not told him how to make a formal complaint as he was sure that he knew or could find out for himself, and he thought that the interview had satisfied him.

12. The psychiatric ward day sister has now left the country. Nurses interviewed by my officer said she had not told any of them that the complainant's former wife had complained to her about the night staff on 22 May. None of the nursing or medical staff interviewed recalled seeing any bruises on the former wife's wrist.

Findings

13. Although it is admitted that cigarettes and tablets were taken from the complainant's former wife on the night of 21 May, I believe this was done for her own protection and I am satisfied that she was neither treated forcibly nor sustained heavy bruising. I am also satisfied that the medical consultant did not ignore the complaint but did his best to reassure him. I do not therefore uphold these complaints.

(b) *The complaint that the former wife was made to go downstairs to receive her medication*

14. The complainant said that on 22 May his former wife's strength was waning and she had spent much of the day asleep. She went upstairs to her bedroom at 8 pm but she was woken up at 9.30 pm and forced to go downstairs to get her medication.

15. The SA did not refer to this complaint in her reply, but in their written comments to me the AHA stated it was routine for patients on that ward to go to the ground floor for their medication, but that if it had been realised how ill the complainant's former wife was she would not have been nursed on that ward. All the nursing and medical staff to whom my officer spoke confirmed that

this was the ward practice, as it was a rehabilitation ward, and several added that had they known then that she had cancer she would not have been nursed on that ward.

Findings

16. It is true that the complainant's former wife had to go downstairs to receive her medication. But this was normal practice on the ward, and as none of the staff was aware of the extent of her physical illness, no exception was made for her. I do not therefore blame the staff on duty.

(c) *The complaint that the complainant's former wife did not receive prescribed drugs*

17. The complainant said that extra drugs were prescribed for his former wife on 24 May but were not given that night. The SA did not mention this in her reply but in comments to me the AHA said that the additional medication prescribed on 24 May was given at 18.15 hours.

18. I have seen the drug record for 24 May which shows that the prescribed drugs were correctly administered until 22.00 hours when one drug was omitted and there is no entry in the 'drugs not given' column.

19. The state enrolled nurse (the second SEN) who gave the drugs at 22.00 hours could not explain why one was omitted but said that she would not have taken a decision that the complainant's former wife should not be given the drug. She told my officer that at that time the 'drugs not given' column was often not completed, although later the nurses had received instructions to make sure it was. Neither the night sister nor any of the four junior doctors who covered the psychiatric unit could recall being asked by nursing staff about whether any drugs should be withheld.

20. The night sister and the first and second SENs told my officer that occasionally when the unit was short staffed at night one nurse alone gave out the drugs as there was no nurse available to check them. Two consultant psychiatrists interviewed by my officer also stated that the number of staff on duty at night had been reduced and this might affect drug procedures if they coincided with the needs of patients requiring a good deal of personal attention.

Findings

21. As at no time in my investigation was it suggested by the AHA or the staff that the drug might have been given but not recorded, I uphold this complaint that one of the drugs prescribed for the complainant's former wife was not given at 22.00 hours on 24 May, but I think it was an understandable error, possibly made because only one nurse was available to issue them instead of the usual two. I am pleased to have the AHA's assurance that they will look into their procedure and have already taken action to remind staff that drugs records should be kept carefully and an explanatory note made where they are not given.

(d) *The complaint about the very hot side ward*

22. The complainant said that when his former wife returned to the hospital on 29 May she was put into a very hot side ward and the bed made on a mattress

on the floor. He said he felt a bed with sides should have been provided. He complained about the temperature in the side room but no mention of this was made in the SA's reply. In their written comments to me the AHA said that they knew the side rooms on that ward suffered from solar heat gain and that the outdoor shade temperature at 18.00 hours on 29 May was 81°F. They had no record of the complainant's former wife being placed on a mattress on the floor.

23. The nursing records show that she was found on the floor at 20.45 hours and that a doctor was called and examined her. My officer was told by the nursing staff that the complainant's former wife had been in a semi-conscious state when admitted on 29 May but had been very restless and throwing herself about. The nurses explained that beds with cot sides were available and if they had thought one was suitable it would have been provided. They felt she would have had no difficulty in climbing over the cot sides and hurting herself on the bedrails. Her mattress and bedding had therefore been moved on to the floor for her own safety.

24. All the staff interviewed told my officer that the rooms did get very hot, and the second SEN said she had sponged down the complainant's former wife occasionally that evening. The nurses mentioned that as a safety measure the extent to which windows could be opened was restricted, but that the blinds had been down and a small electric fan had been placed by her bed.

Findings

25. The decision as to the safest place for the mattress was one which the nurses had to take in the exercise of their professional judgement and I cannot comment upon it. I am however satisfied that they acted in good faith.

26. I am also certain that the room was extremely hot that night and that the nursing staff did all in their power to make her comfortable. I invite the AHA to see if there is any way they could alleviate this seasonal problem.

(e) *The complaint about the food and weight loss*

27. The complainant said that his former wife could not digest all food and because no attempts were made to provide suitable food her weight dropped rapidly to under 7 stones. He was not sure whether she should have been given a diabetic diet as she had told him in April that the medical consultant had said her diabetes had cleared up and she no longer needed a special diet. However, he stressed that the question of providing food which she could keep down was completely separate from her diabetic problems.

28. The SA's reply said that the complainant's former wife was on a diabetic diet and although she often refused to eat or drink, her weight loss might have been attributable to her physical condition, namely carcinoma. The AHA told me that she would not accept that she had diabetes, was unco-operative with her diet and despite encouragement often refused to eat and drink.

29. The medical records case summary states that when the complainant's former wife attended the out-patient diabetic clinic on 4 May 1978 her weight was just over 7 st 9 lbs. There is only one written note of her weight during the period she spent in the psychiatric unit; it is undated and shows that she weighed

46 kg (7 st 3 lbs). I have noted, however, that the post mortem report described her as 'of normal build and fair nutrition'. The nursing notes up to 26 May show that she refused to eat occasionally, that she complained about her food and told nurses she should not have been on a diabetic diet. They also show that she was seen by the locum consultant psychiatrist (the locum psychiatrist) on 26 May and that when she returned from weekend leave her weight, diet and fluid intake were to be charted. This was confirmed by an entry in the medical notes. There are no such charts in her records, but I have been assured by the head of the psychiatric nursing services that although they cannot now be found they were started. The nursing notes for 29 to 31 May record that fluids were to be encouraged.

30. All the nursing staff interviewed told my officer that the complainant's former wife would have been weighed on admission; most did not think she had lost weight but one remembered that she had said that she had lost some. She had been given diabetic food and many of the nurses could remember her saying that she was not a diabetic, and said she had tried to put sugar in her tea and eat sweets.

31. The day charge nurse told my officer that 'Complan' had been provided when the complainant's former wife would not eat, and other nurses confirmed this. Only one nurse could recall her asking for something else to eat; she said that on one occasion she had asked for bread and butter for supper and this had been provided.

32. The psychiatric registrar told my officer that he had been aware that the complainant's former wife was not eating well and that was why he had prescribed vitamin injections and the locum psychiatrist had ordered that a weight chart be kept. He said he was not aware that she did not like the food she had been given; he thought she had not eaten because her appetite was poor. This was also the view of some of the nurses.

Findings

33. I find that the nursing staff were fully aware that the complainant's former wife was not eating well, and that this was reported to her doctors who took the action they considered appropriate in their clinical judgement. There is no evidence that she did not eat because she could not manage the food provided, nor that there was excessive weight loss. I do not uphold this complaint.

(f) *The complaints about the interview with the medical consultant on 1 June*

34. The complainant said that he had gone to the hospital early on 1 June as a result of an urgent telephone call that his former wife had collapsed. At about 10 am he had been asked to go to a ward office, where he met the medical consultant, who was accompanied by at least six other people. The consultant had told him that his former wife was dying of cancer and had only two and a half weeks to live, and said that the complainant must have known this.

35. The complainant said that he had been told by a family practitioner (not his former wife's own doctor) who was called to see his former wife at home on 27 May, and also by a hospital doctor on 29 May, that she was suffering from drug withdrawal symptoms, and so he had been reassured that nothing was

seriously wrong. He also said that he had not been asked if he objected to medical students being present.

36. His former wife's sister told my officers that she had wanted to attend the interview with the complainant but the medical ward day sister, who knew she was the former wife's relative, told her that there was no room for her.

37. In his written comments to me and in an interview with my officers the medical consultant said he had seen the complainant's former wife in March, had noticed a gland in her neck and a mass in her abdomen which he had reported to her family practitioner (the FP). On 1 June he had asked particularly to see the complainant because he had heard he was extremely upset. His house physician, registrar, the medical ward day sister and medical students had been present. He said it was his normal practice to ask if the students could be present but the complainant had been so agitated that, in order not to cause further delays, he had decided not to ask him if he objected. He said that he had explained the transfer and treatment to the complainant and that he had known for some time that in his view the complainant's former wife was almost certainly suffering from an inoperable cancer, and as he felt the complainant must have been told by the FP, said something like 'surely you understand your wife is dying with carcinoma'. He had not been aware that she was divorced. He had let the complainant, who was in an excitable state, speak at length because he 'felt the catharsis might in the long run be valuable to him'. The registrar, house physician, medical ward day sister and the two medical students were unable to add to what the consultant told my officer.

38. The actions of the FP are outside my jurisdiction but he told me that he had known about the divorce, or that she was in the process of being divorced, and was unaware of any reconcilation. He had not contacted the complainant at any time.

39. The medical consultant said he probably had known that the former wife's sister was present that morning but he had felt it would be best to see the complainant alone. However, if the complainant had asked for his former wife's sister to attend he would have agreed. The medical ward day sister said the sister-in-law had not approached her or asked to be included in the interview and she therefore could not have told her that there was no room. The registrar, the house physician and the other nurses said they knew nothing about her exclusion from the interview.

Findings

40. The medical consultant has explained that he thought the complainant had already been told by the FP that his former wife had cancer and that had he known this was not the case he would have conducted the interview differently. While I can well understand how extremely upsetting it must have been for the complainant to learn of his former wife's terminal condition in this way, I am unable to find that the medical consultant was at fault.

41. The statements of the sister-in-law and the medical ward day sister are flatly contradictory. As I do not consider that any further investigation would be conclusive I leave this complaint unresolved.

(g) *The complaint about the bruising on the complainant's former wife's temple*

42. The complainant said that the cause of the bruising on his former wife's left temple was never explained. The SA said there was no evidence of bruising and the AHA confirmed this although they said that on 29 May the complainant's former wife had been found on the ward floor and it was possible that she could have fallen. The complainant told my officers that he had first noticed the bruise on 1 June but he had not then mentioned it to the hospital staff. His son told my officer that it was just an ordinary bruise, about the size of a 10p piece. He thought his mother had said she had 'bumped it', and he did not think it had been inflicted on her.

43. The medical ward day sister told my officers that the complainant had drawn her attention to the bruise on his former wife's temple one or two days after her transfer from the psychiatric unit. She said it had been a small bruise partly covered by the former wife's fringe and it had been fading when she had seen it; she had considered it unimportant. No one else could recall seeing the bruise and three doctors interviewed by my officers said if they had seen a bruise of any significance they would have made a written note about it.

44. The nursing records show that the complainant's former wife was found on the floor and examined by a doctor on 29 May but the AHA have been unable to find an accident form relating to this incident. The doctor concerned could not recall seeing the complainant's former wife after a fall or whether she had any injuries.

Findings

45. I am satisfied that her temple was bruised, possibly on 29 May, but it would seem that the bruise was minor, and I do not uphold the complaint about it. However, an accident form should have been completed after she was found on the floor on 29 May, and I hope that the AHA will review their procedure and ensure that staff are reminded of the importance of completing accident forms.

(h) *The complaint about visiting restrictions*

46. The complainant said that although on 1 June the medical consultant said his former wife might have only two and a half weeks to live she was kept in the main ward and visiting was restricted to normal times. In her interview with my officers her sister said that on 1 June, after the complainant had seen the consultant, she had been told that she could see her sister then but that afterwards the family should keep to normal visiting times. On one occasion during the five days the complainant's former wife spent in the medical ward her sister said she had been told the complainant's former wife could die at any time.

47. The SA said that there was a policy for unrestricted visiting of dangerously ill patients but the former wife's condition improved while she was on the medical ward and her sudden death surprised everyone. The AHA told me that her condition had appeared to stabilise.

48. The medical consultant told my officers that he thought the complainant's former wife should have been allowed unrestricted visiting but that she should not have been moved to a side ward because the 4-bed bay she occupied was

near the nurses' station and easily observed. The house physician said that it would not have caused difficulty to allow unrestricted visiting for her.

49. The medical ward day sister told my officers that she had not thought the complainant's former wife should have unrestricted visiting as she was not considered critically ill and she needed rest. However, she would have allowed a controlled amount of extra visiting if she had been asked. She said she was surprised when she died so quickly. Two nurses confirmed the sudden deterioration on the afternoon of 5 June.

Findings

50. The decision as to the ward or the position of the bed in which the complainant's former wife could best be nursed is one for the doctors' and nurses' clinical judgement and not for me to comment on. The extent to which patients' normal visiting times could be relaxed was at the discretion of the medical ward sister and although she knew what the consultant's prognosis had been she made her judgement in the light of the circumstances as she viewed them at the time. As this was a discretionary decision, made without any evidence of maladministration, I cannot comment on it.

(i) *The complaint that the AHA's reply to the MP was unsatisfactory*

51. The complainant's letter was sent by the MP to the hospital on 26 July. It detailed the events complained of and concluded with a number of specific questions. The SA obtained reports and comments from medical, nursing and administrative staff and replied to the MP on 15 August.

52. The SA told my officer she intended her reply to answer some of the complainant's specific questions but she recognised that there were many points in his letter which had been left unanswered and which she hoped he would discuss. She had therefore offered the complainant an appointment to see her together with medical and nursing staff. She explained in her letter that no one in the psychiatric unit had been aware that the complainant's former wife had cancer. The head of the psychiatric nursing services had told her this and the consultant psychiatrist's letter to her stated 'we greatly regret the patient's distress in the light of the final diagnosis, but we were managing her in the way appropriate to her withdrawal from medication on which she had been dependent for a very long time, as described in [the FP's] full and careful referral letter. In his letter [the FP] pointed out that in the past she had had pains all over for which no organic cause could be found. Despite this she had again been recently investigated by [the medical consultant], and no cause was then found. I endorse [the head of the psychiatric nursing services]'s report . . . the last thing any of us would wish would be to fail to relieve the distress of a dying patient'.

53. The medical administrator told my officer that the medical consultant told him that he had suspected in March that the complainant's former wife had got cancer, but he did not tell the SA as he was not aware that there had been any doubt about the diagnosis. He added that the complainant had telephoned him on more than one occasion but had declined his invitation to come to see him.

Findings

54. Although the SA was not given some information relevant to the complaint, on the information available to her she could have answered more of the complainant's points than she did. I therefore uphold the complaint about the inadequate way his complaint was dealt with.

Conclusions

55. Throughout this investigation, there is one matter which I have borne in mind: that the complainant's former wife was admitted to the psychiatric unit and the medical and nursing staff there were unaware of the severity of her physical illness, which was masked by her psychiatric illness. The AHA have stated that she would have been treated quite differently had this fact been realised. The written and oral evidence I have obtained confirms this.

56. The complainant made a number of specific complaints, and I have indicated in the body of the report those which I have found justified in whole or in part. The AHA have asked me to apologise to the Member of Parliament and the complainant for the failures I have found, and this I gladly do. They have also assured me that they will review those matters I specifically mention in paragraphs 21, 26 and 45.

Case No. W.327/78–79 – Care and treatment in maternity unit

Complaint and background

1. On 4 January 1978 the complainant was taken to the Maternity Unit of a hospital (the hospital) and shortly after her admission gave birth to her second child. She was discharged on 12 January. She complained that:

(*a*) the nursing staff had not read the medical notes in the interval between her husband telephoning the hospital and her subsequent arrival there;

(*b*) the ward sister (the sister) failed to administer an epidural anaesthetic although she (the complainant) was told she should have one;

(*c*) the sister told her that she was only going to examine her when, in fact, she ruptured the membranes with her finger-nails without explaining to her what she was doing and without her consent; the sister also failed to check the foetal heart rate;

(*d*) the anaesthetic gas cylinder was empty at the start of her labour and was not replaced throughout her labour with the result that she suffered unnecessary pain;

(*e*) her husband was not allowed into the delivery room until the labour was nearly completed;

(*f*) an unnecessarily large number of nurses were present during the delivery;

(*g*) a number of the facilities provided were unsatisfactory; namely, insufficient pillows were provided during the birth, no stool was available from which to step on to the delivery bed, no bath safety mat was provided in each baby's bath sink and the floor surface in the ward was unsuitable;

(*h*) the replies received to her and her husband's complaints were unsatisfactory.

Investigation

2. In the course of the investigation I obtained the views of the Area Health Authority (the AHA) and saw the relevant correspondence, medical and nursing notes. My officer discussed the complaints with members of the hospital medical, nursing and administrative staff concerned. He also met the complainant.

(a) *The unread medical notes*

3. The complainant was a consultant's private ante-natal patient, but a booking was made with the hospital for her to have her baby as an NHS patient. This was an arrangement which caused subsequent confusion although in itself it is not part of the complaint. In discussion with my officer and in correspondence the complainant said that she was seen by the consultant on 4 January and it was arranged that she enter the hospital on 7 January for an induction.

4. Later on 4 January she thought that she was starting labour and as a result her husband telephoned the hospital concerning her condition at about 9 pm. At 10.30 pm he rang again and after discussion with the sister brought her in, arriving at 11 pm. The complainant said that although they were given at least two hours in which to do so it was obvious when she arrived at the hospital that none of the staff had read her medical notes nor did they know anything about the background to her case. She said that there could have been important information in her notes, which were only four or five pages in length, and that the midwife on duty was aware of the fact that the consultant brought her notes into the labour ward that afternoon and had left them there.

5. The consultant told my officer that he examined the complainant in his rooms early on 4 January and arranged with the hospital that she be admitted for an induction on 7 January. He confirmed that he handed the medical notes (which I have seen consist of four pages) to a member of the nursing staff and explained the background to the case. The sister said that she did not come on duty until 8 pm but the Nursing Officer (the NO) said that she herself was on duty during the afternoon when the consultant handed in the notes and she confirmed that he had spoken about the case. The midwife referred to by the complainant has since returned to New Zealand and I am unable to obtain a statement from her.

6. The sister confirmed that she took a telephone call from the complainant's husband that evening, sometime she believed, between 9.30 pm and 10 pm. She thought that the complainant arrived at the hospital very soon after. She agreed that she did not have much of an opportunity to read the notes. My officer discussed this aspect of the complaint with a student nurse, the only other member of the nursing staff he could trace who could remember the complainant. She thought that there was at least an hour between the telephone call and the complainant's appearance on the ward. She said that the practice of reading the notes beforehand was encouraged but she could not remember what occurred on this occasion. The nursing kardex records an arrival time of 23.30, with the additional comment that the patient had been experiencing contractions since 21.30. The senior registrar who assisted in the delivery of the baby told my officer that there was in fact very little in the notes.

Findings

7. There is some confusion about the chronology of events on the night of 4 January which I cannot now resolve. Estimates in this case as to how long the nursing staff had in which to read the notes vary from only a short time to two hours and take no account of other duties that may have been pressing at the time. Obviously it is desirable that nursing staff should familiarise themselves as soon as possible with the background information relevant to patients who may be arriving and, particularly as here, when they are about to give birth. I have not, however, been given any reason to suppose that in this instance the fact that the notes may not have been properly digested by the nursing staff in advance made any difference to what took place.

(b) *The administration of the epidural anaesthetic*

8. The complainant has said that she was given an epidural anaesthetic when she gave birth to her first child and that she found it helpful. In the months preceding the birth of her second child she was told by both the consultant and the senior registrar that she would benefit from having an epidural on this occasion too. When she arrived at the hospital she asked the sister for an epidural but the sister told her that she could not give her this and that she had to carry out a vaginal examination first. The complainant said that she told the sister that both the consultant and the senior registrar advised her to have the epidural but the sister paid no attention; after her membranes ruptured she knew that there remained no chance of her being given one. She later discovered that the consultant had made no reference in the medical notes to her requiring an epidural.

9. The sister agreed that the complainant asked for an epidural but she did not tell her that she had been advised to have one. Her first priority when a patient arrived was to conduct a vaginal examination in order to establish where the baby was lying, as was hospital practice. On doing this she found that the complainant was about to give birth. It was not possible for an epidural to be given without an anaesthetist being present to administer it and no anaesthetist would have agreed to do this at such an advanced stage of labour. She explained this to the complainant but she would not accept it. The sister said that she in fact tried unsuccessfully to contact the consultant but that in any case the senior registrar arrived on the ward within a very short time.

10. The consultant told my officer that it would have been of value to the complainant for her to have had an epidural if there had been time but in the circumstances the sister was entirely correct in not giving one, a decision he thought as being perfectly within her professional competence. In a letter he wrote to the complainant shortly after the baby was born, the consultant made the additional point that at that late stage an epidural could have been damaging to the baby.

Findings

11. It is clear that the complainant arrived at the hospital expecting that an epidural would be given. I can well understand that she was upset at its absence and accept that she may well have suffered pain as a result. But even had the hospital staff been in a position to administer an epidural on her arrival the

complainant would have been required to undergo a vaginal examination first. The sister decided, having carried this out, that in the circumstances there was no time for the anaesthetic to be given. This was a decision made by her in the exercise of her professional judgement which I cannot question although I have noted that it has the support of both the doctors concerned. I think it unfortunate that the consultant did not record in the notes that an epidural should be given, but I accept that the absence of such a record made no difference in this case.

(c) *The rupturing of the membranes*

12 The complainant said that when she arrived at the hospital she immediately asked to see the consultant but the sister refused to try to find him and, despite her objections, carried out a vaginal examination. The sister did not say anything to her about rupturing the membranes and the complainant assumed that she was merely going to conduct an examination; the complainant said that she was opposed to rupturing because it increased the pain, was not natural, sent the labour 'wild' and was in any case unnecessary when the labour was proceeding very quickly, which was the case with her. She was experiencing fast and violent contractions at the time, ranging from one every two minutes to one every five seconds, but despite this the sister told her that she preferred to conduct the examination while contractions were taking place rather than between them. Without either informing her or seeking her consent the sister then ruptured her membranes by scratching at them with her fingernails. The complainant said she was subsequently told that it was the hospital's policy that membranes should be ruptured and that the sister was told to rupture them by the senior registrar. She also said that the staff neglected to establish whether or not the baby was alive, before carrying out the rupturing, because they did not check the foetal heart rate.

13. My officer discussed this complaint with several members of the hospital staff. The sister told my officer that the complainant demanded to see the consultant as soon as she arrived at the hospital. She tried to contact him but was unable to do so and instead telephoned the senior registrar who was the duty doctor. She thought that no more than fifteen minutes elapsed between the complainant's arrival and that of the senior registrar. She carried out a vaginal examination because her first task was to establish the position of the baby. The complainant was making a great deal of fuss and she took some time to relax sufficiently to permit a proper examination to take place but when it was done it was clear that she was about to give birth. She denied that she said that she preferred to carry out an examination while a contraction was occurring but pointed out that the complainant was at that time experiencing very frequent contractions and that it was impossible to carry out an examination without an overlap. The medical and nursing notes refer to the difficulty experienced in carrying out the vaginal examination due to lack of co-operation and screaming by the complainant.

14. The sister said that she did not rupture the membranes nor did she receive instructions from the senior registrar to do so. The membranes ruptured spontaneously (as was not uncommon) during the course of the vaginal examination. There was therefore, no reason to explain to the complainant that she was going

to rupture the membranes. The sister told my officer that she would have carried out the vaginal examination with her fingers but said that she would have been wearing gloves. At such an advanced stage of labour, however, rupturing was an automatic procedure which she would have performed had it not happened of its own volition. She also checked the foetal heart rate.

15. The senior registrar said that it would have been a perfectly routine practice in the circumstances for the sister to rupture the membranes. In fact he believed they ruptured spontaneously during the vaginal examination and before his arrival. But he agreed that his recollection was inconsistent with his entry in the medical notes which reads '12.05 Membranes intact' followed by 'Membranes ruptured'. The delivery itself proved to be without incident. He confirmed that it would have been impossible to carry out an examination at that stage of labour without it coinciding with a contraction. He agreed that, if there was sufficient time, he would normally explain to a patient that he was going to rupture the membranes artificially if that was the case. He confirmed that rupturing was a standard practice and said that it was done to augment labour.

Findings

16. There are discrepancies in the various accounts of what took place but I think it more than likely that the sister's recollection that the membranes ruptured spontaneously during the vaginal examination is correct. This would explain why the sister did not tell the complainant that she was about to rupture them or seek her agreement and also why at that stage she was only employing her fingers (I think it is inconceivable that she would have used the fingernails of her ungloved hand) rather than forceps which are normally used for this purpose. But even if the evidence of the medical notes – that the membranes were still intact at 12.05 am – is preferred this still does not support the main complaint that they were ruptured by the sister since the senior registrar had taken over the delivery by then. I have not been able to establish whether or not the sister said to the complainant that she preferred to conduct vaginal examinations during contractions, but I do not dispute the statements that contractions were coming very fast at that time and I accept that there was an inevitable overlap between examination and contraction. I have seen an entry in the nursing notes indicating that the foetal heart rate was checked and what it was and I do not uphold the complaint that this was not done.

(d) *The empty gas cylinder*

17. The complainant said that the entonox gas cylinder with which she was provided at the start of her labour proved to be empty and she was not given another one during the one and a half hours that her labour lasted thus causing her to suffer considerable unnecessary pain. She subsequently learned that spare cylinders were available in the corridor but said that despite this none of the nurses went to fetch one for her and that the midwife just laughed about it. She did not believe that all the nurses on the ward knew where the spare cylinders were kept and she also understood that, although the cylinders were apparently too heavy for the nurses to manoeuvre, they could be rolled along the floor but was not sure if all the nurses knew that. And, in a letter to the hospital, her husband referred to his belief that the cylinders could run out within three hours and though that they ought to be checked after every birth.

18. My officer discussed this complaint with members of the staff concerned. The sister was the only one present at the birth who could recall the problem with the cylinder. She said that the entonox cylinder was checked at the start of her shift (8 pm) and at that time it was virtually empty; it did in fact run out about fifteen minutes after the complainant began to use it, but the complainant was using it continuously instead of only during contractions as most patients did. The sister said that as soon as it was noticed that the cylinder was empty she instructed one of the nurses to fetch a full one from the adjoining ward. This would have taken only a very short time and she told my officer that the complainant would have been without gas for no longer than a couple of minutes. She denied that the cylinders were difficult to move and said that they could be pushed along very easily. She explained that the cylinder was not replaced with a full one at the beginning of the shift because it was difficult to dispose of small residues of gas and it was easier to allow the cylinder to empty.

19. My officer examined an entonox gas cylinder. He found that although the cylinders themselves are heavy they are normally housed in trolleys with wheels, which are easily moveable. (One nurse told him that most of the difficulty arose in trying to loosen the screws of the cylinders.) There are meters attached to each of the cylinders recording the gas level but these are rather small and could easily be overlooked. He was also told that the tone of the cylinders alters when they are empty but that this is not always immediately apparent. He was shown the area where the spare cylinders are usually kept and noted that this is a very short distance away from the labour wards.

Findings

20. Although I am in no doubt that for some time during the course of her labour the complainant was without the benefit of gas I cannot be certain how long this lasted. But of course the complainant suffered some pain as a result; this being so, I think the incident regrettable. The hospital has already apologised to the complainant for this, correctly so in my opinion. But I would draw their attention to the need to ensure that all staff know where to locate spare cylinders, and also how to fit them; it seems to me too to be a matter for concern that a cylinder can become empty without it always being immediately apparent to staff that this has happened and I invite the AHA to consider whether anything can be done to avoid such incidents recurring.

(e) *The husband's exclusion from the delivery room*

21. In discussion with my officer, the complainant alleged that her husband was not permitted to be with her until near the very end of her labour and I have also seen this matter mentioned in letters written both by herself and her husband. She said that although she had come to no prior arrangement with hospital staff about this she understood that it was the usual practice for a husband to be present and this was what she herself wanted. She accepted that the room in which the initial examination was carried out was probably too small to permit him to be present but believed that he ought to have been allowed to be with her once she was transferred to the delivery room. Instead, she said he was ejected from the room by a short, dark-haired nurse and made to remain in a waiting room from approximately 11 pm to 11.45 pm. He was only allowed to return when she specifically asked for him at about the time that the senior registrar arrived to assist with the birth.

22. The senior registrar told my officer that he could not now recall seeing the complainant's husband at the birth but said that there was no reason why he should have been excluded from the delivery room. It was, however, customary to ask husbands to wait outside while the vaginal examination was being carried out in the treatment room. The NO told my officer that it did appear that the complainant's husband was left outside the delivery room but had no reason to suppose that this was done intentionally. I have been unable to identify the nurse described by the complainant and her husband but my officer was able to discuss this matter with the sister and with the student nurse. They both believed that the complainant's husband was not excluded from the delivery room; the sister told my officer, however, that for part of the time the curtains around the complainant's bed were drawn and that her husband was sitting outside them. Despite this I have seen letters from the hospital in which it is regretted that the husband was not with his wife until her labour was nearly over.

Findings

23. I am unable to establish exactly what happened to the complainant's husband while his wife was in the delivery room. Indeed, the apology that he has already had is not entirely consistent with the evidence of some of those present. But, I think it more than probable that he was not with her for as long as he and his wife would have wished.

(f) *The large number of nurses*

24. The complainant said that about half a dozen nurses (who she described as like a 'sea of vultures') were crowding around her in the delivery room, which she thought to be an excessive number, although she told my officer that she would have been more enthusiastic about their presence if she thought they were going to assist with the birth rather than merely observe it.

25. I have seen several estimates of the number of nurses who might have been present at the birth; from information supplied by the hospital in relation to staff on duty at the time, the maximum number of nurses that could have been there is estimated to be five. The student nurse told my officer that when a birth was imminent it was the custom to ring a bell so that students not engaged elsewhere could add to their experience by witnessing it. The NO said that she did not think an excessive number of people were present and added that it was perfectly reasonable that students in a teaching hospital should be expected to witness births. The sister said that no objection was made to their presence at the time.

Findings

26. I am satisfied that there were a number of nurses around the bed at the time the complainant gave birth, not all of whom were directly involved. But there is no evidence that they were in the way, nor that the complainant made any objection previously or at the time to them being there. The birth took place in a teaching hospital and I think their presence was in the circumstances perfectly justifiable; further I accept as an essential part of their training that student nurses should observe, not assist, on such occasions.

(f) *The unsatisfactory facilities*

27. The complainant made a number of minor complaints. So far as the lack of pillows is concerned the NO told my officer that foam wedges were now made available to supplement the pillows. The complainant said that a stool should have been available in the delivery room to help her step from the wheelchair to the bed. The sister told my officer that stools are normally available in each ward but I have been unable to establish whether there was one available for the complainant's use on this occasion. The complainant also thought safety mats would be beneficial in the sinks used for bathing the babies. This suggestion has been universally rejected by the hospital and medical staff as a potential source of infection and I accept their view. Finally, I do not accept the complainant's criticism of the stone floor surface provided in the ward in the absence of evidence to show that such surfaces have caused more accidents than any other.

28. The complainant was also aggrieved about a number of other matters some of which have already been dealt with separately through correspondence; these require no further comment from me. There were, in addition, trivial complaints which have not been separately dealt with either because the passage of time precluded any useful investigation or because the complaint was not clearly expressed. For the same reasons I cannot express any views either; and I put into a similar category the minor complaints submitted to me some time after my investigation began.

(g) *The unsatisfactory replies to the complaints*

29. The complainant told my officer that she received a number of letters from the hospital in reply to her various complaints but said that she was dissatisfied with the answers that she was given.

30. I have examined the correspondence between the complainant and her husband and various members of the hospital staff. Shortly after the birth of her child the couple exchanged a number of letters with the consultant which referred, *inter alia* to the matters that formed the subject of the complainant's later letters to the hospital. The first of the latter was dated 18 February and addressed to the NO. In it the complainant referred to the non-availability of entonox gas; the failure to allow her husband to enter the delivery room until labour was nearly complete; the rupturing of her membranes; the failure to administer an epidural anaesthetic and the conducting of an examination while she was experiencing a contraction. This letter was acknowledged by the Divisional Nursing Officer on 1 March and a substantive reply was sent on 13 March, signed by the Divisional Administrator (the Div A). In his reply the Div A answered all the questions raised by the complainant, with the exception of the matter of the examination being carried out during a contraction. But he referred to a recent visit he believed she had made to the post-natal clinic at which, so he understood, her medical queries were satisfactorily answered.

31. The Div A told my officer that he dealt with the complaint because it was not wholly restricted to nursing matters. He discussed the various matters raised with both the senior registrar and the NO. The senior registrar had told him that he discussed the medical aspects of the complaint with the complainant at a post-natal clinic and she was content with what she was told; this was why

he did not say much about them in his reply. He thought that he answered the questions satisfactorily although he conceded that it might have been of value to meet the complainant.

32. The Div A said that early in April he was spoken to on the telephone by both the complainant and her husband and this was followed by a further letter, this time from the husband. The Div A acknowledged this on 6 April but then learned that the consultant had also received a further letter from the complainant herself. The complainant's husband had written on the envelope of this 'I'm sorry that my wife is still going on about this. I would ignore this letter and let the whole matter die a natural death!' In view of this the Div A decided not to pursue the matter any further. Later he received further telephone calls which indicated that the complainant and her husband were still not satisfied. He spoke again to the NO and the senior registrar and subsequently wrote to the husband on 21 June. In this letter he referred again to the question of the cylinders and also told the husband that his wife's membranes were ruptured on the instruction of the senior registrar. The Div A told my officer that he now thought this to have been misleadingly expressed in that it supported the complainant's contention that her membranes were artificially ruptured. What the senior registrar actually said was that they should be ruptured if they did not do so spontaneously; the fact was that the membranes did rupture spontaneously.

33. I have seen that during the summer of 1978 this correspondence continued and that a number of the letters were addressed directly to the senior registrar who, in a letter dated 7 July, replied to the complainant. He covered much the same ground as the earlier letters although he did apologise for what happened with the gas cylinder. The senior registrar told my officer that he replied to the complainant without consulting others about what he intended to say. The Div A said that he discussed these letters with the senior registrar but played no part in drafting replies to them. He said that the senior registrar saw the earlier replies that were sent and he thought it unfortunate that the senior registrar apologised about the gas cylinder as there was no evidence to show that the complainant was without gas for more than a few minutes.

34. The Div A said that it was eventually felt that no more information could usefully be given to the complainant and her husband. He accordingly wrote to the husband on 12 September to terminate the correspondence. But by this time the complainant had written to a Member of Parliament, and the Department of Health and Social Security (the Department) became involved.

Findings

35. I have seen a total of twenty six letters written by the complainant or her husband about these complaints, to eleven different addressees between February 1978 and January 1979. Six of these were hospital staff, one an ex-member of staff and four either MP's or Department staff whose letters eventually fell to be dealt with, in the first instance, by the hospital. Nor were all these letters by any means easy to understand and in particular the subject matter was constantly changing. The first (to the NO) containing the complainant's initial criticisms was comparatively mild in tone. It commenced: 'I thoroughly enjoyed my stay in your hospital and the staff were so kind but there are one or two points I

think you will agree I should mention'; and it concluded: 'I know you are very busy. Please don't bother to reply to this letter unless you have time'. But the longer the correspondence went on, the more the original complaints were embellished as further complaints were added.

36. When the complainant first referred her complaint to my predecessor; she included the comment: '. . . I thought of kicking the sister in the face . . .' and I subsequently discovered during my investigation that the complainant had written a most unpleasant letter to the sister. I do not propose to reproduce that letter here although I appreciate that the sister must have been very upset to receive it. It is to her credit that she did not complain about the letter at her interview with my officer although I would not have criticised her if she had.

37. I am satisfied that a real attempt was made to answer the complaints and I do not criticise the hospital for their general approach towards answering them. Nor do I criticise the Div A for terminating the correspondence when he did. I think he had little option in the face of a bombardment of letters and telephone calls and the additional factor that the husband appeared on occasions to be satisfied with the replies he received whereas his wife was not.

Conclusions

38. The complainant was a private out-patient, but an NHS in-patient. As a result of the confusion about this she arrived at the hospital on 4 January expecting that the consultant would personally deliver her baby. In fact, she appeared to expect full private treatment under the NHS and I believe her complaints (concerning which my findings are recorded under each item of complaint) stem primarily from the disappointment she felt when she found that this was not to be. I think that her demands that the consultant be summoned added to the initial confusion and to an extent may have distracted the staff attempting to examine her. Further, her belief that the consultant would attend personally probably made her that much more critical of the nursing staff's attempts to assist her. Possibly if she had been willing to attend regularly at the hospital's ante-natal clinic this might have benefited her subsequently. Indeed, I have seen that the consultant expressed surprise when she came to see him after she had booked at the hospital at the 36th week; he feared that she would find herself in unfamiliar surroundings when she went into labour. His fears were undoubtedly realised.

39. I feel that the complainant was to a large extent the author of her own misfortunes. She was a difficult patient, readily prepared to find fault; the sheer volume of letters and telephone calls and the confusing way in which some of the former were worded made it difficult for the hospital to investigate her complaints. I particularly deplore the contents of the letter she sent direct to the sister which I regard as uncalled for and spiteful. I am pleased to note that despite all the difficulties, the end result was a normal and healthy child.

Case Nos. W.354/78–79 – Care and treatment at two hospitals.
and W. 462/79–80

Background and complaint

1. The complainant gave birth to a baby boy in hospital (hospital A) on 18 May 1978 and was discharged on 20 May 1978. On 24 May the baby was taken

to the accident and emergency department of hospital A and transferred to another hospital (hospital B) where he died the same day. The complainant was concerned about certain aspects of her own and the baby's care and treatment and complained to the two health authorities concerned. She attended meetings with officers of both authorities but remained dissatisfied and my predecessor agreed to investigate her complaints.

2. Those concerning the first AHA exclusively were

(i) that at hospital A:

(*a*) the antenatal clinic (the clinic) was often overcrowded;

(*b*) she was not given the results of diagnostic tests;

(*c*) the oxygen cylinder in the delivery room was empty and had been for two previous births;

(*d*) she was not given any help with feeding or caring for the baby;

(*e*) she was not told whether her baby was examined by a paediatrician before discharge;

(*f*) no papers were given to her on discharge (and see paragraph 3);

(*g*) there was no incubator available at the accident and emergency department on 24 May; and

(ii) that she did not receive a death certificate or any report on her baby's death from hospital B.

3. She also complained that because of a failure in communication between the first AHA and the second AHA (who were responsible for the community midwifery services for her home area) she was not provided with any help by a midwife for four days following her discharge from hospital A which, in her opinion, could have contributed to the baby's death. (For convenience I deal with this complaint with 2(f)).

4. She further complained that neither AHA dealt satisfactorily with her complaints.

Investigation

5. During the investigation my predecessor obtained the written comments of both AHAs and I have seen these together with the medical and nursing records. One of my officers interviewed medical, nursing and administrative staff of both AHAs, and the Coroner's assistant. He also met the complainant and her husband and spoke to his brother. In each section of my report the first paragraph consists of a summary of the complaint derived from her letters to the AHAs and to my predecessor, and from her interview with my officer.

(a) *The complaint about conditions in the clinic at hospital A*

6. The complainant said that the waiting facilities in the clinic were inadequate. There was insufficient seating for patients and visitors and it was constantly overcrowded.

7. The divisional nursing officer (midwifery) of the Health District (the Div NO) in her report to the Sector Administrator (the SA) of the first AHA said

that seating in the clinic was inadequate: at the time of the complainant's attendances larger chairs had been provided and they had been arranged to give the waiting room a more pleasant appearance, but the resultant reduction in the number of seats posed problems particularly when the clinics were extremely busy. The Div NO said that following the complaint stacking chairs had been provided and she had altered the arrangement of the chairs.

8. The consultant obstetrician told the SA that the complaint was fully justified and that on occasions patients as well as visitors were obliged to stand. Improved clinic facilities were needed to deal with the increased work load.

9. The SA told my officer that the difficulties arose largely from an increase in the local birthrate and from the recent closure of a nearby maternity hospital and I was also informed that the District Managment Team were aware of the overcrowding problems at the clinic. They were taking action to deal with the immediate problems but the long-term solution was to build a new clinic.

Findings

10. I uphold this complaint but am pleased to learn that the first AHA have taken some action to improve the waiting facilities in the clinic.

(b) *The complaint of failure to provide the results of diagnostic tests*

11. The complainant said that during her pregnancy she complained of considerable pain and other symptoms. Swabs were taken on two occasions but although the results were said to be negative she was not told what they had actually revealed and her complaints of pain were totally ignored.

12. The consultant obstetrician told my officer that as a consequence of her complaints at the clinic the complainant underwent six investigations, and treatment was prescribed on two occasions. A swab taken a few days before labour showed that no infection was present. The consultant said she would expect her junior staff to inform patients of the results of tests. If further information or reassurance were required she herself was always available during clinic sessions and if the patient felt diffident about approaching her direct she could do so through the clinic sister. The consultant could not remember being specifically asked for information by the complainant. I have seen copies of ten pathological reports provided between 8 March and 16 May.

13. The Div NO told the AHA that the complainant had complained during her last month of pregnancy of a great deal of pain but that if her complaints had been ignored the investigations would not have been carried out or prescriptions issued.

14. I have been unable to obtain the comments of either the registrar or the senior house officer who treated the complainant at the clinic as both have left the AHA's employ and their present addresses are unknown.

Findings

15. The complainant's contention that her complaints of pain were totally ignored is certainly not correct. She has acknowledged that she was told that the results of tests were negative but in the absence of the doctors immediately

concerned I cannot come to any definite conclusions as to whether or not further explanations were given.

(c) *The complaint about the oxygen cylinder*

16. The complainant said that shortly after her baby was born he was found to be in need of oxygen. The midwife discovered that the oxygen cylinder was empty and told her that it had been empty for the two previous deliveries.

17. The midwife in a written statement told the Div NO that the cylinder was empty but that in her comment to the complainant she had been referring to three occasions over a period of several weeks and not to three consecutive deliveries. The Div NO in her report to the SA and in her interview with my officer said that the midwife had been reminded that it was the responsibility of nurses undertaking a delivery to ensure in advance that equipment, including oxygen cylinders, was in good order.

Findings

18. The first AHA have stated that although the oxygen cylinder was empty and they have taken action to avoid a recurrence, the complainant misunderstood the midwife's comment. I am satisfied with their explanation and action.

(d) *The complaint about the absence of help and advice on immediate post natal care*

19. The complainant said that on the day after her baby's birth she asked nursing staff for help and advice on feeding and caring for him. She was told that as she had previously borne a child she should know what to do. She subsequently received assistance from a patient in a nearby bed.

20. The Div NO said in her report and to my officer that although there was a normal complement of staff on the day in question it was possible only to give limited help to each patient. There were thirty women on the ward, seven having been admitted in labour during the morning, and eighteen infants, twelve of whom were under forty-eight hours old. As the usual number of women in labour was three or four the labour ward was exceptionally busy. Midwives would give priority to the needs of those patients and attention to others in the post natal ward would, regrettably, suffer.

21. I have been unable to identify the nurse who made the alleged remark to the complainant, and the Div NO considered that any such remark would have been tactless.

Findings

22. I accept the complainant's account but I am equally sure that had the pressure of work been less the nurses would have been able and willing to give her more help.

(e) *The complaint about whether the baby was examined by a paediatrician before discharge from the hospital*

23. The complainant said she did not know whether a paediatrician had examined her baby before they were discharged on 20 May. Though she had

been told during a meeting held at hospital B to discuss her complaint that such an examination had taken place, she still did not believe it.

24. The consultant paediatrician told my officer that all babies were examined as a matter of routine by one of the two resident paediatric senior house officers the day before discharge, and he confirmed that one of them had done so in this case. Normally the examination would be undertaken in the presence of the mother, but if she were absent for any reason at the time she should have been informed of the result by a midwife. I have seen from the medical notes that a paediatric examination did take place on 19 May. The Div NO told my officer that during the discussion at hospital B the complainant had appeared to accept that the baby had been examined in her presence on the day before discharge, but had not realised that this was the final examination, and felt that he should have been seen again immediately before discharge.

Findings

25. I am satisfied that the complainant's baby was examined by a paediatrician before their discharge from hospital. I do not uphold this complaint.

(f) *The complaint of lack of discharge papers and of breakdown in communication between the two AHAs*

26. The complainant said that no papers were given to her when she left hospital A on Saturday 20 May. She had expected a community midwife to visit her either the same day or at the latest the following day. When no-one had called by the Monday morning she became concerned and her husband telephoned the Health Centre (the health centre) where her family practitioner (the FP) was based. Her husband was told by a receptionist at the health centre that a midwife would be calling soon. The FP visited soon after this and told her that a midwife was on her way. No midwife called either on Monday or Tuesday. On Wednesday 24 May the complainant's mother went to the health centre to ask why no midwife had called but while her mother was out the complainant became so disturbed by her baby's condition that she rang the health centre from a neighbour's telephone and a midwife and a health visitor arrived within twenty minutes. The midwife saw that the baby was having breathing difficulties and administered oxygen while her colleague telephoned for an ambulance which took the baby to hospital A.

27. The Div NO said that owing to an oversight the normal discharge letter had not been given to the complainant, but as soon as the omission was discovered the nursing officer on duty had passed the relevant information by telephone to another hospital (hospital C). The details had also been conveyed to the FP on Monday 22 May, as he had not been available on 20 May. I have seen an entry in the medical notes confirming that the information was passed to hospital C and to the FP. The Div NO added that as a result of the complaint they had reviewed the procedure on discharge and hoped that the same type of mistake would not occur in the future.

28. The senior midwifery officer (the SMO) at hospital C told my officer that her department was responsible for community midwifery in the complainant's neighbourhood. Where, as in this case, a confinement took place in hospital A, hospital C were informed of the patient's discharge so that a community mid-

wife might be asked to visit her at home. The procedure at weekends was that during the morning staff at hospital A would telephone the sister at hospital C giving details of the patients being discharged which would then be entered on a 'transfer' form which was left in a book. About 2 pm a community midwife, (the on-call midwife) nominated to receive and pass on messages to her colleagues and to deal with urgent matters, would call or telephone for the details. As a result the mother should receive a visit from a community midwife soon after discharge.

29. The SMO told my officer that details of the complainant's discharge had been received at hospital C by telephone in mid-afternoon on 20 May, and the form had been completed and placed in the book. As the on-call midwife had earlier been given details of the day's discharges, a telephone call was made to her home to give her the additional information. She was not at home, and a male relative who answered the telephone agreed to ask her to ring back, and the transfer form had been cancelled as though the details had been passed to the on-call midwife personally. The SMO said that during her antenatal care the complainant would have received a card containing the telephone numbers of the community midwife allocated to her post-natal care and of the delivery suite at hospital C in case a difficulty should arise.

30. The senior sister on the delivery suite at hospital C told my officer that she had taken the message about the complainant's discharge from hospital A at 2.45 pm on 20 May and filled in the transfer form. She had then telephoned the home of the on-call midwife who was out and left a message for her to call hospital C when she returned. She placed the transfer form in the book without any endorsement, and when she went off duty at 4 pm left the book open so as to display the form. She told her colleague (the second sister) to expect a telephone call from the on-call midwife and asked her to pass on the message about the complainant's discharge, and expected the second sister to tell the nursing officer when she came on duty at about 5 pm.

31. The second sister told my officer that she could not remember either seeing the transfer form or receiving any message from the senior sister about the midwife's call. Nor could she remember any conversation about the matter with the nursing officer.

32. The nursing officer told my officer that when she came on duty at 5 pm she saw the book containing the transfer forms and in answer to her question the second sister confirmed that those received late had been notified to the on-call midwife. The nursing officer said that it was possible that she had cancelled the form because of this information.

33. The on-call midwife told my officer that she had telephoned the hospital at 1 pm and the complainant's name had not been on the list of those discharged that day and she had not been told of any message by the members of her family who had been in the house during the afternoon of 20 May.

34. The manager of the health centre told my officer that a message had been received from hospital A at about 11 am on Monday 22 May informing the FP that the complainant had been discharged and stating that the midwifery service at hospital C had been informed. Thus when the complainant's husband telephoned later that morning, he was assured that a midwife had been asked to

call. The receptionists who took the calls confirmed this. When the complainant telephoned on 24 May indicating that the baby was ill a midwife and health visitor went to her home as quickly as possible.

Findings

35. The complainant did not receive documents on her discharge from hospital A, but telephone messages were made to rectify this omission as soon as it was discovered. I am pleased to learn that the first AHA have since improved their discharge procedures.

36. I also find that there was a serious breakdown in communication between staff based at hospital C arising from procedural weakness and a series of human errors or misunderstandings. It is not for me to speculate whether an earlier visit by a midwife would have made any difference to the outcome of the baby's illness but the confusion undoubtedly added to the complainant's distress. I fully uphold this complaint and am also pleased to learn that, since this incident, procedures have been reviewed by the second AHA to avoid a repetition of this unfortunate lapse.

(g) *The complaint about the incubator*

37. The complainant said that her baby was taken by ambulance on Wednesday 24 May to the Accident and Emergency Department at hospital A but there was no incubator available in the department and the baby had to be wrapped in blankets to keep him warm. She said that the child waited in this state for an hour, gradually turning yellow, before being transferred to hospital B. The complainant said that the consultant paediatrician had subsequently told her that there would have been no point in trying to bring into use the incubator from the labour ward because before it reached the correct temperature the baby would have been transferred to hospital B.

38. The Div NO told my officer that a portable incubator was available on the labour ward at hospital A, but that when the complainant arrived it was not plugged in. However, there was another one which was kept in a constant state of readiness at hospital B, which was nearby, and which could have been fetched if the doctor felt it necessary.

39. The consultant paediatrician assured my officer that the locum paediatric senior house officer on duty at the hospital on the day of the child's admission would have known of the existence and ready availability of the incubator at hospital B and it was for him to decide whether the circumstances justified its use. This doctor has now left the employment of the first AHA and his whereabouts are unknown, so I have been unable to obtain his evidence.

Findings

40. I have found that although at hospital A there was not an incubator ready for immediate use one could have been obtained at short notice. I have been assured that the doctor knew of this and his decision not to make use of it would therefore have been made in the exercise of his clinical judgement on which I cannot comment.

(ii) *The complaint of lack of documentary information about the baby's death*

41. The complainant said that after her baby had died at hospital B on 24 May she did not receive a death certificate or any report describing the cause of death. The only information given to her and her husband was contained in a telephone call on 26 May from the Coroner's assistant, giving the cause of death. My officer spoke to the complainant's husband's brother who said that he enquired at the hospital about the correct procedure to follow after the baby's death. He was told that the matter had been referred to the Coroner in accordance with normal practice; that everything was to be handled by the Coroner and that a meeting had been arranged with the Coroner's officer for later that morning. The husband and his brother went to hospital B and saw the Coroner's officer, who explained to them the procedure which would be followed. I have been informed by the AHA that the advice given to the husband's brother conformed to the practice followed in such cases.

42. The Coroner's assistant told my officer that he met the husband and his brother at hospital B on the morning of 25 May. He had explained to them that a post mortem examination was necessary and that a death certificate could not be issued until it had been carried out. He promised to let the husband know when the enquiries had been completed so that the death could be registered. There was no need to give him any documents at this stage. He said that he telephoned him later that evening and told him that the post mortem was completed and that he could now register the death. He also told him that the registrar of births and deaths would be expecting him and that he had himself told the registrar of the cause of death. He had explained the diagnosis in layman's terms and told him that he could obtain a copy of the death certificate from the registrar.

Findings

43. The actions of the Coroner and his staff are outside my jurisdiction but I am satisfied that the hospital were obliged to report the baby's death to the Coroner and told the husband's brother this and arranged for them to meet the Coroner's officer. I do not uphold this complaint against the first AHA.

The handling of the complaint

44. The complaint about lack of communication between the hospital and the community midwifery service was sent to the Health District of the second AHA on 12 June 1978 with a copy to the Health District of the first AHA. The administrator at hospital C wrote to the complainant on 29 June admitting a breakdown in communication and giving an assurance that consideration was being given to improvements in the procedure to obviate future similar failures. It also included an offer of a meeting should further clarification be required.

45. The meeting took place on 6 July with the complainant, her husband and her mother and the vice chairman of the Community Health Council was also present. Following the meeting the administrator of hospital C wrote again to the complainant on 7 July and 10 July explaining and apologising for a misunderstanding which had arisen over her husband's call to the health centre on 22 May.

46. On 14 July the complainant wrote to the Health District of the first AHA complaining about the attention she and her baby had received at hospital A before, during and after her delivery. This letter was acknowledged on 18 July and the investigation already begun as a result of the complainant's earlier letter was extended to cover her additional complaints. On 26 July the Div NO provided a statement amplifying a report she had made on 22 June as a result of the earlier complaint. The consultant obstetrician and the consultant paediatrician were also asked to give their comments on the second letter but one of them was on holiday. A letter explaining the delay was sent to the complainant on 10 August, and it contained a suggestion that a meeting would probably be arranged.

47. On 1 September the district administrator for the Health District of the first AHA wrote to the complainant inviting her to a meeting to discuss her complaints. On 6 September the consultant paediatrician visited the complainant and her husband at home and had what he described to my officer as a constructive discussion. The formal meeting was held on 11 September and was attended by the Div No, the consultant paediatrician and the administrator who dealt with this complaint, together with the complainant, her husband and mother, and the vice-chairman of the Community Health Council. No further correspondence took place until my predecessor was asked to investigate the complaint on 2 October.

Findings

48. The complaints were dealt with promptly, the investigations made by both AHAs were thorough and the results were conveyed to the complainant at meetings with the senior hospital staffs concerned. There is no detailed record of what was said at these meetings, but I believe that the representatives of both AHAs did make reasonable efforts to reassure the complainant and to give her adequate explanations in response to her questions. I do not uphold the complainant's contentions concerning the way her complaints were handled.

Conclusions

49. I have found occasion to criticise both AHAs concerned. Both have asked me to apologise on their behalf for the shortcomings I have found and have assured me that they have taken remedial action (see paragraphs 10, 18, 35 and 36). I offer my sympathy to the complainant and her husband and hope that they may take some comfort from the fact that their complaints have led to improvements in procedures which should lessen the likelihood of similar failures in the future.

Case No. W.398/78–79 – Delays in arrival of ambulance and in hospital treatment

Complaint and background

1. The complainant's son aged 20 months, became ill on 17 June 1978 and was admitted to hospital (the hospital) at about 7.30 pm on 20 June 1978, and about two hours later his parents were told he had died. The complainant says that there was a delay of an hour between the time his family practitioner's colleague (the FP) ordered the ambulance to take the child to hospital and the time it arrived at his home and a further delay of an hour after his arrival at the hospital before a doctor saw him. He further complains that the Area Health Authority (the AHA) failed to give an adequate answer to his complaints.

Investigation

2. During the investigation written comments were obtained from the AHA and I examined clinical and nursing records and other relevant documents. My officers interviewed the hospital medical, nursing and administrative staff involved in the complaint and also the FP. One of them met the complainant, his wife and his father.

(a) *The complaint about delay in the arrival of the ambulance*

3. The complainant said in his letter of 30 August 1978 to the AHA and in his interview with my officer that his son was taken ill on 17 June 1978 and was seen by his own family practitioner several times during the next few days. On 20 June he was taken to his family practitioner's surgery, where he was examined at about 5.50 pm by the FP, who decided that he needed hospital treatment and arranged for his admission. The complainant and his wife went home to await the ambulance which arrived about an hour later. The AHA's reply of 27 October made no reference to this aspect of the complaint.

4. The AHA's chief ambulance officer (the CAO) told my officer that the action taken by the ambulance service was dependent upon the degree of priority given by the doctor calling the ambulance. Emergency or urgent calls were dealt with immediately or within the time limit set by the doctor. Non-urgent journeys were made as soon as possible. In a report to the CAO the divisional ambulance officer said that the FP's call was timed at 18.02 and not recorded as 'urgent'. However, within eight minutes the first available ambulance had been despatched, but the crew had experienced some difficulty in finding the complainant's home. The CAO told my officer that crews would radio to central control for directions if they had such difficulties on an urgent journey, but would make their own efforts to find the address in a non-urgent case, unless they were completely lost.

5. The ambulance request form records the time of the FP's call at 18.02: the condition of the patient as 'dehydration' and the reason for the journey as 'admission'. The form provides for three categories of priority, 'urgent', 'special', and 'planned', and the item marked 'planned' has been marked with a circle. The divisional ambulance officer's report stated the total distance was just over 20 miles and the time taken 1 hour 18 minutes. The ambulance journey log book shows the time of arrival at hospital as 19.20.

6. A complaint against a family practitioner is outside my jurisdiction but I have seen a transcript of evidence given at the hearing by the Medical Services Committee of the Family Practitioner Committee, arising out of a complaint against the FP and his colleague by the complainant and his wife. The FP stated that he had examined the child at 5.00 pm, or soon after and had seen nothing to suggest that he would die that day. He had certainly looked dehydrated and this had been his diagnosis, so he decided the child should be admitted to hospital. He called a local hospital but they had no 'infectious' beds available. He had therefore rung the hospital and spoke to the duty doctor, who agreed to accept the child. He had not considered him a medical emergency, but decided that he was dehydrated and needed to go into hospital straight away. In an interview with my officer the FP said that, while he had not considered the case an 'emergency' – which he described as one in which the patient's life was in danger – he

had in fact regarded admission to hospital as a matter of urgency, and had asked his receptionist to order an ambulance on that basis. No record was made by the FP or the receptionist of the terms in which the request was in fact made, and the receptionist has now left the practice and was not available for interview.

Findings

7. The only contemporary evidence available is the record completed by the ambulance service which did not classify the call as urgent but nevertheless I find the ambulance was despatched promptly. I further find there was certainly delay en route due, I am told, to the crew losing their way. In the circumstances I do not therefore criticise the ambulance service.

(b) *The complaint of delay in the attendance of a hospital doctor*

8. In his letter of complaint and in his interview with my officer, the complainant said that he and his wife and son arrived at the hospital at about 7.30 pm, and were shown to a single room. His father waited outside in his car. A ward sister (the day sister) took the letter which the FP had given him and said she would telephone the doctor. She returned about ten minutes later and told them that the doctor was dealing with an emergency case. A nurse then took written information about the child and, during the ensuing wait, the day sister returned twice and gave him drinks. Later a nurse whom the complainant and his wife thought was another ward sister came in; they assumed the shift had changed. She reassured them that the doctor was coming. After they had been waiting an hour, the doctor arrived but did not examine the child until she had gone through what seemed to the complainant and his wife to be 'an interminable process of form filling', which they estimated took five or ten minutes. She then tried to insert an intravenous infusion (IVI), but appeared to find difficulty. They were asked to leave and wait in the nearby waiting room and the complainant went out to tell his father what was happening; the complainant's father said this was at about 8.55 pm. The complainant and his wife returned to the waiting room and at about 9.30 pm either the doctor or a nurse came to say the child had died. They were told that everything possible had been done and that a number of doctors had been present at the end. They left the hospital at about 9.55 pm.

9. The AHA's reply to the letter of complaint was signed by the District Administrator for the Health District (the DA). He said that the nursing records showed that the child was admitted on 20 June 1978 at 7.30 pm, that the senior house officer (the SHO) on duty was immediately informed and arrived within 10–15 minutes. The delay was caused because she was at that time treating another very sick child. The letter quoted the consultant physician to whom the SHO was responsible (the consultant) as saying that on the SHO's arrival no time was wasted in form filling and she immediately instituted the necessary treatment and this included half an hour of 'her personal time' attempting resuscitation to save the child. The consultant had expressed his full confidence in the ability of the SHO and the sister, and said that everything possible was done in the circumstances.

10. The ward to which the complainant's son was admitted is used for patients suffering from infectious diseases and is divided into cubicles by glass partitioning. The day sister told my officer that a cubicle had been prepared for the child with IVI equipment ready on a trolley. This would have been a normal precaution in expectation of the admission of a patient suffering from dehydration and would not necessarily have been specifically ordered by the SHO. In this case she could not be sure whether she prepared it on her own initiative or the SHO's instruction. When she saw the child at 7.30 pm he looked very ill, so she decided to contact the SHO immediately, although the usual procedure would have been to take written details first. She took the FP's letter and telephoned the paediatric ward where she knew the SHO to be. A nurse answered and said the SHO was busy, so the day sister asked her to let the SHO know that the 'gastro-enteritis baby' had arrived and was very dehydrated and lethargic and the nurse said that the SHO would come soon. The pupil nurse in the ward entered routine information on the medical record and remained in the cubicle with the child and his parents. The day sister confirmed that she returned twice and gave him drinks, and I have seen that she entered the amounts on a fluid chart. Between 7.50 and 8.00 pm she telephoned the paediatric ward again and spoke directly to the SHO; she reported that the child was dehydrated but was able to take drinks orally. The SHO said she would come as soon as she could. The two other nurses on duty on the ward at the time, a staff nurse and a pupil nurse, confirmed that the day sister's first telephone call had been made immediately after admission. The AHA's records showed that there were three nurses on duty in the paediatric ward at the time of the day sister's telephone call; they were each interviewed by my officer but none could remember the call.

11. In his interview with my officer, the FP said that he had diagnosed the child's illness as gastro-enteritis. He had considered he was severely dehydrated and in need of urgent hospital treatment and had conveyed his opinion by telephone, in those terms, to the SHO. The letter of referral completed by the FP, which was taken to the hospital by the parents when their son was admitted, begins 'Thanks for taking this child who is showing severe dehydration today', and goes on briefly to describe the treatment already given.

12. The SHO told my officers that she could not recall what time the FP had telephoned. He had not suggested that the case was urgent, saying that the child had gastro-enteritis. She could remember no mention of dehydration, and was quite sure the FP did not refer to severe dehydration. Had he done so, she would have given advice on interim treatment and would have alerted the nursing staff on the ward to expect a serious case. They would have arranged for him to be put in the cubicle next to the sister's office reserved for emergencies and would have prepared a drip trolley immediately. As it was he was accommodated in a cubicle in the middle of the ward, and she said that the drip trolley was not set up until she gave instructions on receiving the day sister's second call. Had the FP sought an emergency admission, she would have expected him to have sent the child to the nearest casualty department, and not subjected him to a long ambulance journey. It was not uncommon for patients to be referred to the hospital for isolation or observation, and she surmised that this could have been the reason given in this case. Nonetheless she did not think the treatment given would have been very different if he had been expected as an emergency.

13. The SHO said she had been attending to a sick new-born baby when the day sister first telephoned. The message she was given by the nurse on the paediatric ward was just that the patient had arrived; there was no mention of dehydration, or any other information. As she therefore had no reason to think the case was urgent, she started to write up the medical notes of the baby she had been treating. She did not know what time the telephone call had been made and could not therefore confirm that it was made immediately the patient arrived at the hospital. About ten or fifteen minutes later the day sister called again. She said he was dehydrated and as the SHO knew her to be a very competent nurse and she was obviously worried about his condition, she left the paediatric ward immediately and went to the other ward. She estimated that the walk took about seven minutes as the wards were on different sides of the hospital. Her recollection was that the day sister had been in the cubicle when she arrived on the ward, and the other day staff were still on duty.

14. The SHO told my officer that although she had recorded the time of death as 9.45 pm she thought on reflection it might have occurred earlier.

15. The day sister told my officer that the night staff came on duty at the usual time of 8.30 pm. Her recollection was that as they arrived they told her they had just seen the SHO come onto the ward – the day sister would not have seen her arrive as it was not necessary for the SHO to pass the nursing office to reach the cubicle. The pupil nurse said that, as far as she could recall, the SHO arrived in the cubicle at about 8.30 pm. The pupil nurse remained until relieved by a member of the night staff at 8.45 pm, but she could not recall what actions were taken by the SHO in the interim. The day sister made a note of the admission and condition in the nursing record before handing over the ward to the night staff and going off duty at 8.45 pm. The note would have been made at 8.30 pm or soon after. Had the IVI been inserted by then, she said, the fact would have been recorded. I have confirmed that the entry contains no mention of the IVI insertion.

16. Of the three nurses on night duty two were involved with the child's care and they told my officer they remembered entering the ward together at 8.30 pm, but not seeing the SHO at that time. The state enrolled nurse in charge of the ward (the SEN) said that she thought the day sister had told her that the SHO had been contacted but had not yet arrived to see him, but she recalled that she then looked through the glass partition from the nursing office and saw the SHO in the child's cubicle. The nursing auxiliary's recollection was that the SEN went to see the child when the handover report was finished, at which time the SHO was not on the ward. The SEN returned to the nursing office and suggested the nursing auxiliary should look at the child with her. By the time they reached his cubicle again the SHO was there. The nursing auxiliary estimated that this was between 8.35-8.40 pm. The SEN said she relieved the pupil nurse at the child's bedside at about 8.45 pm. The SHO had completed her initial examination and was ready to start the IVI.

17. The SHO told my officer that when she saw the child she realised he was seriously ill and spent less than five minutes on preliminary procedures. It had been difficult to start the IVI because his tissues were collapsed and she asked the parents to leave the room. Despite further efforts, his condition deteriorated and the SHO asked a nurse to call the resuscitation team. The SEN corroborated

this account and said the night sister (who covered several wards) had come to the cubicle and escorted the complainant and his wife out. By the time she returned the child was collapsing. The night sister told my officer she began her tour of duty in another ward and she was told there of the child's admission. She went to the ward at about 8.50 pm and after taking the parents to the waiting area relieved the SEN. She had called the resuscitation team, but could not say what time this was and no record was kept of the time.

18. After he died, the night sister made an entry in the nursing record which was countersigned by the SEN. I have seen that the entry regarding the IVI was originally timed at 8.30 pm but had been subsequently altered to 8.00 pm. It stated that after attempts to insert the IVI, and resuscitation for forty-five minutes, the child was certified dead at 9.45 pm. The night sister told my officer that she had made the entry soon after the time of death. She was not present when the IVI was inserted, and therefore had no direct knowledge of the time this was done, but had made the entry as a result of what she had been told. She thought that the alteration from 8.30 to 8.00 pm had been made at the request of the SHO at the time the entry was made. The notes made by the SHO in the medical record do not indicate the time treatment began, but corroborate that death was certified at 9.45. In her report to the coroner the SHO stated that he died within one-and-a-half hours of admission. After the receipt of the complaint she had given the consultant her estimate that 10-15 minutes had elapsed between the child's admission and her arriving at his bedside. The SHO has assured me that she asked the night sister to amend her record as she had honestly believed that it was nearer 8.00 pm than 8.30 when she began her attempt to resuscitate him. She now agreed that this might have been an underestimate but was sure it was less than an hour and that she arrived within 10-15 minutes of the day sister's second call. She said that, in her clinical judgement, the child would not have survived even if he had been admitted to hospital the previous day. The consultant agreed with this opinion, saying that the chest infection which caused his death, bronchiolitis, was, once established, difficult to combat and from his discussion with the SHO and his examination of the clinical facts he thought it was already too late on 20 June to save the child's life.

Findings

19. There is a direct conflict of evidence between the FP and the SHO about whether 'dehydration' was mentioned in their conversation. But the form completed by the ambulance service as a result of the FP's call and the referral letter written at the time of the FP's examination both include it. However, it is equally clear that the FP did not regard the case as an emergency. On the child's arrival at the hospital the day sister immediately appreciated the seriousness of his condition and I am satisfied that she did her best to convey this indirectly to the SHO without delay. The SHO states that she was not aware of the sister's anxiety until she spoke to her personally. The SHO has said that a realisation that the child was dehydrated would have influenced her actions. In the event it was for her solely in the exercise of her clinical judgement to decide what degree of priority to give to his care taking into account such information as she had about his condition and the needs of her other patients and in particular the sick new born baby at the material time. I cannot comment on that clinical decision but clearly the extent of dehydration was not effectively conveyed to the SHO.

20. There is a difference of recollection about the time the IVI trolley was made ready: the day sister says it was prepared before the patient's arrival, the SHO that it was not set up until she received the day sister's second telephone call. The SHO's estimate of the time she arrived to examine the child is clearly mistaken and I have no doubt that she did not actually see him until 8.30 pm or thereabouts. Although I accept her assurance that the alteration was made in good faith, I find it disturbing that the time shown on the nursing record was altered. But the SHO's opinion and that of her consultant is that the delay in coming to see the child had no effect on the final outcome, and I am satisfied that once the SHO arrived there was no delay in commencing treatment.

(c) *The complaint about the AHA's reply*

21. The complainant sent his letter of complaint to the DA on 26 September. The DA acknowledged it on 2 October and through the Sector Administrator of the hospital (the SA) referred it to the consultant. The consultant's report dated 17 October provided the basis for the DA's reply to the complainant (see paragraph 9). It said he had questioned the day sister and the SHO and examined the nursing record. The consultant's letter was virtually reproduced in the DA's reply of 27 October to the complainant, except that the phrase 'half an hour of her personally attempting resuscitation to save the child' became 'half an hour of her personal time attempting resuscitation to save the patient'. The reply concluded with an offer of further help if required and the suggestion that, if he were not satisfied, the complainant should put his complaint to my predecessor. The reply contained no reference to the complaint about delays in the ambulance service.

22. The consultant told my officer that during his enquiries the SHO had told him that she was informed of the child's arrival at about 7.30 pm and had gone to the ward about fifteen minutes later Before doing so she had received a second phone call during which she was told that he was taking fluids orally, which should have meant that he was not desperately ill. (The SHO told my officer she could not recall telling the consultant this.) The consultant told my officer that the day sister had told him she had not seen the SHO arrive at the child's bedside.

23. The day sister told my officer that the consultant had shown her the letter of complaint. She had not regarded the enquiry as a formal one and had not offered her estimate of the time the SHO had arrived but had referred the consultant to the medical and nursing notes. Had she been asked formally she would have supported the account given by the child's parents.

24. The general administrator at the Health District told my officer that he had prepared the reply to the complaints on the basis of information provided by the SA. He agreed that the failure to reply to the complaint about the ambulance service was an oversight. He acknowledged that it was common practice for replies to contain an expression of sympathy and that it would have been reasonable to include one in this case. He agreed that the reference in the reply to the SHO's 'personal time' was regrettable and that it would have been more appropriate to quote the consultant verbatim. He also accepted that the nursing notes did not, as suggested in the reply, support the assertion that the SHO had arrived 'within 10-15 minutes'. He had assumed that the SA (who had since left the AHA's employ) would have confirmed this for himself.

25. The DA confirmed in his interview with my officer that he had read and approved the draft reply before signing it. He told my officer that on re-reading it he could see nothing wrong with it: he did not consider the statement about the SHO's personal time capable of misinterpretation; nor did he think an expression of sympathy either necessary or appropriate, as such sentiments could be taken for granted.

Findings

26. As the complaint related to the actions of a doctor the DA quite properly asked for the comments of the responsible consultant about it. The investigation carried out by the consultant did not reconcile the disparity between the statements made by the complainant and the SHO. The DA signed the reply obviously without satisfying himself that it was accurate and that it fully answered the complaints made.

27. I find the reply sent to the complainant was inadequate and careless and must have seemed unfeeling as well. No reference was made to the alleged failure of the ambulance service and the reply implied incorrectly that the SHO's account of the time-lapse was supported by the nursing record. The clumsy translation of the phrase 'half an hour of her personally attempting resuscitation' into 'half an hour of her personal time' I find to be quite inexcusable: it plainly carries in the latter form an implication that the SHO's 'personal time' was something uniquely valuable for which the complainant ought to be grateful. It is also derogatory of the SHO who I know would give her time freely and without limit to the task of saving a child. I regard such thoughtless clumsiness as reprehensible. The AHA have, I am glad to say, recognised the severity of my censure of the shortcomings both of their investigation and reply and have asked me to apologise to the complainant and his wife on their behalf which I gladly do.

Conclusion

28. I have established that the complainant's account of the events leading up to his son's death is correct. It was particularly tragic that there were two independent delays affecting admission and treatment but I have been assured and accept that they did not affect the sad final outcome. I deeply sympathise with the complainant and his wife in their loss.

Case No. W.408/78–79 – Interview at an out-patient clinic

Complaint and background

1. A man complained of events which began when he sought help from a Social Services Department of a County Council (the County Council) on 5 October 1978 and culminated in an allegedly unsatisfactory interview with a consultant psychiatrist (the consultant) at an out-patient clinic (the clinic) on 16 October 1978.

2. A Commissioner for Local Administration in England and I are empowered to undertake investigations jointly, and one of my officers (our investigator) undertook all interviews of staff of the County Council and the Area Health Authority (the AHA) on behalf of both of us. He also saw the assistant administrator of the Family Practitioner Committee (the FPC) and the

family practitioner (the FP) involved in order to obtain information. Another of my officers saw the complainant and his wife soon after the events complained of, and our investigator also saw them subsequently. The details of the complaints were contained in their letters and statements and in these interviews but I have not felt it necessary to differentiate between these sources. I have seen copies of other relevant correspondence and records. Only that evidence appropriate to my own enquiry has been included in my report. A Commissioner for Local Administration is reporting separately on the related complaints against the County Council.

3. I agreed to investigate the following complaints about the complainant's interview with the consultant on 16 October:

(*a*) that he tried, unsuccessfully, before the interview to find out whether his wife could be present and to obtain an assurance that a particular social worker (the SW) would not be in attendance;

(*b*) that although he was given an appointment for 2 pm he was not seen by the consultant until 3.10 pm, and no explanation was given for this delay;

(*c*) that the consultant refused to allow the complainant's wife to be present at the interview although the complainant told her that both the FP and the complainant's wife's solicitor felt that they should be seen together;

(*d*) that although the consultant's name was shown on the appointment card she insisted that the SW, in whom the complainant had previously lost confidence, should also be present at the interview;

(*e*) that the consultant shouted at him during the interview and threatened to call the police if he would not leave;

(*f*) that the replies of the AHA to his complaints were unsatisfactory.

Introduction

4. After matrimonial difficulties the complainant's wife left home in June 1978 and returned in late July. On 2 October the complainant visited his FP who then wrote to the consultant asking her to see the complainant who he said 'was keen to see her'. The complainant in a letter to the FPC had said that when writing the letter to the consultant the FP had insisted that the complainant should check his grammar and punctuation. The FP told our investigator that he had insisted that both the complainant and his wife should see the letter of referral.

5. The consultant holds two out-patients' clinics a week at the hospital (hospital A) on Mondays and Thursdays. She told our investigator that she would not have received the FP's letter for a few days after 2 October and as she gave the complainant an appointment for 16 October it showed that she had regarded his referral as urgent.

6. The complainant's wife said that on 4 October she went to the FP's surgery after an argument with her husband the previous evening. She was unable to see the FP but a receptionist told her that the FP had telephoned the

Social Services Department and that she was to go to see the Senior Social Workers (the SSW) or the SW. The FP told our investigator that the complainant's wife had been to see him and he had told her that she should see a social worker.

7. The complainant's wife said that she thereupon called at the Social Services Office. The SSW saw her for a few minutes; then the SW saw her for at least three-quarters of an hour. She told him that an appointment was being made for her husband to see the consultant. At the end of their discussion the SW said he doubted if the consultant could treat her husband. The SW said that he would be at hospital A on the day her husband had his appointment and that he usually sat in with the consultant.

(a) *Complaint about the presence of the complainant's wife and the SW at the interview*

8. The complainant said that he telephoned the area director of the Social Services Department (the AD) on about 10 October (when he knew he had an appointment to see the consultant on 16 October) and complained about the SSW and SW but did not say anything to the AD about the SW's presence at the hospital appointment. The AD in his report (dated 16 November) of a telephone conversation with the complainant on 12 October confirmed that the complainant had complained about the SSW and the SW and he told our investigator that at no time in the conversation did the complainant make any request to him to exclude the SW from his case in the future or mention his hospital appointment about which at that time the AD knew nothing.

9. The complainant said that when he received the hospital appointment he telephoned the consultant's secretary (the secretary) and asked if it could include his wife and whether any social worker would be present. The secretary answered that she could not tell him anything as the consultant ran her own clinic and that he would have to ask her. He said that the secretary made no other suggestion and in view of her attitude he thought it was pointless to discuss the matter with her any further; he did not therefore explain why he did not want to see the SW. The complainant then rang hospital A about the arrangements and was told they did not manage the clinic, as it was the responsibility of another hospital (hospital B).

10. The secretary told our investigator that she could not recall the actual terms of any conversation with the complainant; when such questions were asked she would tell a patient that if it was at all possible the consultant would see a husband and wife together but she would not be absolutely definite because it might be that the spouse or the patient did not want a joint interview and they had to leave that possibility open. The secretary was sure she would have made no reference to the presence of the SW, because it was not part of her responsibility, but if she had been asked she would have said it was for the consultant to decide.

11. The consultant had dictated a letter to the FP immediately after the conclusion of the interview on 16 October and in this she said that the complainant had stated that he had telephoned the AD before coming to the clinic to get an assurance that the SW would not be there but that both she and the

SW were quite unaware of it. The complainant had also said that he rang her secretary who assured him that the consultant would see the complainant's wife: the consultant added that it was most likely that the secretary did give this assurance.

Findings

12. The complainant did try to find out whether his wife could be present at the clinic and was given an indefinite answer, but in the circumstances that was all that could have been given. The complainant has produced no evidence that he asked anyone for an assurance that the SW would not be present. I reject this complaint.

(b) *Complaint about the wait to be seen at the clinic*

13. There is no dispute about how the clinic is organised. The hospital is a small cottage hospital with an extremely busy out-patient department consisting of four consulting rooms, a common waiting area and a utility or treatment room. In a separate building is an office used by the SW for his interviews. The clinic is administered by the consultant from her base at hospital B: she makes the appointments, brings the case papers to the clinic and writes the letters from hospital B. The hospital administrator told our investigator that he was responsible for the accommodation only and not for the operation of the clinic; his receptionists kept their eyes on the out-patient department generally but it was no part of their job to ensure that the clinic ran smoothly. He and the hospital's nursing officer reviewed the operation of all other out-patients' clinics by observation, and if they felt waiting times were excessive they would discuss them with the consultant concerned.

14. The complainant's wife said that she and her husband arrived at the hospital out-patient department on 16 October at about 1.45 pm for a 2 pm appointment with the consultant. They did not see the consultant arrive and as other doctors were working at the clinic they did not know whether the consultant saw any other patients before seeing them. They saw the SW arrive at about 2.10 pm and go to the outside hut. At about 2.55 pm the SW returned. They contiuned to sit in the reception area and did not ask anybody for information until they were called at 3.10 pm.

15. The consultant told our investigator that on 16 October two patients had been listed to be seen before the complainant. She allocated half an hour for each new patient and a quarter of an hour to each old patient, and the appointments list confirms that there had been appointments at 1.30 and 1.45, with the complainant's at 2.00 and the next at 2.30. The consultant said that the clinic had been running very late, as if often did, and she felt that the complaint about the long wait was justified.

16. The SW said that patients were often kept waiting because of the nature of the work, particularly if members of a patient's family turned up and were seen or if there was an urgent request to see an extra patient. He said that the clinic began about 1 pm and often did not finish until 8 or 9 pm.

Findings

17. The complainant was given an appointment for 2 pm on 16 October and not seen until about 3.10 and I believe the complainant and his wife's statement that they were given no explanation for this wait. The AHA have asked me to convey their apologies to the couple for the lack of explanation for this delay, but I do not in any way blame the consultant or her immediate staff who work hard and conscientiously. I am concerned that the divided administrative arrangements apparently means that no one has responsibility for overseeing the waiting time for the clinic. The AHA have told me that they will investigate the delays which, according to the evidence, commonly occur.

(c), (d) and (e) *Complaints about the events at the interview with the consultant*

18. For convenience I deal with the evidence on these complaints together.

19. The complainant and his wife said that the community sister (the sister) called the complainant and they followed her to the consulting room and were asked to wait outside. They told the sister they wanted to see the consultant together and without the SW but the sister ushered the complainant into the consulting room and told his wife to wait outside. The complainant's wife said that she was very annoyed at having to wait so long without any explanation and she entered the room; the consultant refused to see her and her husband together and in very strong terms stated that she was boss of the clinic and always had the SW with her. The complainant's wife said her husband spoke very forcefully, saying that the secretary had told them they could discuss the request by their FP and solicitor to be seen together and without the SW when they attended the clinic. The complainant's wife said that during the argument the SW had stood motionless but full of rage, gripping the back of a chair firmly as if to control himself; the consultant who did not appear in control of the situation asked her husband to leave as she (the consultant) could not be of any help, and after they had been asked loudly several times to leave the room or the police would be called the wife left and her husband followed soon afterwards.

20. The complainant said that when he went in to the consulting room he told the consultant 'I want my wife to come in and the SW to go out' and the consultant replied 'I run this clinic, and I please myself who I have in it. I always have a social worker present'. The complainant then suggested the SW had influenced the consultant against him but the consultant denied that and told him that she had not discussed his case with the SW. The complainant said that he then explained that his FP and the solicitors had suggested that the complainant's wife should also be seen.

21. The complainant and his wife said that the consultation proceeded for about 25 minutes in a very unsatisfactory way. The complainant said that he could not remember specific instances of the consultant being rude but he and the consultant both lost their tempers. The complainant said he left after his wife when he realised that the consultation was pointless. He shook hands with the consultant and the SW and said that it was obvious that neither of them could help him.

22. The consultant dictated a letter dated 18 October to the FP immediately after the incident explaining what had happened, namely the complainant had come to the doorway of the room and had been immediately aggressive and hostile complaining that he had been kept waiting. He demanded that his wife be allowed into the room and that the SW should leave. The consultant had no opportunity to extend the normal courtesies, but she invited the complainant into the room and to sit down but he declined and then entered into a tirade of abuse concerning the SW and pointed his finger at the consultant in a menacing manner. The consultant tried to explain to the complainant the normal procedure for such a consultation but he was not prepared to listen: throughout he made unreasonable demands and tried to control the interview. The consultant told him that as he was so hostile she felt unable to help him. The complainant said that he was prepared to sit the whole afternoon. The consultant several times asked him to leave as otherwise she would be forced to call the police, but as he did not move the consultant went to another room. When she returned the complainant had become quite subdued; he said he was sorry he had wasted her time, shook hands and said that he had hoped that the SW would be able to help. The consultant concluded her letter by saying that she had told the complainant that he should seek further advice from the FP.

23. The consultant told our investigator that she had not refused to allow the complainant's wife to be present. The FP's referral letter was for the complainant only and the consultant's intention was to see the complainant first, then his wife and then perhaps to see them together. She knew nothing about the solicitor's wishes in the matter. Only the consultant's name appeared on the appointment card as it was her clinic. If, as in this case, she would want the SW to be present, her practice was to introduce the SW and say why he was there. Invariably patients agreed. The SW was highly skilled and she had a very high opinion of him.

24. The consultant emphasised that patients were often hostile because they were anxious and that her training and experience had taught her how to deal with hostile people but she was rather nervous when the complainant made his outburst; it was in her opinion much more difficult to deal with violent patients than ones who were just psychopathic. The situation was so serious that she wondered whether she ought to leave the SW to handle it while she got help. She had said that she would call the police because patients were waiting to be seen and were being caused considerable inconvenience. But she did not in fact do so. She went to another office and when she returned to the consulting room the complainant had changed completely and he had apologised for wasting her time. She dictated her report immediately.

25. The County Council's Director of Social Services, who was the Deputy Director at the time of the complaints, told our investigator that the presence of social workers at consultants' interviews was very common in many specialities and very necessary in psychiatry. As a normal procedure patients would be introduced to the social worker and told the reason for his presence, but the ultimate decision about whether or not the social worker should stay was the consultant's.

26. The SW told our investigator that he did not have any prior knowledge of the complainant's appointment to see the consultant, nor of any objection

the complainant had to him personally. He said that if he was to be at an interview the consultant would introduce him to the patient and ask if the patient minded. He could not recall an objection. If there was one he would leave on a tacit indication from the consultant. Sometimes he felt it advisable to stay because of possible physical danger or as a witness in a difficult matter. The SW said that immediately the complainant came in he was aggressive. The SW was surprised to see the complainant's wife because he thought she was away and also by her change of attitude towards her husband. The interview proceeded as described and at the end the complainant shook hands with him and was most effusive in his thanks. The consultant immediately prepared her notes.

27. The sister told our investigator that she could not recall the incident on 16 October at all although she worked in the room next to the consultant's she heard nothing that she could remember. It was normal for the consultant to see the patient, then the spouse and then see them together. She said that she thought the allegation that the consultant shouted was totally uncharacteristic: she had never heard her shout at anyone, patient or staff.

28. Our investigator also spoke to a health visitor who arrived just after the incident and who had seen the complainant and his wife immediately after they had left the consulting room. They had explained their concern to her, and she had gone to see the consultant who seemed to be in a rather nervous state.

Findings

29. I am completely satisfied that the consultant after having discussed the procedure to be followed with the complainant and his wife would have allowed the complainant's wife to be present. There is no justification whatever for this complaint (3*c*) and I dismiss it accordingly. Moreover I similarly reject the other complaints (3*d* and *e*) for I consider the consultant had every reason to act as she did.

(f) *Complaint about the AHA's replies*

30. The complainant and his wife's letter of complaint dated 19 October 1978 enclosed individual statements by them about the events complained of and was sent to the administrator of the hospital, the chairman of the FPC and the Director of Social Services. Only in respect of the AHA did the complainant express dissatisfaction with the handling of the complaint. The AHA sent acknowledgements on 20 and 23 October, and on 25 October wrote to the complainant saying that as the complaint referred mainly to social workers it should be made to the County Council. To this the complainant replied on 2 November that as the consultant was 'an AHA employee' the complaint was for them to answer. His letter addressed to the Chairman of the AHA, detailed nine questions and concluded with a statement that a copy was being sent to my predecessor as the complainant did not expect to find the AHA's reply satisfactory. The Area Administrator (the AA) answered on 27 November explaining that the chairman was recovering from a serious operation and that the consultant was also on sick leave and assuring the complainant that a reply would be sent at the earliest possible time. The consultant replied to the AHA on 15 May 1979, and the chairman of the AHA wrote to the complainant on 25 May 1979 apologising for the delay, and answering each of the specific questions. He referred to the complainant's expectation of dissatisfaction with the reply which, he said, tended to prejudge the reply before it was made.

31. The AA told our investigator that he had regarded the complaint as predominantly relating to social services and to clinical matters; it was impossible to comment about the conduct of the interview until the consultant was available. The AA said that there was no specific administrative routine monitoring of out-patient waiting times at the clinic but a careful scrutiny of complaints was made. The AHA had had no other complaint about the clinic from a patient or from the Coummunity Health Council.

Findings

32. I do not criticise the AHA for the delay in replying to the complaint as they had to wait for the consultant to return from sick leave. They replied fully and promptly thereafter. I therefore dismiss this complaint.

Conclusion

33. None of the complaints has any validity except for the one about clinic waiting time. I can only conclude that the complainant's interpretation of events and his action in complaining as he did were prompted by the stress which he was experiencing at the time.

Case No. W.436/78–79 – Hospital admission and lost medical records

Complaint and background

1. The complainant states that in 1977 he had two operations on his left eye at the hospital, one in January and one in August 1977. After the second operation he suffered from double vision in the eye and he then attended the hospital as an out-patient. After nine months' treatment he was told that, in the opinion of the consultant ophthalmologist (the consultant), further surgery was necessary and he was put on the waiting list for admission to the hospital. In the meantime he attended as an out-patient; he was seen in the late summer of 1978 by a 'doctor' who had not seen him before and, the complainant said, she expressed the opinion that further surgery was unnecessary. Two weeks later he received a letter notifying him of admission to the hospital on 25 September 1978.

2. The complainant says that when he reported on that date he was told that his medical records had been lost and that his operation might not therefore take place as planned. On the following day his records were found but a decision was taken not to operate and he was discharged. He said he was told he should not have been sent the letter of admission in the first place.

3. He complains that:

(*a*) there seemed to have been a muddle over his admission to the hospital;

(*b*) the hospital had lost his medical records; and

(*c*) he is not satisfied with the response by the Area Health Authority (the AHA) to the representations addressed to them by his wife.

Investigation

4. During the investigation I obtained the comments of the AHA and I have examined these and other relevant papers. My officer interviewed members of the medical, nursing and administrative staff concerned with the complaints. He also met the complainant.

(a) *The complaint that there was a muddle over his admission*

5. The complainant's wife first wrote to the hospital on 29 September 1978 explaining the history of her husband's eye problems and complaining about the treatment he had received there. She said that the two operations in January and August 1977 had caused her husband considerable pain and that he had had to have some four and a half months off work. Both she and her husband had found the prospect of a third operation difficult to accept after all the treatment he had already received and they were concerned about the loss of his earnings because of further time off work. They had, however, eventually accepted the decision that the operation was desirable.

6. She went on to say that, when her husband, as an out-patient, saw a 'doctor' he had not previously seen, she had expressed the opinion that he did not need an operation but further exercise and experiments with different lenses. The complainant told her that he had been receiving this treatment for the past nine months and that he had understood that, short of an operation, no more could be done. The complainant's wife said her husband left the hospital thoroughly confused and that neither of them knew what would happen next. It was only two weeks later that the complainant received a letter of admission for 25 September 1978.

7. In her letter to the hospital the complainant's wife then described what had happened after her husband's admission. She said that when she visited him on the evening of 25 September 1978 he had told her that his medical records had been lost and that a doctor had said that they might not be able to operate, as planned, on the following day if they were not found. However, they would continue as if the operation was to go ahead until the consultant had made his final decision. On the following morning, the complainant's wife said, her husband had telephoned her and told her that the operation had been cancelled. When she arrived at the hospital at about 4.30 pm her husband was waiting to go home and he told her that, although his hospital notes had been found, the doctors had decided not to operate. She said that her husband had been told by a doctor that a mistake had been made by the appointments department and that he should not have received an admission letter.

8. The complainant told my officer that he had not taken much notice of the opinion of the 'doctor' at the out-patient clinic (paragraph 6) because it was expressed after a five-minute appointment with someone he had not seen before, whereas the decision to operate on his eye for a third time had been the culmination of many months' attendance at the out-patient clinic. He said that the 'doctor' said nothing to lead him to believe that she would try to arrange a cancellation of the operation and it was no surprise to him when he received the letter of admission. Indeed he told my officer that, after the out-patient clinic, he had telephoned the hospital to find out the likely date of his admission because he wanted to make arrangements to go away for a short while.

9. The complainant said that when he was admitted to the hospital on 25 September 1978 he was examined by two doctors one of whom, he thinks, mentioned that his notes had been lost. The nursing notes for 26 September 1978, the day of the planned operation, include the following entry 'Nil/by mouth from midnight; prepared for theatre'. He said that at about 11 am a

sister told him that the operation was cancelled; and about an hour later he was told that he was being discharged. He told my officer that no explanation was given for the cancellation and that he had not seen the consultant throughout the time he had been an in-patient.

10. My officer interviewed the staff who had seen the complainant between the time when he was put on the waiting list and the time he was admitted. These members of the staff were orthoptists (not doctors). One of them told my officer that she had formed the opinion that it might have been possible to deal with the complainant's condition without an operation but with conservative treatment. She could not remember what she had said to him or whether she had left him with a feeling of uncertainty about whether his operation would go ahead.

11. The consultant told my officer that, although he did not himself see the complainant during the few months before the proposed operation, he had discussed the complainant's treatment with his medical staff and on 31 July 1978 had put him on the waiting list for an operation. When he was admitted, he was examined by the senior house officer, who has since left the hospital, and a locum registrar. The consultant said that as a result of this examination the two doctors formed the opinion that it might be possible to correct the complainant's vision by means of lenses. In the light of what they told him he took a clinical decision to call off the operation. (And there is a note by him in the clinical records which reads: 'Try prisms before surgery.') He agreed that it was understandable for the complainant to have been upset by the change in treatment, having mentally prepared himself for an operation but, he said, the *final* decision to operate is never taken until the patient is admitted and it is obviously better to put off an operation if there is a chance that alternative treatment might be successful.

12. My officer also interviewed the ward sister who remembered being unhappy about the situation when she went off duty at 5 pm on 25 September. The suggestion, she said, had been made that there should be conservative treatment rather than surgery but that a final decision was awaited from the consultant who, at that time, was 'not in the picture'. The sister returned to duty at 11 am on the following day and said she heard that the operation had been postponed. When she had spoken to the complainant after lunch that day it was obvious to her that he was upset and annoyed that no explanation had been given him. The nursing notes record the fact that the complainant was 'rather annoyed that Doctor did not explain to him the reason for cancellation'. The sister told my officer that such a complaint would normally have prompted her to arrange for a doctor to speak to the patient but she could not recall in this case whether this, in fact, happened. Neither the locum registrar nor the senior house officer, both of whom discussed the case with my officer, could recall whether an explanation was given to the complainant although both accepted that it should have been. The consultant told my officer that an explanation was given. He took a decision, in the light of advice, not to operate and arrangements were made for the complainant to attend the orthoptist's clinic on the afternoon of his discharge. The consultant believed that this could not have been done without some sort of explanation being given to the patient. He had seen the patient himself but thought it was probably only briefly and he could not remember exactly when.

He remembered talking to the ward sister about the complainant's dissatisfaction on the afternoon of his discharge but by that time he had left the ward and no further explanation could therefore be given to him.

Findings

13. Although there are some disparities between what the complainant's wife told the AHA and what her husband told my officer, I am sure that the complainant was first given to understand that he would be having the operation; that doubt was then cast on this decision; that, by virtue of his admission notice, he believed he would have the operation; and that lastly he was told that he was not to have it. I am unable to resolve the question of whether an explanation was given to him and, if so, by whom. But what is quite clear is that he did not understand why his operation had been cancelled and that whatever explanation may have been given to him he failed to grasp it fully.

14. In taking the decision not to operate, the consultant was exercising his clinical judgement, and this I cannot question. I do not uphold the complaint that there was a muddle over admission, but I am not surprised that the complainant thought so since, clearly, he did not understand reasons for the change in his treatment. I invite the AHA to consider, in consultation with the District Medical Committee, how such communications can be improved. Nothing demoralises a patient more than to be led to believe that some treatment (and especially some surgical intervention) will alleviate his condition and then to be told that it is delayed or abandoned.

(b) *The complaint that the medical records were lost*

15. The complainant told my officer that he had learnt from a doctor on the day of his admission that his hospital notes had been lost and, from the ward sister, on the following day, that they had been found.

16. The senior house officer told my officer that the notes were not available to him when he saw the complainant on 25 September and I have seen a medical note written by him on a loose-leaf sheet which starts: 'Please trace the notes'. The consultant told my officer that, as far as he was concerned, there had been no difficulty over the medical notes. They had been available when he wanted them.

17. My officer interviewed members of the administrative staff in the Information and Admission Room who remembered that the notes had been missing when the complainant was due to be admitted to the hospital. The notes were booked out to the ward to which he was being admitted, but were eventually found – they thought by the ward clerk – in the medical records department on the morning of 26 September 1978. My officer interviewed the ward clerk who remembered helping to look for the notes and finding them in the medical records department on that morning.

Findings

18. There is no doubt that the medical records had been mislaid when the complainant was admitted, but they were found on the morning of the following day. To that extent the complaint is well-founded; but the consultant who took

the decision to cancel the operation evidently had the records at hand and I do not therefore think that the complainant suffered any injustice as a result of their being mislaid for a time.

(c) *The complaint about the response by the AHA*

19. The complainant's wife was not satisfied with the reply to the letter she wrote to the hospital on 29 September 1978 and she wrote again on 7 November 1978 to say so. The replies dated 31 October and 10 November from the District Administrator dealt only with the clinical decision not to operate, and did not adequately answer either the complaint about the several changes proposed in treatment or the temporary loss of the medical records.

Findings

20 I am not surprised that the complainant and his wife were not satisfied with the responses they received from the AHA which did not adequately answer their questions; and I uphold this part of the complaint. However, I am glad to record that when the Area Administrator, who had not previously known of the complaint, learned of my investigation and received my request for his comments, he reviewed the case and took the trouble to make a much fuller reply to the complainant and apologised for the omissions in the previous letters.

Conclusions

21. The complainant was very understandably concerned about his eyesight and his confidence in what was being done for him was undermined by the conflicting information he was given about his treatment. I have given my findings in paragraphs 13, 14, 18 and 20 of this report. I am in no doubt that he did suffer unnecessary worry either because he failed properly to understand any explanation given to him or because he received no explanation at all. In view of the conflict of evidence I cannot say which; but, either way it is regrettable. The Area Administrator has already apologised for the inadequacies of the original replies sent to the complainant's wife and I do not consider that they are called upon to do any more.

Case No. W.508/78–79 – Attitudes of nursing staff at maternity unit and failures in communication

Complaint and background

1. On 14 July 1978 the complainant's wife was admitted to the maternity unit (the unit) of a hospital to prepare for the birth of their first child. The complainant says that:

(*a*) the nursing staff were terse and rude both to his wife at the ante-natal clinic and later to himself during her confinement; and, despite being previously informed that with the permission of the doctor concerned he would be allowed to remain with his wife throughout her labour and confinement, this was denied to him;

(*b*) a doctor, who had a note-pad but was not helping in any way, was unnecessarily present during confinement; and

(*c*) his wife was given conflicting information about their child's health after her return to the general ward.

Investigation

2. During the investigation I obtained the written comments of the Area Health Authority (the AHA) and I have examined these and other relevant documents including medical and nursing notes. One of my officers interviewed members of the AHA's staff involved. He also met the complainant and his wife.

(a) *The complaint about the attitudes of the nursing staff and about the complainant not being allowed to remain with his wife*

3. In correspondence, and when interviewed by my officer, the complainant said that both he and his wife had been looking forward to sharing the experience of the birth of their first child but in the event they considered they had been totally let down by the attitudes of the nursing staff. As an example of this, the complainant's wife said that when she first attended the ante-natal clinic a nurse had enquired, because of her age, whether or not the pregnancy had been an accident – she was then 33.

4. The complainant told my officer that he did not regard this as serious and would have 'turned a blind eye to it' but for subsequent events. He went on to explain that on 14 July when he took his wife to the hospital for admission they both met one of the unit's doctors and a sister to discuss the proposed delivery by induction the following morning and, although he himself was not in favour of this method of delivery, they agreed to accept the advice they were given. The complainant expressed the wish to stay with his wife throughout her labour and confinement. The doctor explained to him that there was a possiblity of a forceps delivery in which case he would be asked to leave the labour room. The complainant said he very much wanted to see the complete delivery and mentioned the fact that having spent a few years at a veterinary college he had some knowledge of such matters and was not squeamish. The doctor told him that he himself would not be on duty when the complainant's wife was expected to deliver but he felt sure that if he asked the doctor in charge at the time he might accommodate his wishes. The sister also told the complainant that the decision to allow him to remain would rest with the doctor but she thought he might be allowed to stay providing he kept out of the way.

5. When the complainant arrived at the hospital the following morning he found that his wife was being taken to the labour ward. He spoke to the sister, who he understood was in charge of the labour ward, and told her that he objected to induction and that he would blame the hospital if anything went wrong. He then learned that his wife was to be taken back to the ward as it was not intended to proceed with the induction. He said he spoke again to the sister and explained that he and his wife had accepted the doctor's decision to induce and he had only been registering his personal objection. Preparation for induction was then recommenced.

6. The complainant said that when the induction procedure was started and an epidural anaesthetic was being given to his wife he was surprised that he was asked to leave the labour room. The doctor, however, was unsuccessful in giving the anaesthetic and the consultant anaesthetist had to be called. It was some time before he came, so the complainant rejoined his wife. The consultant did not object to his presence but a nurse ordered him out of the room while the anaesthetic was given. He said that thereafter from time to time he was ordered

out of the labour room in what he described as a 'most peremptory manner' without reason or explanation other than to be told that the doctor was coming. He said that when delivery started and forceps were used he was asked to wait outside, although he might return once the baby's head had emerged. The complainant said he tried to ask the doctor if he had any objection to his continued presence but the sister snapped – 'hospital rules'. He therefore left, although his wife, who was in considerable pain, begged that he be allowed to stay. He waited outside and became more concerned as another doctor was summoned to help with the delivery. Shortly afterwards the sister told him that he should have been in the waiting room. He admitted that by this time he was feeling somewhat incensed about the situation as the doctors appeared to be experiencing difficulty with the delivery and he remarked – 'have you messed it up then?' The sister replied that there was no need for him to react in that way. Shortly afterwards the same sister came out of the labour room and told him brusquely to come immediately 'if he wanted to see the body born'. The complainant thought that a remark like that was uncalled for.

7. My officer spoke to the nursing staff who were on duty 24 January 1978, the day the complainant's wife first attended the ante-natal clinic. None of them could remember the incident of rudeness complained about, but remarked that there would have been no valid reason for even querying the pregnancy on account of the wife's age as 33 years is not considered old. One of the sisters told my officer that, for background information, the staff need to find out amongst other things, whether or not any pregnancy was planned, but, if the information was not volunteered, personal questions were asked as tactfully as possible.

8. The senior house officer (the SHO), who discussed the proposed induction with the complainant and his wife on 14 July, told my officer that he had pointed out to them that, although it was the hospital's policy to let fathers stay to watch births if they wished, there were occasions when it was more practical and less embarrassing for all concerned if they left the room – for example during a forceps delivery and when stitching the mother after the birth. The SHO said he had explained to the complainant that it would be the doctor's final decision whether or not he stayed in the delivery room. But, as I find, it is the nursing staff who as a matter of routine ask the husband to leave at an appropriate time.

9. The sister who was on duty in the labour ward on the morning of 15 July told my officer that the complainant had expressed to her his strong disapproval of birth by induction. She had then seen his wife who was in a tearful state and she explained to her that it was a free decision whether or not to go ahead with the induction and she asked her if she wished to do so in view of her husband's evident opposition to it. The complainant's wife then started to collect her things to return to the general ward; but when the husband heard of this development he changed his mind and told the sister that he understood it was necessary to go ahead with it. The sister said that, later, when the registrar came to administer the epidural anaesthetic he (the registrar) asked the complainant to leave the room which he did without any fuss although he had said earlier on that he wanted to be with his wife all the time.

10. In a written statement made not long after the complainant first complained to the hospital, the sister who took over at 8.30 pm on the evening of

15 July said that the complainant had been periodically asked to wait in the visitors' room while his wife was being either internally examined or being given a bedpan. She said that he did so after strong objection. Later when the house officer (the HO) decided that delivery would involve the use of instruments, the sister asked the complainant again to sit in the visitors' room. She said he insisted on staying but she had apologised and explained it was against hospital policy for husbands to witness deliveries in such circumstances. The complainant told her that if the doctor agreed he would then be entitled to remain. The HO however decided that the complainant should wait outside in the corridor but that he would be allowed to attend should the delivery by forceps prove straightforward. A little later the sister asked the registrar, who had been called to assist, if the complainant could witness the delivery but he said that he ought to remain in the visitors' room until the baby's body was being delivered which he could come and see. The sister said that she then explained this to the complainant who, having remarked that none of the doctors knew what they were doing, retired reluctantly to the visitors' room. The sister said that after the baby's head had been delivered she hurried out to fetch the complainant to tell him that he could watch the baby's body being delivered. She said that he was not very pleased and questioned the point of witnessing the remainder of the birth once the head had already been delivered. The evidence given by the sister about incidents in the labour ward and the delivery room has been substantiated in a written statement by the staff midwife who attended the complainant's wife during her confinement. She also said that whilst still in the delivery room the complainant's wife apologised to her and the registrar for her husband's attitude and behaviour.

11. The nursing notes for the morning of 15 July record '0900 hrs Patient very upset. Husband says she is not to have induction unless he is there. He is being very difficult . . . Apparently seen by [the SHO] yesterday and reason for induction explained. Labour ward informed'. A further record reads – '1430 hrs . . . Patient very agitated by husband's behaviour and awkwardness towards medical and nursing staff'. Reference was also made by medical staff in the clinical notes to the complainant's attitude.

Findings

12. I have been unable to establish what was said or how it was said to the complainant's wife when she first attended the ante-natal clinic. I have found that nurses are (very properly) required to obtain background information from patients first attending the clinic and obviously this will sometimes be of a sensitive nature. I have been assured that any questions are put with tact and diplomacy and I do not believe that the nurse concerned was deliberately rude. But it may be that on this occasion she put a question rather clumsily.

13. The relations between the complainant and the nursing staff got off to a bad start on 15 July when he reiterated to them his opposition to induction at the time his wife was in the labour ward for this procedure – to which he had previously agreed. This led to misunderstanding and temporary confusion for which I find the complainant bears the main responsibility. The complainant has said that he was told that he could remain throughout his wife's confinement provided the doctor involved agreed and, accordingly, he expected to receive his

instructions from a doctor. But I have been told, and I accept, that in practice it is the nursing staff on behalf of the doctors who generally request husbands to leave. In asking the complainant to leave at certain stages of his wife's confinement the nurses followed the hospital practice. With the benefit of hindsight, I think it was unfortunate that this was not made clear to him, but I believe that, for the most part, the nurses were simply relaying to him the decisions of doctors who were greatly preoccupied. It must have been obvious to the complainant that the delivery of his son was at times not straightforward and I think it was unreasonable to expect the nurses whose main concern and duty was for the care of the mother and baby to engage in any but the briefest explanations to him. And as to his complaint about the use of the phrase – 'see the body born' – I consider that, as he had already been told that he would not be allowed to witness the delivery of the head, but could join his wife to see the rest of the birth, the sister's phraseology was perfectly understandable. I am in no doubt that the complainant was extremely unreasonable and I do not uphold his complaint.

(b) *The complaint that a doctor was present unnecessarily*

14. The complainant said that during his wife's confinement a doctor was present who had a note-pad but was not helping in any way. He said that he could not recall being told that his wife would be used for demonstration or training purposes.

15. The doctor in question was a senior house officer in paediatrics. He told my officer that it was the hospital's policy that a paediatrician should be present at all instrumental deliveries. He explained that naturally his assistance was not required until after the actual delivery, as until that time the obstetrician was the responsible doctor. His job was to examine the baby when it was born. He did not know why he should have had a note-pad as had been alleged but he thought he might well have been studying the case notes while he was waiting for the complainant's wife to deliver.

Findings

16. I am satisfied that the doctor referred to in this complaint was present in accordance with the hospital practice to examine the baby as soon as it was born.

(c) *The complaint that the complainant's wife was given conflicting information about the baby's condition*

17. The complainant's wife told my officer that after the birth (at about 3.30 a.m. 16 July), her son was briefly held over her and taken away. She then had stitches and was given a cup of tea; at about 5.30 am she was taken to the general ward. She asked a nurse to see her son as she was very anxious about him but the nurse replied that he was ill. Just before lunch he was brought into the ward and the nurse accompanying him said that there was nothing wrong with him. The complainant's wife said that until then nobody had volunteered any information about her son's condition since she had been told he was ill.

18. The senior house officer in paediatrics told my officer that the clinical notes showed that after the delivery, mucus had been extracted, the baby had been given oxygen for three minutes and then transferred to the special care baby unit for routine observation, as with all forceps deliveries. He explained that

babies are generally observed there for a few hours but he was unable to say precisely when the complainant's wife would have been reunited with her son on the main ward. He said that the clinical notes showed that the baby's condition was satisfactory and there had been no cause for any concern. (I have confirmed this from my examination of the notes.)

19. None of the nursing staff on duty in the general ward could recall the complainant's wife. The district nursing officer told my officer that although it was not the designated responsibility of either the medical or the nursing staff, it was essential that explanations were offered to a mother when her baby was taken to the special care unit and also that she was reassured about the baby's progress from time to time.

Findings

20. There is no doubt that in accordance with the hospital's usual practice when babies are delivered with the help of instruments the baby was taken to the special care unit for routine observation. It was most unfortunate if, as I believe, a nurse referred to him being ill when that was not so. The reasons for his routine transfer to the special care unit should have been explained to the mother and reassurance given from time to time about his condition. I have been told that this task is not a designated function of any particular member of the delivery team. If such information is not given, considerable distress can clearly be caused to the mother, as I think it was in this case. I regard this as a defect in the hospital's procedure.

Conclusions

21. I have not upheld the complaint by the complainant about the way he himself was treated by the hospital staff. No doubt he was under emotional stress at the time, but I consider that to a very large extent he engendered the incidents of which he complains. I think, however, that his wife was not kept adequately informed about her baby's progress or why he was taken away from her almost immediately after the delivery. I am glad to record that the AHA have recently told me that they are taking steps to ensure that mothers are kept adequately informed in future.

Case No. W.585/78–79 – Cancellation of hospital admission for operation

Complaint

1. On 23 January 1979 the complainant who suffers from glaucoma was due to be admitted to hospital (the hospital) for an operation on his right eye. He complains that his admission was cancelled at short notice and that he was given no indication when he could expect to receive the treatment he needed.

Investigation

2. During my investigation I obtained the written comments of the Area Health Authority (the AHA) and I saw other relevant papers. One of my officers interviewed the consultant ophthalmic surgeon (the consultant), his former secretary, the chairman of the hospital's Medical Staff Committee (the MSC) and administrative staff of the AHA. He also met the complainant and his wife.

3. In an interview with my officer the complainant said that he suffered from glaucoma and since this condition had been diagnosed he had attended hospital every three or four months as an out-patient for it to be monitored. He believed that he had inoperable glaucoma, but at a routine appointment on 14 December 1978 the consultant advised him that an operation should be performed on his right eye and that this could be done after Christmas. The complainant, who was naturally very concerned about his sight, had occasionally gone to see a consultant in London privately for a second opinion; on 2 January 1979 he saw the London consultant who confirmed the need for an operation and said it should be carried out as soon as possible.

4. On 3 January the complainant wrote to the consultant at the hospital and asked him to proceed with the operation as soon as convenient. The consultant replied on 9 January and said that the complainant's name had been placed on the waiting list and that he would be sent for in two weeks' time. A few days later he received official notification from the hospital that he was to be admitted on 23 January. But on 22 January a one day strike by hospital ancillary staff took place and he received a telephone message to say that his admission had been cancelled because of the industrial action.

5. The complainant's understanding was that the operation was essential to preserve his sight and he assumed that he would be on the emergency list and would be going into hospital as soon as there was a bed available. On 25 January he wrote to the consultant and asked to know how long his eye operation could be delayed and, should the disruption continue, whether there was any alternative course he could take. On 31 January the consultant telephoned and told him that the operation should be performed within eight weeks and meanwhile he (the consultant) could only sit out the industrial action. The consultant said that only matters of life and death were regarded as emergency cases and none of his patients who needed eye operations was classified as an emergency. The complainant said that the news from the consultant increased his anxiety about whether his sight would be saved and he was worried that if treatment to his right eye was much delayed there might be insufficient time for him to recover before an operation was needed on his left eye.

6. On 3 February the complainant saw his family practitioner who did his best to be helpful and made enquiries about referring him to another hospital for the operation but learnt that the industrial situation was similar elsewhere.

7. On 5 February the complainant wrote to the general secretary of the Trade Union who were mounting the industrial action (the union) to point out that people could go blind if they were not treated as emergency cases. In his letter the complainant said: 'Despite the fact that unless I have the operation very quickly now my eyes will deteriorate to the point when no operation will be possible, the surgeon says that under emergency regulations, [the union] and not the surgeon consider my case as urgent but not an emergency and I cannot be admitted'. The complainant told my officer that he believed that decisions about the admission of patients had not been taken by the consultant himself and although the consultant had not mentioned the union by name he had drawn what was to him a clear inference that they were responsible.

8. On 6 February the complainant's wife telephoned the consultant's office and, in his absence, spoke to his secretary. The secretary said that the complainant had been one of two glaucoma patients due to be admitted on 23 January and that everyone knew that there should be no delay in treatment. The secretary said that the consultant had been told by the union that he would be called before a committee and asked to explain his actions if he admitted the two patients.

9. The complainant said that since there had seemed to be no end in sight to the industrial action he started seriously to consider having private treatment. Eventually he decided to take this course and he informed the consultant by telephone. The operation was performed in London on 1 March. On 12 April the complainant attended hospital for a routine out-patient appointment and the consultant, who was annoyed that in his correspondence the complainant had described his operation as an emergency when, in his view, it was not, revealed that the other glaucoma patient due for admission on 23 January had in fact been operated on two weeks after the complainant's private operation.

10. The papers I have seen show that on 9 January the union gave formal notice to the AHA that they were instructing their members to participate in a National day of Industrial Activity on 22 January, following which there was to be further industrial action. On 11 January the District Management Team (the DMT) for the Health District (in which the hospital is situated) met and resolved amongst other matters that the admission of in-patients other than emergency cases should cease on 17 January until further notice. The reason for this decision was to safeguard both those patients already under care as well as those likely to be admitted under the emergency arrangements. (The union members, in fact, returned to normal working on 26 February.)

11. The district administrator told my officer that the DMT's decision was conveyed to the administrators in the hospitals in the district who had the task of implementing it. The unit administrator at the hospital confirmed this and in an interview with my officer he emphasised that while it was for the management to negotiate with the unions on the level of services and supplies they were willing to provide, decisions about the admission of individual patients or categories of patients were a matter for the medical staff. The district medical records officer said that in consultation with the consultants and acting *only* on their authority his staff had initially cancelled non-emergency admissions 'booked' from 17 January (and some earlier) until a day or two after 22 January. He also said that the terminology used in the hospital to denote priority was 'urgent', 'soon' and 'in turn'. The complainant's classification was 'soon'.

12. A higher clerical officer in the admissions office told my officer that the consultant responsible for the complainant's care had not had any patients due for admission on 22 January but two patients (one of which was the complainant) were booked in for 23 January and she would have routinely been asked on 15 January to send these patients their admission papers. But at this time she had been engaged in cancelling other consultants' admissions and as far as she can recall she queried the two admissions because it was quite clear that the industrial action was going ahead. She was told however that the two patients were urgent cases and their admissions should not be cancelled. But on 22

January she was instructed that the admissions were to be cancelled and she telephoned the complainant who was understanding and seemed to be prepared for the news.

13. In an interview with my officer the consultant gave him the information recorded in this and the following four paragraphs and explained that glaucoma which causes a rise of pressure within the eye cannot be cured but can be arrested and that treatment is primarily by medication; without treatment glaucoma leads to blindness. When he saw the complainant on 14 December 1978 he formed the opinion that an operation on his right eye was necessary as the pressure was not being adequately controlled and the operation would carry less risk to the patient than continuing medication. There had been no risk of rapid deterioration in the complainant's sight and it had not therefore been necessary to urge him to agree immediately to the operation. Glaucoma patients are seen every three months and the consultant said he would have pressed the complainant harder at the next appointment had he not in the meantime (on 3 January) decided to accept his advice.

14. Glaucoma patients are put on the waiting list with high priority and they are usually admitted within four weeks as the prognosis does not remain constant; he had in fact placed the complainant's name on the waiting list on 9 December in anticipation of him agreeing to the operation. The consultant explained that his practice is to examine the waiting-list every Monday and to select patients (who are notified the same day) for admission the following week. When he wrote to the complainant on 9 January he had however given him advance notice of his admission in two weeks (ie on 23 January) before his admission papers were despatched (on 15 January).

15. The complainant had been one of two glaucoma patients due for admission on 23 January. He had known that industrial action was threatened but he was optimistic and he had not wanted to lose an operating list when his non-urgent patients had to wait a year for surgery. He decided therefore to let the two admissions stand in spite of instructions that all admissions to the hospital other than emergency (and obstetric) cases should cease.

16. On the morning of 22 January he had received a personal letter (a copy of which I have been unable to trace) from the chairman of the MSC which, so far as he could recall, said that if the two patients he had booked for admission the next day were not emergencies he would have to answer to his consultant colleagues for his actions in using limited resources in this way. He had examined his conscience and as the admission of the patients 'was not a matter of life or death' he took a personal decision to cancel the admissions. He had telephoned in response to the complainant's letter of 25 January and, although he could not recall exactly what he had said he would have pointed out that if the delay in surgery was measured in weeks this would not be damaging to the patient's prospects but, if the delay ran into months it might be different. As far as he could remember he had not told the complainant that he himself had ordered the cancellation of his admission.

17. The consultant explained to my officer that, if the pressure in the complainant's eye had continued unchecked and without treatment, he would after a time have started to experience a gradual and irreversible loss of visual field;

and ideally the operation should be performed before this process starts. If the industrial action had continued he would have called in his high priority patients for reassessment and he had, in fact, almost reached the point of doing so when the action ended abruptly. He said he had not been informed, in advance, of the complainant's private treatment either by the complainant himself or by the London consultant. (He also told my officer that the complainant had taken a second medical opinion on more than one occasion whilst under his care without his prior knowledge.) If the complainant had not been operated on privately and the consultant had found on later examination that his visual field was beginning to contract he said he would have admitted him. (The only record by the hospital of the complainant's decision to have his operation privately is a note by the hospital dated 6 March 1979 (after the operation had been carried out) that the complainant had asked to be withdrawn from the waiting list as he was making private arrangements.)

18. The (former) chairman of the MSC told my officer that before and during the industrial action he, the unit administrator and a senior nursing officer had met daily and at an early meeting it had been brought to his notice that a few consultants were still arranging what appeared to be non-emergency admissions. He had written a personal letter to each of the consultants reiterating the DMT's decision and inviting them to review their actions. The chairman told my officer that the MSC is not a statutory body; his letter had been purely 'advisory' and there had been no question of any consultant being asked to defend his assessment of the priority accorded to an individual patient.

19. In an interview with my officer the consultant's former secretary (who has since left the hospital) said it was her understanding that during the industrial action the chairman of the MSC gave the final ruling whether or not a patient could be admitted. She said that some time after the cancellation of the complainant's admission she had received a telephone call from someone she later identified as the complainant's wife and subsequently she had written a note to the consultant about the call. This note records that in answer to questions from the complainant's wife she had explained that she had agreed with her that the strikers were to blame for the cancellation of her husband's operation, and she had advised her to see the family practitioner about the possibility of her husband being referred for treatment elsewhere. She told my officer that she had also explained to the complainant's wife that the consultant responsible for the patient's care was normally responsible for deciding on admissions but during the industrial action the chairman of the MSC was acting as a 'go-between'.

20. The secretary told my officer she could not remember having said anything about emergency cases being referred to a committee but if she had done so this would have been a reference to the MSC. She said she could understand members of the public believing that the union were deciding which patients could be admitted but this had not been so.

Findings

21. The complainant's operation was cancelled as a consequence of the DMT's decision to restrict the services at the hospital to emergencies only in readiness for industrial action by ancillary staff which had been threatened (and which did, in fact, take place). The decision to cancel his admission in conform-

ity with these arrangements was taken personally by the consultant in his clinical judgement and there is no evidence that the union were involved in any way in classifying his condition as a non-emergency case. Indeed, the complainant himself agrees that the consultant told him at the end of January that the operation should be carried out within eight weeks. And clearly neither the consultant nor the AHA were in a position to say when the industrial action might end.

22. I am in no doubt that the AHA and hospital staff were in great difficulty during the industrial dispute and that many of the staff were faced with problems they had not previously encountered; nevertheless, I think that the complainant was given inadequate information. I have little doubt that the term 'life and death' was used in the information he was given as to what constituted an emergency – it was used to my officer, too – and I think it understandable that the complainant took this to mean that, however long the industrial action lasted, his was the kind of case that would not qualify for emergency admission. I think also, that he was misled into gaining the impression that the consultant did not himself take the decision not to admit him. I cannot resolve the conflict of evidence about whether or not the consultant was told in advance of the complainant's intention to have the operation done privately. I accept the consultant's assurance that he would have reviewed the complainant's condition and would have admitted him for operation should it have become urgent. But I think it a pity that the complainant was not told this.

Conclusions

23. It is common ground that the complainant's operation was cancelled at very short notice, but I am sure that this happened only because the consultant was hopeful, until the last, that he would be able to admit him and I do not find any evidence of maladministration. I uphold his complaint that he was given no indication after the cancellation, of when he might expect to be admitted. While nobody could forecast when the industrial action would come to an end, I think it should have been made clear to the complainant that if his sight became at risk he would be admitted for operation. That this was not done, I do regard as maladministration. The AHA have asked me to convey their apologies to the complainant for the fact that the point was not made clear to him and this I gladly do.

Case No. W.25/79–80 – Circumstances surrounding delivery of child

Complaint and background

1. The complainant's baby was born in hospital on 5 April 1978 but she was dissatisfied with the treatment she received. The first indication the Area Health Authority (the AHA) had of her dissatisfaction was when she telephoned the District Nursing Officer on 23 November 1978. On 6 December the District Administrator (the DA) of the Health District of the AHA wrote to the complainant to tell her that the consultant obstetrician/gynaecologist had offered to meet her to discuss her complaints. She turned down the offer of a meeting but asked for a written reply instead. This reply was sent to her by the DA on 1 February 1979. She was not happy with the reply and, on 22 March, sent a detailed letter containing additional complaints to the DA via the District Community Health Council (the CHC). On 4 April the DA wrote to ask the complainant to advise him which matters in his letter of 1 February she wished

to be followed up. At this stage she asked me to look into her complaint because she thought the DA was 'prevaricating'. I made enquiries of the AHA and learned that it was intended that a full enquiry would be made into the detailed complaints. I therefore informed her that I was not prepared to investigate the matter until the AHA had themselves had an opportunity to investigate and reply. The DA carried out an investigation and replied on 7 June. On 14 June the complainant wrote to me and said that statements made in the DA's reply were not true and asked me to investigate. A number of the complaints were outside my jurisdiction but after one of my officers had interviewed her I agreed to investigate her complaints that:

(*a*) when she was planning to have a second child she enquired locally about the Leboyer method of delivery and was told that it could not be made available to her;

(*b*) the delivery room at the hospital was unacceptably noisy;

(*c*) the delivery sisters were rude to her;

(*d*) the acting registrar (the registrar) curtly ordered her husband out of the room and left it himself when her husband refused to go;

(*e*) that communications between the medical staff and herself about the method of delivery and treatment were very poor;

(*f*) that the consultant in charge of her case was rude to her.

Investigation

2. During the investigation I obtained the written comments of the AHA and saw the documents relevant to the complaint. My officers interviewed the nursing, medical, and administrative staff concerned and talked to a patient who had been on the ward at the time. One of my officers also met the complainant.

(a) *The complaint that the Leboyer method of delivery was not made available*

3. The Leboyer method of delivery emphasises the sensitive care of the baby in that its eyes should not be exposed to bright light straight away; noise should be kept to a minimum; and skin to skin contact between baby and mother should be made as soon as possible. In practical terms, this means that there should be subdued lighting in the delivery room, that everyone involved with the birth should speak quietly and that the baby should be given to the mother as quickly as possible.

4. The complainant told my officer that her first child had been delivered in this way in London; and when she was planning to have a second child in April 1977 she began to make local enquiries about where she would be able to have her second baby by this method. She said she telephoned the maternity unit of the hospital on a number of occasions but was told that they did not practice the Leboyer method and her requests to speak to a consultant were refused. She also telephoned various other people. At that time she was living elsewhere and her family practitioner agreed to a home confinement and said he would arrange for the delivery to take place as near as possible to the Leboyer principles. But before the baby was born she had moved house and had registered with a new family practitioner who had agreed reluctantly to a home confinement. Both he

and the local midwife knew of her wish for a Leboyer delivery. In the event, there was difficulty in the second stage of labour and she was taken by ambulance to the hospital.

5. My officers interviewed the Community Divisional Nursing Officer (the Div NO) with whom the complainant had already been in touch who said that the complainant had not asked her about the Leboyer method of delivery. She said that the complainant had telephoned her at her office in October 1977 complaining that she had been refused a home confinement by local doctors and midwives. She had therefore gone to the complainant's home accompanied by a local midwife to try to resolve her difficulties. She said that during this interview the discussion centred upon the complainant's wish to have a home confinement. The complainant, she said, had not in fact consulted a midwife at this stage, but had been trying to find a woman doctor to look after her during her pregnancy. At the end of the interview the midwife 'booked' the complainant for a home confinement, and offered to help her to find a woman doctor.

6. The Div NO told my officers that she is sure that the complainant did not ask her about the possibility of having a Leboyer birth, either by telephone or when she visited her at home. However, before the baby was born she moved and was transferred to the care of another midwife. This midwife told my officers that she remembered discussing the possibility of a Leboyer delivery with the complainant and she agreed to try to meet the conditions for her as nearly as possible. She also said that if the complainant had not, unfortunately, had difficulty with the second stage of her labour such as to require an emergency admission to hospital, she would in fact have had a Leboyer delivery because the conditions in her home were as recommended by Leboyer.

Findings

7. I have been unable to find evidence to support or refute the complainant's account of the response to her early local enquiries about delivery by the Leboyer method. But I am satisfied that subsequently the Div NO took a keen interest in the complainant's welfare and did all she could to help her. Indeed, I was impressed by the concern that the community nursing staff showed in their attempts in both areas in which the complainant lived to carry out her wishes about the kind of domiciliary delivery she wanted and I am sure these wishes would have been met so far as possible had complications not arisen requiring her emergency admission to hospital. I do not uphold this complaint.

(b) *The complaint that the delivery room at the hospital was unacceptably noisy*

8. The complainant told my officer that when she arrived at the hospital she was taken to the labour ward or delivery suite where the noise and level of activity 'resembled Piccadilly Circus'.

9. My officers questioned all the nursing staff who were in any way involved in the complainant's delivery about the level of noise in the labour ward. The consensus view (although all were questioned separately) was that no excessive or avoidable noise was being made. The complainant's admission was in the early hours of the morning and there were no other patients in labour. However, most nurses also pointed out that a certain amount of noise in an emergency such as this was inevitable.

Findings

10. This complaint is essentially the complainant's subjective assessment of the conditions prevailing at the time. My only comment now can be that some noise is admitted and was inevitable in the circumstances.

(c) *The complaint that the delivery sisters were rude to the complainant*

11. The complainant told my officer that a delivery sister had told her to, 'shut-up, be quiet – we do things our way here. If you want to be home again by 6.30, you must behave yourself and be good'.

12. The two nursing sisters present at the time of the complainant's admission to the maternity unit categorically deny being rude to her. Evidence was taken from other members of the medical and nursing staff who were either present at the material time or who had experience of working with these two sisters. No one witnessed the alleged rudeness and all the staff questioned found the criticism a most surprising one. Furthermore, the Div NO told my officers that when the complaint was originally made to her by telephone in November 1978 she specifically asked if any of her complaints were about nursing staff and that the complainant had replied that 'all the midwives were wonderful'.

Findings

13. After so long a lapse of time I have been unable to establish exactly what was said to the complainant by the delivery sisters but I find the story in the highest degree unlikely and I am not prepared to accept it in the absence of corroboration.

(d) *The complaint that the registrar curtly ordered the complainant's husband out of the room and left it himself when her husband refused to go*

14. The complainant said that when the registrar arrived at the labour ward he said to her husband, 'you out'. She had then grabbed her husband's hand and said 'don't go again' and to this the registrar replied: 'right then I will'. He then left the room.

15. In the registrar's statement to me he said that it was not in his nature to give people orders. He said that he quietly asked the complainant's husband if he would care to wait in the visitors room. He said he preferred to stay and this was accepted by everyone present and never mentioned again. He in fact stayed throughout the subsequent examination. The registrar also explained that he left the room, first to put on his hospital white boots and apron, which were kept in a cupboard just outside the room; and secondly to read the ante-natal notes so as to familiarise himself with the history of her pregnancy and to see if there was any obvious reason for her failure to deliver. He said that he might not have explained his movements, but that he was not at any time more than a few feet away from the delivery room.

16. My officers interviewed a member of the nursing staff who witnessed this incident and she said that it was the registrar's policy to ask husbands to wait outside while he examined the mother. When he asked the complainant's husband to do this he refused to go. The registrar left the room, she thought, to telephone the consultant. He was not rude or curt to either the complainant or her husband. The registrar was described by most of the nurses concerned with

the case as being 'quietly spoken' but it was said that on occasions they had found his broad Scottish accent a little difficult to understand, and some felt that it was possible that in the stress of the moment this could mistakenly have been interpreted as brusqueness.

Findings

17. As with the last complaint I have been unable to establish exactly what was said to the complainant and her husband. I have little doubt that the registrar asked him to leave the room in accordance with his normal policy but the evidence suggests that this request was not made rudely and that the decision to stay was accepted. It may be that the reasons for the registrar leaving the delivery room were not explained to the patient and her husband, but I would certainly not criticise him for putting his clinical responsibilities first.

(e) *The complaint that communication between the medical staff and the complainant about the method of delivery and treatment were very poor*

18. The complainant told my officer that the registrar had said to her husband: 'I think it will have to be theatre'. The complainant's husband asked if he meant that he wanted to do a Caesarian section and the registrar had replied that he had not said that. The complainant said that, following this exchange she had asked the registrar for her baby to be delivered by ventouse extraction. The registrar had then left to telephone the consultant, who had agreed to come in and do the delivery. The complainant said that no mention was made of a forceps delivery. She did not particularly want this but said that if the registrar had told her that either he could do a forceps delivery straight away or she would have to wait three hours for the consultant to do a ventouse extraction, she would certainly have agreed to a forceps delivery. She said she was left with the impression that the registrar kept her waiting because he did not know what to do.

19. The registrar said in his statement to me that, following his examination of the complainant, he felt that he could have delivered the baby by forceps. She and her husband, however, had told him that a forceps delivery would be quite unacceptable to them. He readily accepted this because it is any patient's right to refuse treatment, and, on examination he had been content that the baby was in good condition despite the long labour. When delivery by ventouse extraction was requested the registrar thought he ought to get in touch with the consultant because it is a method which is rarely used and he himself had had no experience of it. He added that communication with the complainant and her husband was difficult. He said: 'they seemed to be anti-hospital in some way – they were aggressive, and there was an atmosphere of lack of co-operation I had never experienced before'.

20. The sister who admitted the complainant told my officer that a delivery by ventouse extraction had been specifically requested from the outset. She said that she particularly remembered this request because she wondered how the complainant knew about this fairly unusual kind of delivery. The consultant confirmed, during an interview with my officers, that delivery could easily have been carried out by forceps. It was done by ventouse extraction simply to accommodate her wishes.

Findings

21. It is clear that the registrar gained the impression that the complainant was not prepared to have a forceps delivery in any circumstances. If this and other alleged deficiencies arose from any failure in communication I do not believe that any fault lay on the registrar's side.

(f) *The complaint that the consultant was rude*

22. The complainant referred to two instances when, she said, the consultant was rude to her. She said that after the baby was born he got up to leave and said: 'Will somebody do this embroidery for me', and he left. (He was referring to the stitches she required.) Later, when she had been taken to the post-natal ward, the consultant had returned and lectured her for wasting the valuable services of an ambulance.

23. The consultant told my officers that it was quite likely that he would have referred to stitches as 'embroidery', but that that was 'common medical parlance' and certainly not meant in any disrespectful way. He also told my officers that he absolutely denied making any remark to the complainant about the use of an ambulance. He said that hers was a case which had clearly needed ambulance transport. She told my officer that the exchange of words with the consultant about the use of an ambulance had been witnessed by a fellow patient and she supplied my officer with her name and address. When my officer spoke to this witness by telephone she said that she did not recall such an incident. She said she remembered the complainant telling her about her husband being 'ordered out of the labour ward' but she was not a witness to any conversation between the consultant and the complainant, and she did not remember any discussion about the use of an ambulance.

Findings

24. I have found no evidence to support the complainant's allegation that the consultant was deliberately rude to her. Accordingly I do not uphold this complaint.

Conclusions

25. I have found no significant substance in any of these complaints. I think the AHA took considerable pains to help her to have her baby delivered at home. When complications arose, she was admitted promptly to hospital and, despite her and her husband's entrenched views, was successfully delivered of her baby. I am dismayed by her ingratitude and I deplore the great waste of time caused to the staff and the AHA who have much more important things to do than investigating and answering groundless complaints.

Case No. W.28/79–80 – Care and treatment in hospital

The complaint

1. The complainant's disabled husband was admitted as an emergency to hospital (the hospital) on 28 October 1978 in need of intensive nursing care and rehabilitation. However, his condition deteriorated and he died there on 14 February 1979.

2. The complainant alleged that:

(*a*) her husband was not regularly turned by the nursing staff and this caused a deterioration in the condition of his bedsores; he refused to let the nurses turn him because they were unable to do it properly;

(*b*) he was not given sufficient help when given his meals and some of them were cold when served;

(*c*) staff from the ENT clinic were not prepared to visit him in the ward in connection with making a new ear mould for a hearing aid but expected him to visit the clinic;

(*d*) on one occasion, probably early in December, he was left wet, unclothed and unattended on a bathroom hoist for fifteen minutes, with the bathroom windows open;

(*e*) there was a delay of two hours in moving him after Pharaoh's ants had been found in his bed and the bed to which he was transferred also contained the ants;

(*f*) on 14 January the temperature of a water bed on which he was being nursed reached 48°C and a nurse who was asked to adjust the thermostat did not know how to do so;

(*g*) on 10 February there was a delay in meeting the complainant's request for an extra blanket for her husband;

(*h*) she found it difficult to arrange a meeting with the consultant and when she met him he was rude and unsympathetic; a staff nurse who witnessed the argument said to her that the doctor 'had gone too far';

(*i*) injections which caused her husband's feet to swell were only stopped when she drew attention to the deterioration they were causing; and

(*j*) the reply to her complaint by the Area Health Authority (the AHA) was unsatisfactory.

Investigation

3. During the course of the investigation I have corresponded with the AHA and have seen relevant papers from their files, including the clinical and nursing notes. One of my officers visited the hospital and discussed the case with members of the medical, nursing and administrative staff involved. He also met the complainant and her son.

(a) *Bedsores*

4. On 8 February 1979 the complainant handed to the assistant administrator at the hospital a list of complaints about her husband's treatment, including one about bedsores on his back and heels. In a formal letter of complaint to the hospital dated 22 February she said that on his admission to the hospital he had two small red sores on his heels but the skin was not broken, although his feet were swollen. Initially he was nursed in a ward where the care was excellent but he was transferred to another ward where the sores deteriorated and he developed another at the base of his spine. Although it was arranged that he should be turned regularly this was not done and the bedsores increased in size and severity. In his reply of 29 March, the hospital administrator (the HA) said that when the complainant's husband was examined on admission, the medical

staff recorded the presence of sores on the buttocks and ankles. Surgical management of the sores was considered on 31 October but, in view of the patient's extremely poor state of general health, conservative management was advised. After a time he refused to allow the nurses to turn him and insisted on sitting on the sores with his legs hanging over the bed. In consequence the sores became oedematous and despite various treatments, including antibiotics, they continued to deteriorate.

5. In her letter of complaint to me and in discussion with my officer the complainant maintained that on admission to the hospital her husband had only two small sores on his heels. But she admitted to my officer that the skin on one heel might have been broken and said that she only allowed him to go into hospital because she became frightened about the state of his feet. She alleged that deterioration of the bedsores was due to poor management in hospital and said that, although her husband was turned regularly at first, he later refused to allow the nurses to turn him because, she thought, they were not strong enough to do it properly. The complainant's son confirmed this and added that his father asked him on several occasions to turn him.

6. The doctor who examined the patient at home and arranged his admission to the hospital recorded in the referral letter the presence of 'a large ulcerated pressure sore on his buttock' and of 'self neglect pressure sores'. The hospital doctor who examined him on admission on 28 October recorded in the clinical notes that the patient complained, among other things, of buttock sores which had developed about two weeks previously and of swollen ankles; following his examination of the patient this doctor wrote 'large pressure sore on buttock' and 'black necrotic pressure sores on both heels'. On 31 October the pressure sores were examined by the surgical registrar who recorded that one area of the sacral sore was infected and needed desloughing. The clinical notes also show that between 31 October and 6 February 1979, when the patient underwent an operation for the surgical debridement of the sacral sore, doctors in the team of the consultant physician caring for him (the consultant) examined, reported on the condition of and prescribed treatment for these sores on some ten occasions; they also consulted their surgical colleagues three times about the management of the sores. In addition, and apart from normal ward rounds, the patient was examined twice during this period by consultant geriatricians from another hospital who also advised on treatment for the pressure sores. The nursing notes covering the whole of the period record that regular care was given to pressure areas, including regular turning, although the patient was not happy about it.

7. In a written statement dated 13 February 1979 the sister in charge of the second ward at that time (the ward sister) said that after admission the patient had been given total nursing care – two hourly turns, pressure area care, high protein diet, care of catheter, care of pressure sores, care of bowels. However, he became a very difficult nursing problem mainly because he refused to accept medical and nursing advice; he refused to be turned two hourly and sat with his legs hanging over the edge of the bed. The ward sister confirmed this information in discussion with my officer but said she allowed the patient to sit on his bed at mealtimes because he would not otherwise eat. She said that the nurses, who were all qualified, would go round the ward together at set intervals turning patients who required pressure area care but, if the complainant's husband

refused to be turned, the nurses could not forcibly turn him. One of the staff nurses on the ward (the staff nurse) told my officer that sometimes, after allowing the nurses to turn him, he would immediately resume his former position.

8. The consultant made the comment to my officer that the complainant's husband was in a neglected condition on admission, suffering from bad pressure sores and other problems. The consultant admitted patients to both wards in which the patient was nursed and considered nursing care in the second was as good as in the first. He thought it a credit to the nursing staff that they regarded this case as a challenge and devoted so much care and attention to the complainant's husband.

Findings

9. I have found conclusive evidence that the patient was suffering from sores on both his heels and his buttocks when he was admitted to the hospital. The condition of these sores did deteriorate but I have found no fault in the medical and nursing care he received; on the contrary, the evidence shows that a high professional standard of care was maintained, that the nursing staff were capable of turning the patient and that they did so at regular intervals whenever he allowed it. I dismiss this complaint.

(b) *Meals*

10. The complainant said that although her husband was able to feed himself when first admitted, he was later unable to do so and since the staff would not help him he lost a lot of weight. Food, some of which was cold when served, was placed by him and, if left, would be taken away untouched some hours later. The complainant recalled seeing breakfast uneaten by her husband's bed and on one occasion a dish of milk pudding some hours after the previous meal. In his reply the HA said that food was left beside the patient since he was perfectly capable of feeding himself until a short time before his death. Food would be left until he finished with it, but it was unlikely to be left for several hours since the dishes would have to be returned to the kitchen for washing up.

11. The complainant told my officer that her husband was not given the right sort of food and that he lost weight as a result. She said she told the ward sister that when her husband did not appear to be hungry he should have been coaxed to eat and that he should have been put on an intravenous drip when he would not eat at all.

12. In discussion with my officer the consultant said that, although the complainant's husband was overweight on admission, he was in fact under-*nourished* through eating the wrong foods and had already started to lose weight. A special high-protein diet was ordered which, while allowing the patient to continue to lose weight, provided nourishment to enable him to build up the resistance necessary to improve his condition. The staff nurse told my officer that he became upset and difficult if given too much help and would say he was quite capable of helping himself. She explained that food was sent to the ward in insulated containers and was served on plates which were covered to keep it hot. If, however, the meal was cold when served he could have asked at the time for something hot. The ward sister and another nurse separately told

my officer that there were many patients in the ward, including the complainant's husband, who needed help in cutting their food and it was a matter of routine to do so. If he refused to eat his meals, as indeed he did on occasions, he would be offered milk or Complan.

Findings

13. The nursing staff considered that the patient's food needed to be cut up for him but that until a relatively short time before his death he did not want or need more help than this when eating. These were decisions they were entitled to make and I do not question them. I cannot say whether he was served cold food as his wife has alleged but I accept that if this happened the meal could have been changed for one that was hot had he asked a nurse.

(c) *Attendance at the ENT Clinic*

14. In her complaint to the hospital the complainant alleged that her husband's hearing aid was destroyed in hospital and, despite her requests, no action was taken to replace it The HA told her that the staff were aware of the problem and made an appointment for her husband to attend the ENT clinic but he refused to go.

15. When my officer asked the complainant and her son about the hearing aid the complainant said that it was not broken in the hospital but at home when her husband was preparing to go into hospital. She said that her husband himself and her son thought the ENT staff should have visited him on the ward because the journey to the ENT clinic was through draughty corridors.

16. The consultant told my officer that it was untrue to say the ENT staff would not visit the complainant's husband; they were not asked to visit the ward since he was well able to attend the clinic himself and in fact had done so on one occasion but refused to keep an appointment a week later. The ward sister said that she understood the hearing aid was broken at home before the patient's admission to hospital. He had attended the ENT clinic one week but when the porter arrived to take him for his next appointment he refused to go. The staff of the clinic said they were prepared to see him at any time but the ward sister thought he was not particularly interested in having a hearing aid fitted. She told my officer that none of the staff had any difficulty in conversing with him and he appeared to hear normal speech without difficulty. A male nurse on the ward told my officer that he took the complainant's husband to the clinic for his first appointment but that he later refused to attend the ENT clinic following an argument on the ward. He explained that the complainant and her husband had said that they preferred the nursing care in the first ward, but when his transfer back there was arranged the complainant's husband refused to go, became angry and also refused to go to the ENT clinic.

17. It is recorded in the clinical and nursing notes that the complainant's husband attended the ENT clinic on 9 January and treatment was prescribed to clear wax from his ears; another appointment was made for him to attend the clinic on 16 January. The nursing notes show that on that date he was rather uncommunicative and refused to go; that the question of his transfer back to the first ward had been raised with the relatives who had been in touch with the

HA about it, but that meanwhile the patient was to stay on the second ward. The notes also record that his relatives had created difficulties over his temporary transfer to a twin bedded room two days previously.

Findings

18. I find that the staff of the ENT clinic did not refuse to visit the patient; on the contrary, he refused to visit them. He had attended the clinic once and there is nothing in the medical notes to show any good reason why he should have refused to go the following week. I also find the complainant's initial allegation about the destruction of the hearing aid contradicted by her own subsequent oral evidence. I dismiss this complaint.

(d) *Delay while on bathroom hoist*

19. In her complaints to the HA the complainant said that while her husband was being barrier nursed he had a temperature of 104°F due to pneumonia but he was still given a daily bath. She said that on one occasion during this period he was left unattended and unclothed for some time until the nurse came back to dry him. The HA replied that, although the patient was at one time given daily saline baths to assist the healing of his sores, after he was transferred to a single room he was no longer given general baths because he was being barrier nursed and did not leave the room. Subsequently, in her letter to me the complainant changed her evidence and said that the incident on the bathroom hoist did not happen when her husband was being barrier nursed but on another unspecified occasion. Her son told my officer that on the occasion in question which he thought was early in December, he visited the ward to find that his father was in the bathroom; he discovered him sitting alone, undressed and wet on the hoist with the windows open. The nurse did not return for fifteen minutes.

20. The ward sister had no recollection of the complainant's husband being left alone on a bathroom hoist at all, let alone for fifteen minutes. She said that baths were given in the morning and the need to give all patients their baths meant that there was usually a queue of patients waiting to use the bathroom. She thought it unbelievable that any nurse would give a patient a bath in the middle of winter with the bathroom windows open. None of the nursing staff to whom my officer spoke was able to recall any occasion on which the complainant's husband was left unattended on a bathroom hoist.

Findings

21. It is possible that, because the complainant and her son did not restrict their visits to the normal visiting hours, the complainant's son found his father was in the bathroom but I have not traced any evidence in support of the complaint that he was left undressed, cold and wet on a hoist for fifteen minutes. I cannot therefore uphold this complaint.

(e) *Pharaoh's ants*

22. In her written complaint to the hospital and in evidence to my officer the complainant said that on one occasion she visited her husband at 10 am and found his bed full of red ants. She complained to one of the nursing staff who

agreed to transfer her husband to another bed but it was mid-day before this was done and the bed to which her husband was transferred also contained red ants. In his reply to the complaint the HA said that Pharaoh's ants were a pest in most hospitals and continuous efforts were made to control them. Despite these efforts outbreaks did sometimes occur, such as the one complained of, but the outbreak in question was immediately treated by the contractors employed for this purpose. The HA acknowledged that the incident must have been very distressing for the complainant and her husband and expressed his regret.

23. A nurse who was present at the time told my officer that, as soon as the ants were discovered, the complainant's husband was given a bath and put into his wheelchair in the day room while a bed was prepared for him in another room. It was possible that the whole exercise took two hours before he was put into the other bed, but he was not in contact with the ants for any of that time. The bed into which he was moved did not have ants in it, but they had found their way under the floor into his new room by the following morning. However, the contractors then arrived and dealt with the swarm. The assistant administrator told my officer that as soon as she knew of the ants she telephoned the contractors and asked them to deal with them as a matter of urgency. She confirmed that ants were not in the room to which the complainant's husband was transferred when he moved there. Unfortunately, his condition encouraged them and they appeared in the second room, but they did not reach the bed.

Findings

24. When ants were discovered in the bed the staff immediately removed the patient from it and asked their contractors to deal with them. It is not disputed that he may have waited up to two hours before he was put into the second bed but he was not in contact with the ants during that period and I have been assured that there were no ants in the second bed. It is regrettable that the swarm was not dealt with immediately, as the HA claimed in his letter, and I can well understand that the complainant found the incident distressing. The HA expressed his regret when the complaint was first made, and I do not think he could have done more at that time.

(f) *Temperature of the water bed*

25. In her letter of complaint the complainant said that on one occasion when her husband was being nursed on a water bed she found the temperature of the bed so high that he was perspiring. She said she did not herself alter the temperature adjustment of the bed but asked a nurse to do so; he, however, told her he did not know how to adjust the thermostat. The complainant told my officer it was on 14 January that the temperature of the bed was 48°C and her son had loosened the bedclothes round her husband so that air could circulate and cool him. The HA said in reply that the water bed thermostat was set at 37°C which is body temperature and the correct setting for a water bed. The temperature setting mechanism was checked every day by a hospital electrician and by the nursing staff.

26. In a statement compiled at the time of the complaint and in conversation with my officer, the ward sister said that the patient's relatives often tampered

with the controls of the bed and altered the temperature setting. Consequently the nurses constantly checked the setting. On one occasion they found the thermostat set at 24°C which was extremely dangerous and could have caused hypothermia and even death. The sister showed my officer a bed of the type used for nursing the complainant's husband. The control comprised a knob with an indicator pointing to the temperature settings and arrows showing 'hotter' or 'colder' positions. There were warning lights to indicate failure of the equipment and temperature variations.

27. The staff nurse told my officer that all nursing staff were taught how to operate water beds and the equipment officer demonstrated the controls when the water bed arrived on this occasion. A male nurse, probably the one to whom the complainant referred, told my officer it was ludicrous to say that staff did not know how to operate the beds since the controls were so simple. The complainant and her son themselves altered the controls frequently although the nurse had explained to them many times why it was necessary for the bed to be kept at body temperature. He said it became routine after the visitors left to check and, if necessary, reset the thermostat on the patient's bed. The assistant administrator told my officer that at that time the hospital had six water beds on hire. Since they were rather expensive the equipment officer used to check all the beds each day, not only to see that the bed was working properly but also to see that each bed was needed by the patient being nursed on it.

28. It is recorded in the nursing notes for 29 January that the patient was to have a water bed as soon as one was available and on 2 February that he was being nursed on a water bed (which he did not like). The only reference in the nursing notes to problems with the water bed occurs in an entry for 11 February which records that the relatives turned the temperature of the water bed down to 20°C although they had been told that the correct setting was body temperature.

Findings

29. The complainant is mistaken in her belief that the temperature of the water bed was set at 48°C on 14 January; her husband was not nursed on a water bed until early February. I have no doubt that the staff were well acquainted with the temperature controls of a water bed and that the beds on hire at the hospital were checked frequently by the equipment officer and by the nurses. I have no doubt that the complainant and her son altered the temperature setting on occasions without authority and that such problems as there were arose from their actions. I dismiss the complaint.

(g) *Delay in supplying a blanket*

30. The complainant said that on the Saturday prior to her husband's death he was sitting in a chair in his room, extremely cold and shivering. She went to the ward office to ask for a blanket to put round his shoulders but her request was ignored; later she asked another nurse who immediately provided a blanket. In his reply the HA said that the patient could not have been sitting in his chair at the time because he was on total bed rest on a water bed; he did not sit out in a chair for several weeks prior to his death. When my officer questioned the

complainant about this she agreed it was a mistake to say that her husband was in a chair and said that he must have been sitting up in bed at the time. However, she insisted that he was cold and that she had asked, without success, for an extra blanket.

31. None of the staff to whom my officer spoke was able to recall being asked for an extra blanket by the complainant and all of them said there was no shortage of blankets and no reason why the patient should not have been provided with an extra blanket if he wanted one.

Findings

32. In view of the complainant's poor recollection of the event and the absence of any corroborative evidence I find that this complaint is not made out.

(h) *Difficulty in meeting the consultant*

33. In her complaint and in conversation with my officer, the complainant said that she tried without success on many occasions to make an appointment to see a doctor about her husband's condition. She said that on one occasion the consultant went into her husband's room while she was there and shouted at both of them. He was extremely rude, saying that he did not want the complainant's husband in the hospital, that the complainant had been rude to the nurses, that she had neglected her husband and that he wanted nothing further to do with them. The complainant denied that she had been rude to the nurses and said she had merely pointed out what she considered were various shortcomings in her husband's treatment. The consultant then left but the complainant said that one of the nurses who had witnessed the argument said that the doctor 'had gone too far'. The HA told the complainant that at all times the nursing staff did their best to explain the treatment being given to her husband and that the consultant tried to explain the situation on at least two occasions. There was also one occasion when, very reasonably, he would not see her because he was interviewing bereaved relatives when she walked into the office.

34. In a letter to the assistant administrator dated 13 March the consultant said that on one occasion, following his instruction that the complainant's husband should be moved to a single cubicle, he spoke sharply to the patient and his wife at the request of the ward sister and her staff. He told them that their attitude was making life very difficult for the nurses and he thought that the morale of the nurses and the whole ward was suffering because of their attitude. The consultant told my officer that he had deliberately spoken sharply to the complainant but he had not lost his temper and had not said that he did not want her husband in the hospital. He also said that she spoke to the registrar and junior medical staff very frequently, and the ward sister confirmed this, telling my officer that the complainant saw the medical staff more than most relatives by the simple expedient of being in the ward during the doctors' rounds; there was no need to make appointments because she always spoke to the doctors whenever she saw them.

35. The ward sister in a statement dated 13 February, which she confirmed in discussion with my officer, said that on many occasions the patient's relatives upset other patients by their arguments and bad language and, although they

were asked to modify their behaviour they continued to comment and criticise others, often with little knowledge of the situation. The consultant was informed that the situation on the ward was becoming increasingly difficult and a ward meeting chaired by the consultant was called to discuss the problem. The ward sister said that most of the patients were embarrassed by the relatives' criticism of the nursing staff and one patient complained that a remark made by the complainant caused his wife to burst into tears. Shortly after the meeting the complainant's husband was moved to a single room where the consultant spoke to him and his wife; neither the ward sister nor the staff nurse were present at that discussion. The staff nurse was not able to recall an argument between the consultant and the complainant's husband and could not therefore comment on what the complainant alleged she had said.

Findings

36. I am in no doubt that the complainant spoke to junior medical staff frequently about her husband's condition and that all staff made considerable efforts to explain matters to her. I find that the consultant deliberately spoke to her sharply on one occasion, and on another refused to see her because he was interviewing bereaved relatives. I find nothing whatsoever to criticise in that. Indeed, on the evidence, I am in no doubt that his action was entirely justified; the behaviour of the complainant and her son was disruptive and demoralising and measures to curb it were essential. I dismiss this complaint.

(i) *Injections causing swollen feet*

37. The complainant said that her husband was given a course of injections which caused his feet to swell. Despite these symptoms the injections continued for five days after she had brought her husband's condition to the notice of the nursing staff.

38. The consultant told my officer that in fact the complainant's husband was not given any drugs by injection; the only injections he received were of a multi-vitamin preparation which would not have caused his feet to swell. I have confirmed from the clinical records that only multi-vitamins were given by injection and also that these injections continued until the end of January 1979. It is not disputed that his feet were swollen; but in a letter to me based on a statement by the ward sister, the AHA said that after a time the patient refused to allow the nurses to turn him at two-hourly intervals and insisted on sitting with his legs hanging over the bed. It was this practice that caused his feet to become very swollen.

Findings

39. The complainant is mistaken in the detail of her complaint and I find no substance in it.

(j) *The AHA's reply to the complaint*

40. On 18 April the complainant wrote to me referring to the AHA's reply which answered the points she had raised but which nonetheless she regarded as unsatisfactory. My enquiries have shown that the answers the HA gave were essentially correct and I make no criticism of them.

Conclusions

41. I do not doubt that the patient's final illness caused his wife considerable stress and I sympathise with her over that. But the evidence I have seen leads me to the conclusion that she and her son were unreasonable in their behaviour at the hospital and in their attitude towards the staff. The medical and nursing staff concerned have described the patient's stay in the hospital as difficult and an unforgettable experience, yet I consider they behaved with commendable restraint and I have no criticism at all of the care and attention they gave him.

Case No. W.38/79–80 – Attitude of consultant

Complaint and background

1. On 17 November 1978 the complainant was seen at a hospital by a consultant orthopaedic surgeon (the consultant) to whom he had been referred by his family practitioner (the FP). The complainant said that:

(i) The consultant displayed a deliberately rude and insulting attitude towards him and implied that he was a malingerer; and

(ii) the Area Health Authority (the AHA) failed to give a satisfactory reply to his complaint.

2. The National Health Service Act 1977 precludes me from investigating decisions which in my opinion are taken solely in the exercise of a doctor's clinical judgement and I include in this report references to the medical background only in order to explain the circumstances which gave rise to the complaint.

Investigation

3. During the investigation I obtained the comments of the AHA and the consultant and examined relevant correspondence and the medical notes. One of my officers also interviewed the consultant.

The attitude of the consultant

4. In his letters of complaint to the AHA and to me, the complainant said that he had sustained back injuries in 1944 and 1968 which had since required frequent hospital treatment. The second injury was classified as arising from an industrial accident and in June 1970 he was diagnosed as having cervical spondylosis and was awarded a pension on the grounds that this was associated with the accident. The complainant said that in 1978 he applied to the Department of Health and Social Security for a reassessment of his award and was told that he would have to obtain medical evidence to support his claim that his injury had been aggravated. At his request the FP arranged for him to see the consultant on 17 November 1978.

5. The complainant said that the consultant became very angry with him at an early stage in the consultation. He asked him a few questions and pointed out that he had told him at a previous consultation in 1977, which the complainant said he could not recall, that nothing could be done for him owing to a heart condition; he was therefore wasting valuable time which could be devoted

to seriously ill people. The complainant felt that the consultant's remarks implied that he was a malingerer, though he had not actually said so. He had explained to the consultant that, while he appreciated nothing could be done for him he felt that as he thought his condition had deteriorated he was justified in asking for a further medical opinion, particularly as he was applying for a reassessment of his pension. The complainant said that when he tried to describe his symptoms, the consultant angrily repeated that his time was being wasted and said that though the FP had said in his referral letter that he needed an urgent consultation, in his opinion no urgency existed. Nevertheless he examined him and arranged an x-ray examination. Later the consultant told him that the x-ray had revealed no disc lesions or spondylosis, conditions which the complainant claimed had been diagnosed in the past, and that he suffered only from a mild aging process of the spine.

6. In his comments to me and in his interview with my officer the consultant said that the FP had asked him to see the complainant as an urgent orthopaedic referral because of his backache, and his letter made no mention of the disability award. It was the consultant's practice to keep a few spaces free at each clinic for urgent referrals and he therefore arranged for him to be invited to his next clinic, which was already fully booked. The consultant said that when he arrived he sat down and informed him that what he had really come about was the reassessment of his medical condition for the purpose of his DHSS disability award. The consultant said that he did not regard that as justifying his attendance at the next possible clinic as an urgent referral and told him so. He examined the complainant's clinical notes and found that he had seen him 18 months previously (although the complainant vehemently denied this) and had concluded at that consultation that there was a degree of cervical and lumbar spondylosis but that manipulation and surgery would not be possible because of a history of heart trouble. His assessment on this occasion was again that a degree of lumbar and cervical spondylosis was present but little more than he would expect to see in the average member of the population of that age. He told him that he had some wear in the bones of his back, which was the normal ageing process for the majority of the population. He did not feel that his attitude was rude or insulting and he did not imply that the complainant was a malingerer, although he accepted that he could have been described as 'short' in his attitude towards him. At the time of the original complaint he had been prepared to apologise for this, but it subsequently became clear to him that the complainant would not regard this as sufficient as his main demand was for the consultant to retract his medical opinion, which he was not prepared to do.

7. The complainant's medical notes confirm that he was seen by the consultant in June 1977 and a report sent to his then family practitioner. The notes also contain a referral letter from the FP dated 31 October 1978 and headed 'urgent'. This states that the complainant's backache and neck-ache were getting worse and asked for the consultant's help and opinion. The consultant's reply dated 17 November detailed the results of his examination and concluded that in view of the cardiac condition he could not offer any help.

8. My officer questioned the three out-patient nursing staff who were on duty at the time of the incident but none of them could remember anything about it.

Findings

9. The consultant made special arrangements to accommodate the complainant in an already fully booked clinic because the FP's referral letter was for an 'urgent' appointment. It made no reference to a disability pension. The complainant says that he did not expect treatment and merely wished the consultant to confirm his self-diagnosis that his condition had deteriorated sufficiently to justify him asking for an increased disability pension. It is not surprising that the consultant was annoyed. He has accepted that he may have shown his annoyance by being 'short', but it is clear to me that this in no way affected the professional care he gave to the complainant. He gave him a comprehensive examination and a report on his condition and he wrote fully to the FP. I can find no reasonable grounds for the allegation that the consultant was rude and insulting or implied that he was a malingerer. I dismiss this complaint.

The complaint that the AHA's reply was unsatisfactory

10. On 17 November, the day of the consultation, the complainant wrote a letter of complaint to the British Medical Association (the BMA) and sent a copy to the hospital. Having been told by the BMA that the matter did not concern them, he telephoned the offices of the Health District on 18 December and was advised to write to the District Administrator (the DA), which he did on 28 December. He enclosed with his letter a copy of his original complaint and said that he expected the consultant to be disciplined and to give him a formal apology. The documents were forwarded on 17 January to the consultant, who told the DA on 7 February that he was seeking the advice of his medical defence organisation. On 16 February the Patients' Services Officer wrote to the complainant informing him that his complaint was receiving attention. The complainant replied on 28 February expressing his dissatisfaction at the delay and saying that, if he did not receive a personal apology from the consultant by 10 March, he would take up the matter with the General Medical Council (the GMC). An officer of the AHA telephoned the complainant on 6 March to explain that the consultant's medical defence organisation were considering the matter, and the complainant agreed to extend his deadline to 31 March. A reminder was also sent to the consultant on the same date. The consultant's reply to the DA of 29 March formed the basis of the AHA's reply of 30 March. This contained an apology for the delay in replying, and explained why the consultant had not regarded the consultation as urgent and why he had therefore been displeased at the complainant's admission that his main purpose was a reassessment of his disability award. The letter amplified and explained the medical opinions given during the consultation and regretted any misunderstanding that may have occurred. It concluded with an offer of further assistance should this be required.

11. The complainant was dissatisfied with this reply and wrote to the GMC on 3 April. He sent a copy of this letter to the AHA with a covering letter stating that 'as I expected (it) simply whitewashes (the consultant)' and complaining that he had not received a letter of apology from the consultant. He said that if he did not get satisfactory action from the GMC he would consider taking action for damages against the consultant.

Findings

12. The original complaint was addressed to the BMA, and the AHA received a copy on 2 January 1979. In view of the tone of the letters of complaint it was prudent of the consultant to seek the advice of his medical defence organisation and he replied to the AHA on 29 March. The reply sent by the AHA was explanatory and conciliatory. I find their reply was satisfactory.

Conclusion

13. The consultant accepts that he allowed his understandable annoyance to become apparent in his manner. In the circumstances I do not well see how he could have prevented it. It may be that the complainant suffers a good deal of pain, but this does not excuse the intemperate way in which he has pursued this imagined slight. I consider that the consultant and the AHA have shown self-control and courtesy in the manner in which they have handled this complaint.

Case No. W.43/79–80 – Still birth of a baby

Background and complaint

1. On 5 January 1979 an expectant mother was admitted to the obstetric unit of a hospital (the hospital) for induction of labour because her baby was overdue. The induction was performed on Saturday 6 January at 10.00 am and she was delivered of a still-born baby girl at 4.43 am on 7 January.

2. The parents complained that:

(*a*) the senior registrar in obstetrics (the senior registrar) did not arrive to deliver the baby until forty minutes after he responded to a telephone call by saying he would come, and the midwifery sister caring for the wife (the midwifery sister) did not make further attempts to call the senior registrar or another doctor despite the deterioration in the foetal heart rate;

(*b*) the reply to their letter of complaint to the Area Health Authority (Teaching) (the AHA) was unsatisfactory.

The complainants assured me that they did not propose to pursue an action at law in respect of these matters and on that basis I agreed to investigate their complaints.

Investigation

3. During the investigation I obtained the written comments of the AHA and examined the relevant documents including the clinical notes and labour record. One of my officers, sometimes in company with another, met the complainants and members of the medical, nursing and administrative staff concerned in the case.

(a) *The response of the medical and nursing staff to the emergency*

4. On 23 February 1979 the husband wrote to the AHA complaining strongly about the circumstances leading to the still-birth of his child. He gave the following account. The baby was ten days overdue when his wife was told that there was a 50:50 chance of foetal distress and she would be induced. The induction was carried out and by the end of the first stage of labour there were

indications that the predicted distress would occur but no special precaution was thought necessary. At 3.40 am on 7 January the midwife became concerned and immediately telephoned for a doctor to carry out a forceps delivery; ten minutes later a second call was made. At 4.30 am the senior registrar and the chief paediatrician arrived and at 4.40 am the baby was delivered still-born. The husband asked for an explanation of the 50 minute delay between the midwife calling for a doctor and his arrival. On 28 March the district administrator (the DA) replied that the second stage of labour began at 3.05 am and the midwifery sister encouraged the wife to start pushing from about 3.15 am. He confirmed broadly the sequence of events given by the husband but said that on the first occasion the midwifery sister telephoned the senior registrar, he advised that the patient should be encouraged to continue pushing and that he should be called again if there was no improvement. The DA added that on receiving a second telephone call from the midwifery sister, the senior registrar said he would come and asked her to call the duty senior house officer (the SHO) to prepare for a forceps delivery. The DA said that the only explanation for the delay was that the senior registrar fell asleep again after he had put the telephone down.

5. In discussion with my officer the wife said that she remembered very little about her labour because the drugs she had been given caused her to doze or sleep. The husband explained to my officer that he was called into the delivery room at about 3.15 am when his wife, who had been heavily sedated, was awoken. As far as he could recall the medical student allocated to her (the medical student) came into the room at about 3.40 am and the midwifery sister, who was concerned about the foetal heart rate, went out to telephone the medical staff. On her return, with the help of the medical student and the husband she moved the wife to the forceps room and told her to start pushing. About ten minutes after the first call, the husband thought, the midwifery sister asked the medical student to hasten the doctor, and he went out of the room, presumably to telephone the senior registrar. When he returned the midwifery sister asked him to scrub up ready to assist and they waited for the doctor to arrive. The husband thought that it was after 4.15 am that three or four doctors arrived in quick succession and the baby was delivered at about 4.40 am. He could not remember anyone entering or leaving the room in the interval between the medical student's return and the doctors' arrival and he was not aware of any further phone calls to the medical staff. He added that the consultant obstetrician in charge of his wife's care (the consultant) discussed the still-birth with him and his wife about ten days later, when they were told that if the senior registrar had responded promptly to the telephone call all would have been well.

6. The consultant told my officers that at weekends, as on weekdays, there were always on call a senior house officer resident in the hospital, a registrar or senior registrar who slept in the hospital if difficulties were expected or if his home was further than a mile or so from the hospital, and one of two consultant obstetricians on whom the doctors or midwives could call at any time in case of difficulty. The senior registrar on duty on the night of 6/7 January was in the hospital and the consultant explained that it was not the normal practice for a doctor to be present even during the second stage of labour, whether or not difficulties were expected. The registrar, routinely, made four visits to the labour ward at intervals during the day and evening and returned at any time if asked

to do so by a midwife or senior house officer; at night a midwife normally called the house officer first but either the midwife or the house officer might call out the registrar if necessary. In an emergency, both the house officer and the registrar are telephoned by the midwifery staff. Although the hospital had a bleep system it was used only if the staff required were not by a telephone; to call a doctor who had gone to bed a midwife would telephone him directly without using the operator. The doctors' sleeping quarters were 60 to 70 yards from the unit and the consultant said he would expect a doctor to arrive on the ward within three to seven minutes from a call.

7. The Senior Nursing Officer in the obstetric unit (the SNO) told my officers that the unit always had ten to twelve staff on duty; at least four were qualified midwives, two of whom at least were on the labour ward. In practice there were often more than four midwives on duty and the night sister in charge of the unit (the senior sister) could reallocate staff as necessary. The SNO added that it was not normal for a doctor to remain with a patient during labour even if the baby was thought to be at risk; that was the midwife's job but she had to obtain medical assistance in all cases of abnormality of the mother's or baby's condition and a midwife was not allowed to perform forceps deliveries.

8. In her written comments to me and in discussion with my officers the midwifery sister said that at 3.20 am she noticed a fall in the foetal heart rate but it picked up when she turned the patient on her side. At 3.40 am the midwifery sister again became concerned about the foetal heart pattern and informed the senior registrar who instructed her to continue to encourage the patient to push during her contractions and telephone again if the situation continued. The midwifery sister called him again at 3.50 am; the senior registrar said he would come and instructed her to call the SHO and prepare for a forceps delivery. She told my officers that she carried out these instructions and transferred the patient to the forceps room. She said that she became extremely worried by the worsening situation and the non-arrival of the medical team. Because she did not wish to leave the patient again, she asked the senior sister to try to get the doctors to the labour ward and the senior sister telephoned at approximately 4.05 am. At about 4.15 am, the midwifery sister said, she went to the door of the delivery room and asked the senior sister to telephone the senior registrar again, stressing to him the urgency of the situation and asking him to come immediately. The SHO arrived at 4.20 am and the senior registrar at 4.30 am. The consultant arrived soon after the still-birth and the midwifery sister discussed with him the course of the labour; she also discussed it with the SNO the following day but had not made a written statement. The midwifery sister was unable to recall any particular discussion with the consultant about the times at which calls were made and did not think she told him of the calls made by the senior sister; she was very distressed at the time, as were all the staff. She did, however, recall having mentioned to the SNO the senior sister's calls. The midwifery sister stressed that the senior registrar had always responded promptly when called and the delay was quite out of character. According to the written record of the labour, prepared by the midwifery sister, information was passed on three separate occasions that night to the senior registrar about 'Type II Decelerations', the drop in the foetal heart rate and meconium staining, but the record does not indicate exactly when the information was conveyed.

9. The senior sister told my officer that when the night staff came on duty she allocated the midwifery sister solely to the patient because she had been in labour so long and it seemed that there might be problems. The senior sister with the help of other staff cared for three or four other women in labour at the same time. She remembered that the senior registrar paid a routine visit to the ward probably about midnight to check that there were no problems. Some time later, she recalled, the midwifery sister asked her to telephone the senior registrar because she was very worried about the case. The senior sister said she did so and the senior registrar said they should encourage the patient to push and telephone again if there were any problems. The midwifery sister followed these instructions but was still worried and twice telephoned the senior registrar herself; she then asked the senior sister to call him again and she did so. The senior registrar said he was coming and told her to call the SHO, which she did, to prepare for a forceps delivery. The senior sister did not remember the times of these calls but was certain she had made the first and last calls to the senior registrar; she added that she had also phoned the SHO two or three times. It had been a busy night and it was difficult to say exactly when events occurred. The senior sister said that she told the consultant, when he discussed the sequence of events with staff immediately afterwards, that she had telephoned the senior registrar but since they admitted things had gone wrong they had not worried about the exact timings. She too confirmed that the senior registrar was always prompt to answer calls and consequently she might not have pressed him as much as she would some other doctors.

10. The SNO told my officers that when a midwife was busy, time passed quickly and she did not always realise how long a doctor was taking to respond. In such circumstances, she said, it was hard to remember the times of events and if a midwife was busy she did not have time to write them down; it was more important to care for the patient. The SNO had been asked by the district nursing officer for a report on the incident but had not mentioned in it the calls made by the senior sister because she was concerned with the midwifery sister's actions; at that stage the midwives were not under criticism and it had not seemed necessary to her to go into detail about the telephone calls.

11. The medical student allocated to the case told my officers that on 6 January he saw the patient on a number of occasions throughout the day and at about midnight when he was called to another delivery. Sometime between 2.00 am and 3.00 am he was called by buzzer from his sleeping quarters immediately above the obstetric unit when the patient reached the second stage of labour. He remembered that after he reached the delivery room the midwifery sister went out to telephone the medical staff because she was concerned about the foetal heart rate. On her return she said that the senior registrar had told her to encourage the patient to push, but to telephone again if there were any problems. The medical student recalled that the midwifery sister thought for a time that the delivery might be normal and told him to scrub up ready to assist. But when it seemed that a forceps delivery might be necessary the patient was moved to the forceps room. The medical student said that the foetal heart rate was deteriorating and the midwifery sister went to telephone the medical staff again. He thought that the SHO arrived about twenty minutes later followed closely by the senior registrar. The medical student did not know the times at which the two telephone calls were made, did not recollect any other calls being

made and did not make any himself. However, he thought that the senior sister was present from time to time and that the midwives had considerable discussion about the case; he said it was possible that one of them might have made another call. He himself did not subsequently have any discussion with the consultant about the events that occurred during the labour.

12. The senior registrar did not take up my invitation to provide written comments on the complaint but he told my officers that he went to bed after making a round of the ward about midnight and finding no problems. He remembered receiving a call from the midwifery sister telling him that the patient was making reasonable progress but there was a deterioration in the foetal heart rate. He told her to carry on but to call him again if there were difficulties. He received another call from the midwifery sister who was very worried; he said he would attend and asked her to call the SHO. The senior registrar said he had no recollection of more than two telephone calls nor of any calls from the senior sister; he had no idea of the times at which the calls were made and therefore accepted the midwifery sister's timings. He was not aware that he had fallen asleep again after the telephone calls but could give no other explanation for the delay. The senior registrar told my officers that he normally responded very quickly when called and he thought that, knowing this, the midwives had not reminded him as they might have done another doctor. He was greatly upset by the events and deeply regretted that the baby was still-born. The senior registrar had not made a written statement at the time of the incident but he had discussed it with the consultant and prepared a medical report for the Perinatal Mortality Conference. He also prepared the draft reply to the original complaint.

13. The SHO told my officer that he held the position of locum SHO at the hospital for four weeks in January 1979. He remembered doing a round with the senior registrar on 6 January before going to bed and being called later to attend the patient for a forceps delivery. He explained that SHOs were not allowed to perform such deliveries unsupervised. The SHO did not know at what time he was called but he remembered only one telephone call; in fact he did not know that there might have been more until my officer met him. As far as he knew he had responded to the call promptly. On arrival in the labour ward he scrubbed up in preparation for the delivery; the senior registrar arrived a couple of minutes after him. The SHO added that the consultant spoke to him after the delivery but there was no discussion about the time at which he was called.

14. The consultant confirmed to my officer details of the admission and the induction. He added that he arrived in the delivery room soon after the birth. He was in the unit because he had earlier been called by the senior sister to another patient. He interviewed each member of the staff involved and thought that he had established within an hour or so of the delivery the timing of telephone calls to the senior registrar. The consultant told my officer that he was not aware that more than two telephone calls to the senior registrar might have been made and said that, if in addition to the calls made by the midwifery sister, two more were made by the senior sister, then with hindsight it seemed to him a pity that the latter did not inform him of the difficulty since she knew he was already in the labour ward.

15. My officer asked the senior sister to confirm that she called the consultant to another patient that night and to say whether there was any reason for not calling him to the patient when the senior registrar did not arrive. She replied that, to the best of her recollection, the midwifery sister had again telephoned urgently to the senior registrar and the SHO and that their early arrival was expected. She also explained that the consultant was personally conducting the labour of one patient and was therefore asked by the senior sister to come to the hospital when that patient reached the second stage of labour. By the time he arrived the senior sister had delivered that patient of her baby but she required perineal care. After assisting the consultant in preparation for suturing, the senior sister went to assess the condition of the other women in labour. Until then she was unaware that the doctor had still failed to come. She looked into the room where the consultant was working and found he was engaged in suturing. She telephoned the senior registrar, asking him to come to the labour ward immediately, and he responded promptly. When the consultant had completed the perineal repair, the senior sister informed him of the situation and he went to the room where the medical staff were attempting to resuscitate the baby. As the senior sister remembered, the consultant was in the labour ward for five to ten minutes before the senior registrar arrived.

16. The consultant explained that it was not normal practice in the hospital to obtain written statements from staff unless disciplinary action was contemplated, and that was not the case in this instance. The senior registrar had always been most reliable and this incident was completely out of character. I have seen two written reports about the patient's labour; the first prepared by the SNO for the district nursing officer is a statement dated 30 March 1979 in which she summarised the course of the labour and the actions of the midwifery sister. In the report the SNO recorded that the midwifery sister got in touch with the senior registrar at 0340 hrs and again ten minutes later. The second is a medical report prepared by the senior registrar for a Perinatal Mortality Meeting on 19 April 1979; this report gives the medical history of the pregnancy and labour without reference to matters such as the number of telephone calls made to the senior registrar.

Findings

17. The senior registrar has not disputed that there was a long delay in his arrival and the AHA told the complainants the only explanation for the delay was that the senior registrar fell asleep again after the telephone call. His doing so had tragic consequences and clearly these have weighed heavily on the senior registrar's mind. As for the action that was taken to hasten the senior registrar the evidence I have obtained during my investigation has brought to light conflict over both the number and the authorship of telephone calls made to him. Before I started my investigation, the complainants and the DA referred to *two* calls and that it was the second call which led the senior registrar to say he would come and deliver the baby by forceps (paragraph 4). The husband thought the second call was made by the medical student but I think he is mistaken in that. The contemporary labour record refers to *three* calls (paragraph 8), but their precise timing is not indicated. The midwifery sister and the senior sister in evidence to me each refer to *four* calls, but each claims to have made calls at which similar instructions were given by the senior registrar and

each claims to have been told that he was coming. But even if, in total, *four* calls were made to the senior registrar I would not regard as adequate two calls to hasten him in a period of forty minutes (3.50 – 4.30 am) after he had said that he was coming. While it was understandable that the midwifery sister did not wish to leave the patient she was very worried and realised that an emergency situation was at hand. She herself could not perform a forceps delivery, neither could the medical student nor, unsupervised, the locum SHO and it seems to me that the midwifery staff should, in such circumstances, have got in touch with the consultant – a procedure which the consultant himself clearly regarded as appropriate. As it was, the consultant had been called by the senior sister to the hospital and I believe that it was an error of judgement on her part in not informing him of the situation immediately she knew that medical assistance had not arrived.

18. I am also critical of the absence of any contemporaneous statements by the staff involved in this incident. It was clear that the case was one which might well have been taken to court and I would have thought it was in the AHA's own interests for a written record of the recollections of the staff to be made at the time. I do not accept that disciplinary action is the only reason why written statements should be required. The assistant area administrator told my officer that there was no general policy in the Area for recording statements about untoward incidents but he imagined that in general throughout the country staff did record them. My own investigation has shown the difficulties that arise when statements are not taken and I invite the AHA to review their policy regarding the circumstances in which written statements by the staff are necessary.

(b) *The AHA's reply*

19. In his complaint to the DA the husband asked why his wife's labour was induced on a Saturday morning so that the critical stages were likely to occur in the early hours of Sunday morning when few senior staff were available. He said it seemed particularly inappropriate in his wife's case since she was over thirty and it was her first pregnancy, there had been no weight gain for at least four weeks and there was a strong prediction of foetal distress. He sought reassurance that such an incident would never happen again. In his reply the DA said it was common practice to perform inductions on Saturday mornings because there was no reduction in medical or midwifery staff cover at weekends; there was always a senior house officer and a registrar or senior registrar available, as well as a consultant on call. In this case special precautions were taken, in that the baby's heart rate was continuously monitored with a cardiotacograph.

20. In correspondence with me and in discussion with my officers the complainants expressed dissatisfaction with the DA's reply. The husband thought that in cases where difficulties over the birth were expected, an assessment of the probable length of labour might be made and induction so arranged that the expected time of delivery was likely to fall during the daytime of a weekday when more staff were available rather than during the early hours of a Sunday morning. He said he had heard that there had been a staff party in the hospital on the night following his wife's induction and this illustrated that the induction

had not been sufficiently well planned to avoid delivery of their child at a time when the hospital was least geared to cope with an emergency.

21. The consultant told my officers that, unfortunately, it was not possible to predict accurately the time of delivery at the start of labour, even when it was being induced. He gave my officers statistics which showed that at the hospital in 1978 more than eighty five per cent of induced births took place within twelve hours of induction. Most inductions in the unit, he said, were performed early in the morning and most patients were delivered before nightfall but this could not be predicted accurately in any particular case. He did not accept the husband's suggestion that the medical and midwifery cover was reduced at weekends (paragraphs 6 and 7). And I have seen from the labour ward duty rotas that on the night of 6/7 January the midwifery cover was better than it had been generally during the preceding week-nights. The consultant said that, although it might seem paradoxical, at night and at weekends members of the duty team were often more readily available because they did not have additional commitments such as out-patient clinic sessions which had to be interrupted for emergency calls; high risk cases were often induced at the weekends *because* doctors were readily available.

22. The husband thought that the reply he received from the DA to his complaint was complacent because it made no mention of any steps taken to prevent a recurrence of the incident. The consultant told my officers that he had never before encountered such an incident and thought it most unlikely to happen again. Nevertheless he and his team had considered carefully whether there was any way of preventing a recurrence of the situation but they had come to the conclusion that there was no way in which this could be done. The consultant did not consider that any improvement could be made in the timing of inductions but he told my officers that he had reminded the midwifery staff that they should call the consultant if the registrar does not arrive. The SNO told my officers also that the midwifery staff had learned from the incident that they must not rely on a doctor because he normally responded promptly and that they must call him again if there was any delay in his arrival. These points were not included in the reply that the DA sent the husband on 28 March.

23. The DA's reply concluded by saying that the senior registrar, the consultant and all members of the obstetric team extended their sympathies to the complainants. But the complainants said they were not seeking sympathy but thought that an apology should have been offered for the failure to attend the wife promptly and that an offer by the consultant of a further meeting if they so wished should have been repeated in that letter.

24. In his discussion with my officers the senior registrar said that he prepared the draft reply to the complainants and submitted it to his medical defence organisation for comment. The draft was agreed except for one sentence which was removed completely. The senior registrar said that this indicated that the staff were all extremely sorry about the tragic death of the baby, and none more so than the senior registrar concerned. The consultant passed the draft reply to the DA and while he felt diffident about asking the DA to adopt a particular form of words in his reply, he asked him to do so on this occasion at the request of the medical defence organisation 'for obvious medicolegal reasons'. The consultant later indicated that he did not see this as preventing

the DA from adding an apology on the AHA's behalf if he thought it appropriate. The DA told one of my officers that he did not add an apology to the letter because he felt it was not the appropriate time to apologise for the still-birth of the baby. He had therefore kept to the draft sent by the consultant. The consultant said that his offer of a further interview if the complainants wanted one was an offer from doctor to patient which did not need to be repeated and he thought the DA and the senior registrar were probably unaware of it. Although the offer of a meeting was not mentioned in the DA's reply, it was certainly not withdrawn.

Findings

25. A staff party was held on the evening of 6 January but the husband told my officer he 'had no reason to suggest that any of the doctors had been enjoying themselves too much and were other than on duty'. His point in mentioning it was to illustrate that the planning of the induction led to delivery when hospital staffing was low. But from the evidence I have seen I accept that medical and midwifery cover for the labour ward overnight at weekends is no less than the cover on other nights and that the same number of medical staff are on call during nights as during days. I do not question the clinical opinion that the length of labour cannot be accurately predicted and I accept that the consultant's offer to meet the complainants again if they so wished was a personal offer, of which others were unaware. To this extent I do not uphold the complaint about the DA's reply but since it was written more than eleven weeks after the event I do criticise it for making no apology. It is understandable that hospital authorities should not wish their replies to indicate any acceptance of blame when this is contested, but in this case the consultant has said that he had already expressed the view to the complainants that all would *probably* have been well if there had been no delay in the doctor's arrival, and in these circumstances I believe that an apology should have been made to the complainants in the DA's reply of 28 March – not for the still-birth of a baby but for the accepted failure in the service. I also think it might have been of some comfort to the complainants to have known that the staff had learnt some lessons from this case (paragraph 22) even if it was the considered view of the consultant and his team that no substantive changes in procedure were necessary.

Conclusions

26. The failure of the senior registrar to go promptly to the patient when he had told the midwifery staff that he would do so had a tragic result. It has not been denied that the still-birth was avoidable. Overpowering fatigue is a familiar torment to many who work in the caring services. But duty is not to be denied and the senior registrar should have come when called. His failure to do so, isolated though it was, calls forth my severe criticism. The midwifery staff too are not free from blame. They should have taken more persistent steps to get the senior registrar to the scene. And they might have tried to get the consultant who was near at hand. I am keenly aware of the heavy demands made on the medical and nursing professions and of the gallant way in which they generally meet them. But there is no escaping the fact that here was a serious failure. I know that the staff involved feel their personal failing most acutely. So I need say no more.

27. Beside the foregoing shortcomings, the DA's failure to apologise and the absence of written statements seem almost insignificant. But I hope that notice will be taken that I hold them to be failures also, though of lesser degree.

28. The AHA have now asked me to convey to the complainants their sincere apologies for the shortcomings identified in this report and this I gladly do. I am also pleased to record that the District have agreed to remind the midwifery staff in the hospital of the lessons to be learned from this case and the AHA have agreed to consider whether a standard procedure for taking written statements from staff involved in untoward incidents should be introduced.

Case No's. W.55/79–80 and C.429/79 – Refusal to release medical records

The complaint

1. The complainants' child was still-born on 25 January 1978 at a General Hospital (the hospital). They were dissatisfied with the medical treatment the wife received during her pregnancy and confinement and asked their Member of Parliament to make some enquiries on their behalf. The Member sought the release by the Area Health Authority (the AHA) of the medical records, but the AHA refused.

2. The complainants alleged that:

(*a*) the refusal to release the records to the Member as their designated nominee was unreasonable, given the purposes of Section 31 of the Administration of Justice Act 1970 (the 1970 Act), the House of Lords' decision in the case of McIvor and another v Southern Health and Social Services Board (the McIvor case)[1] and the AHA's willingness to release the records to an independent medical adviser nominated by the complainant and her husband;

(*b*) in refusing to release the records the AHA followed unsound guidance from the Department of Health and Social Security (the Department).

The Member also sought on behalf on the complainants the release of the relevant notes and records from their family practitioner. But the Member did not ask me to investigate that issue because he was still corresponding with the Family Practitioner Committee when he referred the complaint to me and the notes to which I refer throughout the remainder of this report do not include those made by the family practitioner.

Jurisdiction

3. Section 31 of the Administration of Justice Act 1970 provides that a person, likely to be a party to subsequent proceedings in which a claim in respect of personal injuries or death is likely to be made, may apply for an order for disclosure of relevant records held by a prospective party to the proceedings. The High Court has power in such cases to order the prospective party to produce the records to the applicant. There is, therefore, a specific statutory legal remedy for the complaint about the AHA's refusal to release the records and under Section 116(1) (b) of the National Health Service Act 1977 I may not investigate any action for which the person aggrieved has a remedy by way of proceedings

(1) McIvor and another v Southern Health and Social Services Board [1978] 2 A11 ER 625

in a court of law, unless I am satisfied that in the particular circumstances it is not reasonable to expect that person to resort to it. But in this case I was asked to consider whether it was maladministration for a public body to require an individual to take legal action to secure his rights. In these circumstances I decided to exercise the discretion given to me by Parliament and to investigate the AHA's refusal to release the records to the Member. After I started my investigation the AHA released the case notes to solicitors acting on behalf of the complainants; but, at the complainants' request, I agreed to pursue my enquiries to a conclusion.

Background

4. Before the 1970 Act came into effect there was no legal obligation on health authorities, or on former hospital authorities, to disclose medical records to patients, who took or who were contemplating taking legal action, before the stage of 'discovery of documents' in the actual proceedings. But in circular HM (59) 88 dated 23 September 1959 the Department's guidance was that authorities should not stand in this respect on the letter of the law. Among other things, the circular stated that in cases where proceedings were contemplated against an authority itself or one of its staff, a request for records in pursuance of a claim of *prima facie* substance should be examined on its own merits, in the light of legal advice and in consultation with any doctor directly involved. The guidance stated that the Minister did not feel that authorities would either wish or be well advised to maintain their strict rights except for some good reason bearing on the defence to a particular claim or on the ground that the request was made without substantial justification. In the guidance no limitation was placed on the persons to whom disclosure could be made.

5. The rights of litigants and potential litigants in cases where a claim in respect of personal injuries or death was likely to be made were significantly extended when Sections 31 and 32 of the 1970 Act came into effect on 31 August 1971. (Section 32 makes provision for orders for disclosure of relevant records held by *third* parties *after* legal proceedings have commenced.) Under the Rules of the Supreme Court (the Rules) a summons under Section 31 must be supported by an affidavit which must, among other things, 'state the grounds on which it is alleged that the applicant and the person against whom the order is sought are likely to be parties to subsequent proceedings in the High Court in which a claim for personal injuries is likely to be made'. In this connection, it is stated in the accompanying commentary that, 'it would be desirable, if not indeed necessary, to give particulars of the accident giving rise to the claim, and of the fact that the claim has been made or intimated, exhibiting the letter before action and so forth. Having regard to the purpose of the procedure, 'likely to be parties' should be liberally construed to include the case where the bringing of the action may depend on the result of the discovery, provided that the claim has a reasonable basis and is not irresponsible or speculative'. In two cases that went before the Court of Appeal in 1973 and 1974[1] it was decided that orders for disclosure of medical records under Sections 31 and 32 should be for disclosure to the medical adviser of the applicant. The Department included details of these cases in circular letters issued to health authorities, the first of which also informed

(1) Dunning v Board of Governors of the United Liverpool Hospitals [1973] 2 A11 ER 454
Davidson v Lloyd Aircraft Services Ltd. [1974] 3 A11 ER 1

authorities that the guidance given in HM (59)88 should be read in the context of the power of the Court to order disclosure under Section 31; authorities were reminded that it would still be open to them to resist an application which seemed to them to be vexatious or entirely exploratory.

6. In the McIvor case, which was taken on appeal to the House of Lords in 1978, their Lordships delivered unanimous opinions to the effect that in the ordinary way an order should be made for the production of the records to the applicant or, if he is legally represented, to his solicitors. The leading speech pointed to the fact that the disclosure called for under the terms of the 1970 Act was narrower than that provided by the ordinary discovery of documents in that the documents were limited to those relevant to 'an issue arising out of the claim in the action'. No sufficient reason was seen in the arguments put forward in the McIvor case for departing from 'the unequivocal meaning of the words used in the Act that the documents must be produced to the applicant which, in the context of litigation in which the applicant is legally represented, includes the solicitor who acts in the litigation on the applicant's behalf'. Furthermore another of their Lordships who heard the appeal foresaw that an applicant seeking an order might indicate his contentment if the relevant records were produced not to him, but to his designated nominee 'be that person his solicitor or his medical adviser or anyone else'. He thought it unwarrantable that if a court in its discretion decided to make an order it should take it upon itself to impose a restriction, to which the applicant had never subscribed, regarding the person to whom production was made.

7. The McIvor case was reported to health authorities in the Department's circular HN(78)95 in August 1978. The circular quoted a relevant extract from the leading speech and stated that in future an order under either Section 31 or 32 would normally be made for the production of the documents to the applicant or, if he was legally represented, to his solicitors. The circular emphasised that authorities must comply with such an order and advised any officer served with an order or subpoena to notify his District Administrator or the Area Administrator who, before any disclosure took place, should consult legal advisers and inform any medical staff involved to consult their medical defence organisation. The circular letters reporting the 1973 and 1974 judgements were cancelled, but the Department's guidance contained in HM(59)88 (paragraph 4) was said to remain in force.

Investigation

8. In the course of the investigation I have obtained the comments of the Department, the Regional Health Authority (the RHA) and the district administrator (the DA) who dealt with the request for disclosure on behalf of the AHA, and I have examined their correspondence. One of my officers (sometimes in the company of another) met and discussed the case with the DA, the Regional Legal Adviser (the RLA), a representative of the medical defence organisation concerned and their legal adviser, and spoke to the consultant obstetrician and gynaecologist who cared for the wife (the consultant), the regional administrator (the RA) and an official of the Department. He also met the husband.

(a) *The AHA's refusal to release the records*

9. On 21 December 1978 the Member asked the DA to make arrangements for him to see, on behalf of the complainants, a copy of the hospital notes and the general practitioner's records in respect of the treatment and advice the wife received during her pregnancy and confinement. He said he understood there would be no difficulty in making the documents available, not least in the light of the decision on the McIvor case. The DA consulted the RLA and informed the consultant in case she wished to refer the matter to her defence organisation. The consultant wrote immediately to the latter who, without seeing the case notes or any grounds for concern, expressed the initial view that the notes would not normally be disclosed to a complainant's legal adviser (in which capacity they had taken the Member to be acting), regardless of the McIvor judgement; they said that their normal advice was that the notes should be disclosed to a medical adviser nominated by the complainant or his legal adviser. On 15 January the DA replied to the Member that the McIvor case did not appear quite to cover the situation of the complainant's case since the effect of the House of Lords' decision was that, when an order was made under Section 31 or 32 of the 1970 Act, the production of records was to be to the applicant or his solicitor. He explained that he was seeking the RLA's advice on the relevance of the McIvor case and asked if the complainants would write to the DA setting out the grounds for their concern so that these could be investigated in the usual way with the consultant and a reply sent to the complainants.

10. On 18 January the Member recognised the DA's need to consult the RLA about his request, although he understood it accorded with modern practice. He mentioned that the purpose of Section 31 of the 1970 Act was to enable prospective claimants to secure disclosure before commencing any kind of proceedings and referred to the opinion of Lord Edmund-Davies in the McIvor judgement that the applicant for disclosure might ask for disclosure to his 'designated nominee', in this case the Member himself. As to the grounds for concern over the wife's care and treatment, the Member summarised these himself in the hope that the summary would be regarded as sufficiently meeting the DA's request at that stage. The DA sought the consultant's views on the causes of concern outlined by the Member and he suggested to the RLA that it would be particularly helpful if his, the RLA's, advice could be agreed with the defence organisation in order to avoid any risk of conflict in the matter. On 31 January the RLA expressed his willingness to release the notes to a nominated medical adviser but not to the Member. The consultant, after getting in touch with her medical defence organisation, gave on 14 February a detailed reply to the points of concern for transmission to the complainants. The defence organisation had already agreed to the disclosure of the notes to another obstetrician (paragraph 9); but the consultant suggested that the DA kept this possibility in reserve. The DA acted on the consultant's proposals and on 19 February wrote direct to the complainants replying to the points of concern raised by the Member on their behalf. At the same time he copied that letter to the Member under cover of a separate one in which he said it was the view of the RLA and the medical defence organisation concerned that it would not be appropriate for copies of the case notes to be made available to the Member.

11. On 28 February the Member replied. He said that, on re-reading the DA's correspondence, it appeared to him that there was no difference between them

over the intended purpose of Sections 31 and 32 of the 1970 Act and the only other ground for the refusal implied in the DA's correspondence was that the right of disclosure was restricted to the applicant or his solicitor. If that was the view of the DA's legal adviser, the Member asked why a Member of Parliament did not qualify as a 'designated nominee'. He said he was reluctant to advise the complainants to instruct solicitors or commence proceedings before they had a sight of the records when, if the AHA were right, disclosure could lead the complainants to the conclusion that there was no cause for commencing proceedings or initiating complaint procedures. The DA again referred the matter to the RLA and the consultant, suggesting to the former that he might discuss with the defence organisation the release of the records to a designated nominee. The consultant, having again got in touch with her defence organisation, agreed on 13 March to the release of the notes to a designated obstetrician nominated by the complainants or their legal advisers. By this time it had become clear to everyone that the Member was writing in his capacity as MP and not as legal adviser. The RLA advised the DA on 27 March that there was no reference in the McIvor judgement to a designated nominee. He also said that the view of the defence organisation since the McIvor case had been that they would generally be prepared to agree to the disclosure of the case notes to a medical adviser, but would otherwise require details of the grounds upon which negligence was alleged before agreeing to the production of case notes to an applicant or his solicitor. Following a further exchange of letters, the DA told the Member on 2 April that the decision in the McIvor case did not make any reference to a designated nominee; he suggested that, in any case, the notes could only be properly appraised by a medical expert in the specialty concerned and offered to disclose them to a consultant obstetrician nominated by the complainants or their legal advisers.

12. Although grateful for this offer, the complainants through the Member pressed for disclosure of the records to him as their designated nominee. In a further letter dated 16 April the Member referred to his letter of 18 January, which pointed out that the concept of designated nominee derived specifically from the McIvor case and suggested that the limitations in the offer in the letter of 2 April went beyond those on which the authority were entitled to insist; it was the applicant who had the right to production of the records although it was open to him 'to indicate his contentment' that they could be produced not to him but to his designated nominee, 'be that person his solicitor or his medical adviser or anyone else'. The DA referred the Member's letter to the RLA copying it to the consultant. He told the RLA he was not clear how the defence organisation's policy as described in the RLA's letter of 27 March (paragraph 11) could be sustained in this case in the face of the McIvor judgement, since the grounds on which negligence was alleged had been stated in the Member's letter of 18 January. He invited the RLA's further comments, if possible in agreement with the defence organisation. In a reply of 25 April the RLA referred back to his earlier comments and said that if the case notes were to be released he did not think it should be on the grounds of a 'fishing expedition' to see whether any negligence had occurred. He offered the DA a draft reply to the Member. The consultant, however, replied on 27 April to the DA giving her defence organisation's view, with which she agreed, that if the complainants were to apply for a court order the notes would have to be disclosed; no useful

purpose would therefore be served by objecting further to their disclosure. On 3 May, using the RLA's draft as a basis, the DA told the Member that the RLA accepted his contention on the question of a designated nominee, but added that it was not the policy of the RHA or the medical protection societies to release case notes on the grounds of a 'fishing expedition' to see whether any negligence had occurred and it seemed to the RLA that that was the case in this instance. The DA suggested again that the case notes be supplied to a medical adviser on behalf of the complainants. On 21 May the Member referred the case to me.

13. On 7 June solicitors acting on behalf of the complainants (the solicitors) replied to the DA's letter of 3 May, which had been referred to them. They commented that the practice set out in that letter did not conform with the law as they understood it. They understood that under Section 31 of the 1970 Act the Court had power in circumstances specified in the Rules to order the production of documents which were relevant to an issue or likely to arise out of a claim. Once these requirements were met, the McIvor case made it plain that the party having custody of the documents was not entitled to restrict their production to medical advisers or lawyers. The only question was whether in all the circumstances the AHA could be required to produce such documents. They said the AHA had conceded in the DA's letter of 3 May that the documents should be produced, and the solicitors invited the AHA to reconsider releasing them voluntarily. The solicitors indicated that they would apply for an order if necessary and they summarised the case showing why there was at the very least a presumption of negligence. They concluded that the request for disclosure was not in any sense 'a fishing expedition'.

14. On 18 June the RLA replied to the solicitors agreeing to disclose to them the case notes regarding treatment of the wife. Having confirmed the agreement of the consultant and her defence organisation, he sent a copy of the case notes to the solicitors on 18 July.

15. When the Member referred the case to me he expressed concern that it should be necessary for the complainants to commence legal proceedings to obtain the case notes through him as their designated nominee. He thought that the guidance contained in the 1959 circular, fortified as it was by the 1970 Act, required a good administrator to respond favourably to a *prima facie* legitimate request without requiring court action. And it was inconsistent to argue against the release of the case notes on 'fishing expedition' grounds while at the same time offering to release the notes to a medical adviser nominated by the complainants.

16. In discussion with my officer the husband supported the stand taken by the Member and provided copies of correspondence in which he had asked the Member to continue pressing for the release to him, as the complainants' designated nominee, of all ante-natal care notes. The husband maintained that there was no limitation in law requiring release to a medical adviser only; he was grateful to the Member for his efforts but disgusted at the obstructive way in which the AHA had replied to him; and he criticised the correspondence from the DA as inaccurate and inconsistent. The husband added that after the Member had advised him in May 1979 to seek legal advice his solicitors, having taken Counsel's opinion, secured the voluntary disclosure of the case notes in a matter of days.

17. In written comments to me and in subsequent discussions the DA explained his position. He said that at the outset it was not clear to him whether the case came within the scope of the McIvor judgement and the request was dealt with in consultation with the RLA and the consultant. He thought the request for disclosure was complicated by the fact that the Member seemed to act partly as the complainants' MP and partly as their legal adviser and said he had to be careful not to permit one MP, on account of his legal standing, to secure privileges that would not be afforded to others: this principle had guided his actions in dealing with the request. It was considered doubtful whether the Member or the complainants could be regarded as competent to assess the case from inspection of the notes, but there was no objection to the notes being scrutinised by another consultant obstetrician. The DA accepted that by the end of January both the defence organisation and the RLA had agreed separately to offer disclosure of the case notes to a nominated medical adviser. However, at that time he had hoped that by answering in detail their points of concern the complainants would be satisfied and disclosure avoided; he had therefore acted on the consultant's suggestion to hold the offer in reserve. A full reply to the grounds of concern was sent to the complainants on 19 February.

18. The DA further explained that when the consultant, in her letter of 27 April, said that she and the defence organisation felt that no useful purpose would be served by objecting further to disclosure, the DA understood them to be agreeing to disclosure in the normal way which, if not to a medical adviser, would have been to a legal adviser, but not to the Member himself as a designated nominee. He did not convey the contents of the consultant's letter of 27 April to the RLA before writing to the Member on 3 May; he made the point that in seeking the RLA's advice he had invited the RLA to liaise and agree with the defence organisation the line to be followed. He said his letter of 3 May to the Member was based on the RLA's advice; it was for the RLA to explain that advice, but in the DA's view there was always room for a second opinion in medical matters, hence the renewed offer of disclosure to a medical adviser; but he considered a request for disclosure to someone who was not medically qualified in order that he might give an opinion on the basis of the claim, to be a 'fishing expedition'. The DA said that the position changed when the notes were released because by then the complainants were represented by solicitors and it was they who had implied negligence in their letter of 7 June.

19. The DA brought to my officer's attention draft guidelines published by the RA in September 1979, following the McIvor case, in which administrators were advised to refer requests for voluntary disclosure of case notes to the RLA together with the case notes and details of the medical staff involved; the RLA would consult the defence organisation concerned and advise the local health authority accordingly. The RA later told my officer that these guidelines were prompted partly by this case and were now in use.

20. The RLA told my officer that he was responsible for deciding whether or not medical records should be disclosed voluntarily. If an application were referred to him for reply his normal practice would be to offer release of the records to a medical adviser nominated by the applicant, irrespective of whether the grounds for a claim had been stated. He would also copy the papers to the appropriate medical defence organisation for their comments, especially on the

question of release to the applicant or his solicitor if that was being sought; the defence organisations, he said, objected to disclosure unnecessarily to anyone other than a medical adviser. He added that the request for disclosure of the case notes was not handled entirely in accordance with this practice because the correspondence between the Member and the DA was conducted on a personal basis. The RLA said that the Member's request for disclosure of the notes to himself as the complainant's designated nominee was breaking new ground; it was the only case to date known to him and to other RLAs in which a third party not acting as a legal adviser was seeking disclosure on behalf of the applicant. The defence organisation concerned, he said, were still resisting strongly that principle despite the judgement in the McIvor case.

21. The RLA accepted that the offer of disclosure to a nominated medical adviser could have been made when he agreed to that course on 31 January, although the emphasis at that time was more towards answering the points of complaint. The RLA was unaware that on 27 April the consultant had told the DA that she and the defence organisation no longer objected to disclosure of the notes and he agreed that, had he known of it, he would probably have altered his advice to the DA; he would certainly have discussed the point with the defence organisation and, if they and the consultant had no longer objected to disclosure to the Member, nor would he have done so. As it was, however, his advice gave rise to the DA's letter of 3 May and on that the RLA said that the grounds for concern given by the Member had been answered in great detail; in the RLA's view they did not amount to grounds for negligence and he thought it right, therefore, and not inconsistent to maintain the offer of disclosure to a nominated medical adviser whilst refusing disclosure to anyone else. The RLA told my officer that he had very little consultation with the defence organisation over this case because he knew their views; his first communication with them was on 5 July after solicitors acting on behalf of the complainants approached the DA.

22. The RHA told me it was the AHA's normal practice to release notes to a medical adviser and they did not accept that it was inconsistent to argue against release to anyone else. Nor did they accept that the method adopted required a person to take legal action to obtain legal or medical advice; case notes could be released to a medical adviser who could then refer them to a legal adviser before proceedings commenced. The RHA said they were not seeking to be obstructive but were in a difficult position because of the traditional attitude of the medical defence organisations. The position, however, changed and a copy of the notes was supplied to the complainants' solicitors on 18 July, the defence organisation having agreed to this course.

23. The consultant told my officer that she was guided by her defence organisation in her dealings with the request. On 16 February she suggested withholding the offer of disclosure to a nominated medical expert because it did not seem appropriate to disclose at a time when she hoped to satisfy the complainants by explanations; the DA had a copy of her defence organisation's initial advice but did not include the offer of such disclosure in his first reply and she presumed therefore that it was not necessary. When the complainants showed that they were not satisfied with the response on the points of concern the next logical step was to offer disclosure of the notes to a medical expert and she did

this on 13 March. In the consultant's view, because of the medical jargon used in case notes it was better to keep disclosure within medical circles; but she agreed that her letter of 27 April to the DA on the subject offered on behalf of her defence organisation as well as herself voluntary disclosure of the case notes to anyone who by court order might be authorised to receive them.

24. The representative of the defence organisation confirmed that the initial advice to the consultant on 5 January was to offer disclosure at that stage to a nominated medical adviser. The defence organisation's legal adviser thought the consultant subsequently suggested holding the offer in reserve because she had just produced a report to the patient and considered the offer unnecessary. The representative confirmed that the consultant correctly represented to the DA their change of view in April; by then the defence organisation had decided that the Member's letter of 18 January provided reasons for disclosure which they considered would have been adequate to secure a court order for disclosure; and, therefore, although it was with some reluctance, they saw no reason for continuing to advise their member against disclosure of the notes to the Member himself, provided that she agreed. The defence organisation's legal adviser added that the Member was a person of standing in medico-legal matters and they would not lightly advise the refusal of disclosure to him personally. The representative also confirmed that the RLA's letter of 5 July was his first approach to them on the case. The defence organisation's legal adviser was unable, on instruction, to confirm or deny the RLA's understanding of their policy, or to discuss with my officers the effects of the McIvor judgement on it. My officers did not ask me to oblige the legal adviser to answer their questions because it was apparent from the consultant's letters to the DA what the advice had been. The consultant, who had sought her defence organisation's advice at every stage, agreed disclosure to a medical adviser, and on reconsideration on 27 April, to anyone to whom the records might be produced under the terms of a Section 31 order. I note that the medical defence organisation's Annual Report for 1978 advised their members that the decision in the McIvor case did not mean that patients and their solicitors had automatic open access to confidential clinical notes; medical records did not *have* to be disclosed unless there was a court order.

Findings

25. I can well understand the complainants' view that the DA's correspondence was inaccurate and inconsistent. His statement that there was no reference in the McIvor judgement to a designated nominee was based on incorrect advice from the RLA. As for the arguments used by the DA and RLA (paragraphs 18 and 21) in defending their 'fishing expedition' letter, it does not seem to me to be consistent to refuse disclosure on what are essentially exploratory grounds when disclosure for the same purpose has already been offered to a medical adviser. If, as the RLA has indicated, the authority use different criteria for disclosure to medical advisers then they should at least have made this clear in their letter of 3 May.

26. Procedurally, I do not think that the Member's request was dealt with as well as it ought to have been. The DA replied to the Member on each occasion and the RLA has explained that normal procedures were not followed in this

case because the correspondence between the Member and the DA was conducted on a personal basis. But, on every occasion the DA sought the advice of the RLA before he replied, often in terms provided by the RLA. And I note that the DA does not regard his correspondence with the Member as being on a personal basis or that the matter was dealt with other than officially. On one occasion, however, the DA failed to refer to the RLA important information contained in the consultant's letter of 27 April. This was the view expressed by the medical defence organisation that if an application were made to the court they would have to disclose the records and that no useful purpose would therefore be served by objecting further to their disclosure. It was unfortunate that the DA did not interpret the consultant's letter as including disclosure to a designated nominee (paragraph 18); and because there was no liaison between the RLA and the medical defence organisation at the material time, the position which the RLA was maintaining (in some degree influenced by what he believed the defence organisation's policy to be) continued until the approach by the complainants' solicitors broke the deadlock. The series of incidents from 27 April amounted to maladministration and served to prolong the delay in releasing the documents. The DA frequently suggested liaison between the RLA and the defence organisation to avoid a conflict of view and he told my officer that he had assumed that such liaison had been established. I criticise the RLA for failing to liaise with the defence organisation at the material time despite his own stated practice, despite the exhortations of the DA and despite the fact that he was dealing with a case which, following the McIvor decision, could become a precedent. I do not accept his argument that very little consultation was necessary because he knew the defence organisation's views; it is evident that he did not.

27. Turning now to the main issue, I find that the medical defence organisation were prepared to agree to disclosure of the records to a medical adviser from the outset but that the consultant quite understandably first attempted to answer the grounds for concern. When she failed to satisfy the complainants, the consultant, after getting in touch with her defence organisation, agreed on 13 March to the release of the records to a designated obstetrician nominated by the complainants, or their legal advisers. And on 27 April, when that also failed to satisfy the complainants, the consultant agreed to disclosure to anyone who could obtain such disclosure by way of an order under Section 31 of the the 1970 Act. On the other hand, I find that the RLA waited until he had seen the grounds for concern before coming to any decision. I make no criticism of this because, unless he did so, he would have been unable to consider whether the request was without substance. I note however that the RLA does not always insist on a sight of the grounds for the claim (paragraph 20). On 31 January the RLA agreed to disclosure to a medical adviser but, thereafter, refused release to anyone else until the complainants' solicitors approached the DA on 7 June. In addition to the maladministration I have described in paragraph 26 I would make three further comments on the consideration given to the request for disclosure voluntarily to the Member. First, the RLA disputed that the concept of designated nominee was considered in the McIvor judgement; in this he was wrong. Second, in my view he was wrong to take into account his opinion that the causes of concern included in the Member's letter of 18 January did not constitute grounds for negligence (paragraph 21). Nothing in the Department's

guidance requires grounds for negligence to be stated nor indeed is it a pre-requisite to the granting of a court order. Even in the latter case, all that is required is a statement of the grounds on which the applicant and the person against whom the order is sought are likely to be parties (paragraph 5).Third, additional grounds for maintaining refusal to disclose to the Member, given by the DA in his letter of 2 April, were that the notes could only be properly appraised by a medical expert. This seems to me to carry little weight when in June the RLA offered them to the complainants' solicitors.

28. Both the DA and the RHA expressed the view that the position had changed when the complainants' solicitors asked for disclosure to them. The DA explained that it was they who had implied negligence in their letter of 7 June (paragraph 18); but I have noted that previously he had accepted that the Member's letter of 18 January had done so (paragraph 12). The RHA added that the defence organisation agreed to the release to the solicitors. I do not accept that the position changed first because, as I have already indicated, the grounds of negligence are not a material factor at this stage, second the defence organisation had agreed in April to release to anyone who might be authorised to receive them by a court order, and third, given the comments of one of their Lordships (paragraph 6), I see no grounds for differentiating between the complainants' Member of Parliament and their solicitors.

29. I find that after the Member and the complainants found unacceptable the initial offer of disclosure to a nominated medical adviser, the defence organisation reviewed the position in the context of whether or not a court order would be granted if sought. They concluded that it would and advised the consultant (albeit reluctantly) that no useful purpose would be served by objecting further to disclosure. The actions of the defence organisation are not within my jurisdiction nor is it for them to decide whether or not an application for voluntary disclosure should be granted. But I commend their practical approach to the question in considering the likely outcome of an application to the court.

(b) *The Department's guidance*

30. The complainants contended that guidance about the disclosure of records given to health authorities by the Department was contrary to the purpose of Section 31 of the 1970 Act. They said it was unreasonable to expect them to go to law in order to obtain medical records when it was, in their opinion, unarguably their right to have them. They also claimed that the guidance was unsound, contending that disclosure of records could on request be to an applicant's designated nominee.

31. The guidance issued by the Department about disclosure of medical records is set out in two circulars – HM (59)88 and HN (78)95 (paragraphs 4 and 7 above). The 1978 guidance, issued after the McIvor judgement, relates solely to action by health authorities on receiving a court order. The Department told me that this circular was drawn up with the benefit of legal advice and, in their view, it complied with the House of Lords' decision and was not contrary to the 1970 Act. They recognised that the purpose of the statutory provision was to enable the High Court to make orders for disclosure in appropriate cases before proceedings commenced, but they made the point that it was open to the court to decide under Section 31 of the 1970 Act whether to make an order requiring

disclosure. In the Department's view, authorities had no absolute obligation, in response to applications for voluntary disclosure, to disclose records nor had an applicant any absolute right to them: neither the Act nor the McIvor judgement could be construed as suggesting that there was a general right of access by patients or their representatives to medical records for the purpose of pursuing a complaint. The Department considered that, except where an order had been made by the court, there was nothing in the Act or in the McIvor case which could be regarded as placing a duty upon anybody to disclose.

32. The circular HM (59)88, the only current guidance on voluntary disclosure, recognises that it may be difficult to make voluntary disclosure in advance of discovery, but encourages authorities to be as forthcoming as possible. The Department told me they did not think it would be proper for them to go so far as to advise authorities that, when a request for disclosure was made, they should try to form their own judgement on difficult questions which the statute had left for decision by the court. As it seemed to me that authorities must frequently be called on to make up their minds whether to disclose, I asked the Department what 'difficult questions' they had in mind in this connection. As an example they cited the case taken to the Court of Appeal in 1973 (to which I have already referred in paragraph 5) in which one of the Lord Justices found it impossible to say on the facts before the court that they were likely to lead to proceedings in which a claim in respect of personal injuries was likely to be made. The Department expressed the view that, although, when a request for voluntary disclosure is made, a health authority may well be called upon to make a judgement on the question, this will be done against the background of long-established policy (unrelated as such to the use of records in litigation) that, except in response to an order of the court or some other statutory provision, a *doctor* should decide on clinical or ethical grounds what information should be disclosed from medical records to a patient or his non-medical representative. This judgement, made in the light of legal advice and the comments of the medical personnel involved and their defence organisations, does not involve consideration of the question as to whether the matter is one in which the court is likely to exercise its discretion to grant an order under Section 31 of the 1970 Act. The Department considered it entirely consistent with proper administration for health authorities, first, to maintain that they are not prepared to make judgements as to the prospects of a successful application for disclosure under the 1970 Act and, therefore, not willing to disclose documents to an applicant before an order is made by a court under the Act; and, second, to limit any voluntary disclosure of medical records to the applicant's medical adviser.

33. From my enquiries it does not appear that the implications of the 1970 Act on voluntary disclosure of medical records were given any special consideration at the time the provisions were enacted. In the ensuing years the Department drew attention to certain relevant court judgements but took the view that the 1959 policy guidance remained broadly appropriate and did not conflict with the McIvor case. They have agreed, however, during this investigation that the 1959 circular has some shortcomings as the only source of guidance to health authorities on voluntary disclosure. My officer's enquiries of the DA and the RLA about the application of the departmental guidance to this case indicated a difference of opinion about its usefulness in that instance. The RLA

confirmed that he had not sought advice from the Department's legal branch in dealing with this particular case.

34. For my part, I do not accept the contention that the complainants or anyone acting on their behalf had an absolute right to the medical records. As Lord Diplock recognised in his speech in the McIvor case, the court may in its discretion refrain from making any order under the Sections of the 1970 Act. While the court has such discretion no one can expect, as of right, a health authority to release records voluntarily. The complainants said that the AHA followed unsound guidance from the Department in refusing to disclose the records to the Member in the complainants case. But the sole guidance on voluntary disclosure – HM (59)88 issued more than 20 years ago – imposes no limitation on persons to whom disclosure can be made. It cannot be said, therefore, that the Department's guidance caused the authority to refuse disclosure of the records to the Member.

35. I can understand why the DA was in some doubt whether the guidance in HN (78)95 should apply in this case, when the title of the circular 'Supply of Information about patients engaged in legal proceedings' was the same as that used in HM (59)88, which did apply. However, I believe there are more serious shortcomings in the Department's guidance. They have provided no evidence to show that consideration was given to the effect that the 1970 Act might have on voluntary disclosure, and concepts such as 'likely to be parties' are not mentioned in the guidance. Although I accept that it is for a health authority's legal advisers to advise on the application of the Rules of the Supreme Court and the interpretation of the phrase in a particular case, I think the Department ought to have reviewed the guidance when the new statutory provisions came into effect. Similarly, they have given no guidance, in the context of voluntary disclosure, on the concept of 'designated nominee', which was referred to in the McIvor judgement and is the issue at the heart of the Member's arguments. The Department told me during the investigation that they were currently considering whether their HM (59)88 should be supplemented or revised. In my opinion a review is long overdue and I invite the Department to consider a total revision of the existing guidance on the disclosure of medical records, both voluntary and pursuant to an order of the Court.

36. Despite the open field to which voluntary disclosure may be made under the Department's 1959 guidance, I have noted that the Department consider it to be consistent with proper administration for authorities to limit disclosure to a medical adviser (paragraph 32). That practice was upheld by the Court of Appeal in 1973 and 1974 in cases where applications to the Court for an order had been made, but was set aside in 1978 in the House of Lords before the Member requested the disclosure of the wife's records. In the McIvor judgement the view was expressed that it would be clearly unwarrantable for the court to impose a restriction, to which the applicant had not subscribed, regarding the person to whom production was made. I take a similar view in cases where an applicant, seeking the voluntary release of records in connection with likely litigation, does not accept the limitation of disclosure to a medical adviser. In such cases, once disclosure has been conceded in principle, I think it must be made to anyone to whom an order would grant disclosure.

37. The Department also considered it to be consistent with proper administration for health authorities to maintain that they were not prepared to make judgements as to the prospects of a successful application for disclosure under the 1970 Act. In this case the medical defence organisation were prepared to grasp this nettle and to agree to disclosure to the designated nominee on the grounds that it was likely that a court order would be granted if sought. The supposed difficulty in deciding whether an application under Section 31 of the 1970 Act is likely to succeed is no greater, indeed may well be less, than the difficulty in deciding whether to defend an action for damages. It is my opinion that the likely success of an application for an order should be one of the factors taken into account when an authority judges whether an application for voluntary disclosure should be granted, and that to ignore such a consideration lays an authority open to a charge of maladministration. As for judgements on the 'difficult questions' which the statute has left for decision by the court, I believe that the circumstances of the particular case will be all-important and that guidance from the Department might well not be appropriate.

Conclusions

38. The disclosure of medical records has always been an exceedingly sensitive issue for the medical profession, not least because of the fear that some of the confidences contained in the records might be damaging if disclosed. Undoubtedly there are and will continue to be cases where the process of law is necessary to determine whether medical records should be disclosed and I have no desire or power to alter that. However I support the Member's view that the Department's guidance, fortified by the 1970 Act, requires a good administrator to respond favourably to a *prima facie* legitimate request without forcing the applicant to resort to court action. In this particular case the serious failure of the RLA to liaise with the medical defence organisation at the material time, the DA's interpretation of the consultant's letter of 27 April and the fact that the DA, believing liaison to have been established, did not bring to the RLA's notice the change of mind by the medical defence organisation, resulted in the RLA maintaining his refusal to disclose, when on his own admission, he might otherwise have agreed. I have also been critical in paragraph 27 of three other factors which affected the consideration given to the request for voluntary disclosure of the records to the Member. Although in the end, the complainants were not forced to the lengths of applying to the court for an order, the AHA's actions were certainly leading them in that direction. I have not seen justification for treating the complainants' solicitors differently from their designated nominee and I uphold the complaint that the refusal to disclose the records to the Member was unreasonable. Although the AHA maintain that the DA reasonably believed that liaison had been established, they and the RHA have asked me to apologise to the Member and to the complainants for the failings I have identified and this I gladly do. I also welcome the RA's guidelines (paragraph 19) as providing a basis for proper and early liaison between the RLA and the defence organisations.

39. I do not uphold the complaint that the Department's guidance prevented disclosure of the medical records to the Member acting as her designated nominee. But I have found shortcomings in that guidance. One of the main purposes of Departmental guidance is to ensure that regional, area and district staff deal

with problems consistently; but the present guidance on voluntary disclosure is sufficiently imprecise to enable a variety of interpretations to be placed upon it. In my opinion, guidance should also be up-to-date and, in matters of this kind, take account of relevant legislation and case law. The 1959 guidance does neither. I am pleased to report that the Department have now agreed that the 1959 guidance needs to be brought up to date. They have told me this will be an 'exacting task' but that they are looking at the best way of discharging it. Provided this is undertaken with a sense of urgency, I regard this, the introduction of guidelines by the RA and the apologies to the Member and the complainants I have conveyed in paragraph 38 of this Report to be a satisfactory outcome to my investigation.

Case No. W.61/79–80 – Provision of hospital accommodation in the UK for a relative living overseas

Background and complaint

1. The complainant's brother, who lived in England until the war years, went to Australia in 1948 following service in the Royal Navy and settled there. In October 1975 after the death of his Australian wife he was admitted to an Assessment Centre in South Australia, where he was found to be suffering from senile dementia and to be in need of nursing supervision. He expressed a desire to return to England and, following correspondence between his mental health visitor in Australia (the MHV) and relatives in this country, the complainant endeavoured to arrange his brother's repatriation to the United Kingdom to suitable accommodation. But none was found nor was his repatriation arranged before he died in Australia on 23 March 1979.

2. The complainant said that although the Area Health Authority (Teaching) (the AHA(T)) accepted responsibility in 1976 for providing hospital accommodation for his brother, they had not done so by the time he died.

Departmental guidance

3. In a letter dated 20 June 1963, the then Ministry of Health issued guidance to hospital authorities in England and Wales on the provision of hospital treatment for visitors from overseas. The guidance relevant to this investigation is as follows:

> '*Persons eligible*
>
> 6. The following are eligible for the whole range of National Health Service treatment:
>
> (*a*) All persons ordinarily resident in the United Kingdom
>
> (*b*) Persons coming from overseas who have links of birth or residence with the United Kingdom *and who have not adopted another country as their country of permanent residence.*
>
> . . . .
>
> *Persons not eligible*
>
> 7. Unless they are visitors from the countries with which the United Kingdom has negotiated certain types of reciprocal agreements (. . . .) the following should be regarded as not being eligible for free National Health

Service treatment and should not be given treatment other than emergency treatment (. . . .) unless they pay for it:

(*a*) Short-term visitors who do not belong to or who have no connection of residence with the United Kingdom.

(*b*) Visitors who have had links of birth or residence with the United Kingdom but who have unreservedly adopted another country as their country of permanent residence (see paragraph 6(*b*) above).'

4. The Department of Health and Social Security (the DHSS) told one of my officers that in practice, if someone with the right of return to the UK actually returns to the country to resume permanent residence here, then that person immediately from the moment of entry is eligible for the full range of NHS treatment. However, such a person has no right to any treatment or privileges before he arrives in the UK and there is no right to be included on a hospital waiting list before entering the UK and taking up residence within the appropriate catchment area. If a health authority accepts someone onto a waiting list before that person enters the UK then the authority is being as helpful as they can; but they could not give any priority to such a person over other patients already resident in the catchment area.

Investigation

5. During the investigation I have corresponded with the AHA(T) and with another Area Health Authority (the AHA) and have seen relevant papers on the case from their files. One of my officers met the Assistant Area Administrator of the AHA(T) (the Asst AA) and discussed the case with him and with the AHA(T)'s Specialist in Community Medicine (Social Services) (the SCM(SS)). My officer also met and discussed the complaint with the complainant and his sister.

6. The papers I have seen include correspondence about the case from the social services department of a London Borough (the SSD), the Foreign and Commonwealth Office (the FCO) and the DHSS. Although the actions of local authorities and central government departments are not within my jurisdiction in my capacity as Health Service Commissioner I have recorded information from this correspondence in my report, which is essentially an explanatory one.

7. From the papers I have seen I have reconstructed the sequence of events as follows. After the complainant's brother expressed a desire to return to England the MHV received enquiries from the brother's son, his sister, and the complainant himself. On 4 February 1976 the MHV replied to all three that, provided they understood that permanent care in a nursing home would be necessary, it should not be too difficult to arrange the brother's return to the UK; he was in very good health physically although mentally his memory was very poor and he needed supervision.

8. The complainant subsequently visited the SSD to ascertain what services were available for people like his brother. The social worker he saw recorded in a letter of 18 February to the MHV that although she was not entirely clear about his brother's medical condition she had discussed with the complainant

the possibilities of private nursing homes, hospitals and local authority hostels as well as domiciliary facilities available. She said that the department's services to the mentally ill and ex-psychiatric patients were very limited but if the brother returned to the country they would endeavour to help in every way they could. On 1 March the complainant's Member of Parliament wrote to the SSD and on 8 March they replied that they had written to the MHV but had heard nothing further. They added that if the brother needed admission to a psychiatric hospital then that was the concern of the area health authority.

9. In correspondence with the MP the complainant explained that although he had room for his brother he was retired and a widower and could not provide the necessary care. A senior social worker wrote to the complainant on 27 April indicating that they had received further information from the MHV about the state of health and the need for supervision of the complainant's brother and stating that, before a decision could be made about the type of residential resource suitable for his needs, he would have to be examined by a consultant psychiatrist employed by a UK area health authority and a full assessment made of his potential by medical and social services staff. If and when he returned to the area, the SSD would arrange the necessary assessments.

10. On 11 May the MHV informed the son of the complainant's brother, to whom he had written on 23 March, that he, the MHV, had received two favourable replies from the SSD who had made arrangements for his father to be seen by a psychiatrist. He said that arrangements were complete in South Australia but an escort to the UK was necessary; he explained that if the son could not provide the escort himself it would be necessary to make arrangements in Australia and the cost would be in excess of 1,000 dollars. The MHV concluded that if he did not hear from the son within three weeks he would arrange for the father to be escorted back to England immediately.

11. On 18 and 21 May the complainant visited the FCO who promised to look at the case. And on 24 May the daughter-in-law of the complainant's brother telephoned the FCO and told them that her husband was about to book a flight to Adelaide to escort his father home. Following discussion with the SSD, who had again requested from the MHV a full medical and social report, the FCO pointed out to her the dangers of allowing a patient to enter the UK without a bed booked for him, advised her husband not to fly out yet and undertook to try to get a message to the MHV, to whom she and her husband had already written asking him not to send his father home yet. The FCO obtained for the SSD a medical report dated 25 May from the doctor in charge of the case stating that the complainant's brother would require placement in a hospital with nursing supervision. The SSD explained the situation to the complainant on 9 June and told the FCO that hospital care was not within their power to arrange; two days later the FCO passed the papers to the DHSS for advice.

12. On 23 June the DHSS obtained the opinion of their medical adviser that the complainant's brother should first be admitted to a hospital assessment unit and seen by a psychiatrist and probably a geriatrician and that he then should either remain in the hospital or be transferred to suitable local authority care

depending on the opinion of the consultants. On 6 July the DHSS passed on this opinion to the AHA(T) and asked them to let them know of a suitable hospital to which the patient might be admitted. The SCM(SS) asked the medical administrator of a hospital (hospital A) if a place could be found, but on 27 July the administrator replied that he felt the complainant's brother had no claim upon their catchment area and the appropriate hospital to take him would be the one covering the complainant's address (hospital B). The administrator added that there had been no male psycho-geriatric vacancies at hospital A for two years and the male admission ward was trying to cope with an impossible and dangerous situation. On 20 August the SCM(SS) asked his counterpart in the AHA, within whose jurisdiction hospital B lies, whether the appropriate consultant could be persuaded to admit the complainant's brother when he was repatriated.

13. In the meantime the complainant continued to hasten action himself and with the help of his MP, and on 7 September the Asst AA wrote to the complainant confirming that the AHA(T) was doing everything possible to try to find a bed. On 15 September the SCM(SS) told the DHSS that the name of the complainant's brother had been placed on a waiting list at hospital B but admission would not be possible until hospital A became the relevant hospital for the area which it was hoped would take place within the next two years or so. He added that the waiting time would be similar if the complainant's brother was resident in that part of the area currently served by hospital A. The SCM (SS) emphasised that they were extremely fortunate to get the consultant to agree to add the name to a list and said that he thought it unreasonable to expect any priority for this case over and above that given to patients in the community in the part of the area concerned. The DHSS passed this information to the FCO for transmission to the complainant.

14. The following month the complainant asked the Asst AA if the two year waiting time, which he thought excessive in view of his brother's age, could be shortened. I have seen that the Asst AA sought the advice of the SCM(SS) before he replied that the medical staff could find no way of making arrangements at an earlier date and he saw no alternative to the brother's name remaining on the waiting list as previously agreed. In March 1977 the complainant endeavoured unsuccessfully to find accommodation for his brother in a British Legion home and he also sought the assistance of the British Red Cross Society.

15. On 2 November 1977 the MHV replied to an enquiry from the son of the complainant's brother telling him that physically his father, who was then in a hospital, was well but he was slowly deteriorating mentally, they planned to place him in a private nursing home for a trial period to see if he could be managed outside the hospital. The MHV expressed his opinion and that of the doctor in charge of the case that it would no longer be to the patient's advantage to return to the UK; whereas twelve months previously he would have been able to appreciate his return and reunion with his family, that was no longer the case and he was happy and contented whatever surroundings he was in. The MHV added that he thought the only way for him to have any chance of returning to the UK was for his son to go over, take him home and make himself fully responsible for his father.

16. This letter was followed immediately by another to the complainant who had written to the Australian Department of Veterans' Affairs about his brother; their reply was equivocal regarding the possibility of the brother's return to the UK. In it the writer referred to a plan to place him in a nursing home to establish whether it was feasible for him to live outside a hospital even if he appeared unsuited to return to the UK. She said that he was not a certified patient, had never been likely to harm himself or anyone else, was always considered amenable but had a tendency to wander because of his mental confusion. The writer pointed out that the Public Trustee held funds on the patient's behalf which would be available to pay for an escort and adequate for regular care in an average nursing home in his homeland. She said that there should not therefore be any financial liability to his relations or his country. She asked in what way the complainant and the son could help the patient and what benefits would materialise from his return to the UK.

17. On 8 December the complainant wrote to the Asst AA enclosing the two recent letters from Australia. The complainant pointed out that he had been pursuing the case for two full years but without result; he deprecated the fact that many foreigners received treatment under the National Health Service as a burden on the economy whereas his brother would not have been a burden on the ratepayers because all expenses were to come from his estate. The Asst AA consulted the SCM(SS) and on the strength of his advice replied to the complainant confirming that his brother's name was on the waiting list for admission to hospital A but no firm indication could be given of when he would be admitted; medical advice from Australia, however, seemed to be against his repatriation. The Asst AA added that if the family decided to bring him back they might wish to arrange a private nursing home place; if so he would be pleased to put the family in touch with appropriate institutions.

18. The situation was reviewed again in May 1978 at the request of the daughter-in-law. The SCM(SS) wrote to the consultant psychiatrist at hospital B who decided that, in view of the continuing uncertainty over timing of the transfer of the area in which the complainant lived to the catchment area of hospital A, the name of the complainant's brother should be put on the general waiting list for patients from that area for admission to hospital B. But he pointed out it was unlikely that a bed could be offered during 1978 since there were already eleven men waiting for admission and no vacancies. The Asst AA conveyed this information to the daughter-in-law and said he would keep in touch with her.

19. On 23 March 1979 the complainant's brother died. The complainant telephoned the Asst AA with the news on 18 April and wrote on 6 May to say that he had received no response, although the Asst AA had said he would ask his superiors to 'investigate the matter'. The AHA(T)'s papers show that the Asst AA did refer the case to the Chairman of the Authority but she decided not to write to the complainant at that time. The complainant went on to say that the three year delay had prevented his brother being reunited with his family and the Asst AA should have known that it would cause the brother's death. The Chairman of the Authority replied on 16 May that if the Authority were at fault it was in being over-optimistic about the date on which a bed might have

become available at hospital A. She said it had been expected that a block of beds at hospital A would become available to accommodate residents from the area in which the complainant lived but for reasons outside the Authority's control that was still unlikely to take place for a little while. Consequently, there had been virtually no vacancies to offer and had one arisen it would almost certainly have been given to a patient in the area with the highest priority. The Chairman added that medical information received from Australia was somewhat at variance with the complainant's letter; both the MHV and the doctor attending the complainant's brother thought it would not be to his advantage to move him. The complainant was dissatisfied with this reply and referred the matter to me.

20. In his letter to me and in conversation with my officer the complainant said that after he described his brother's situation to the Asst AA the latter undertook to find a bed for him as soon as possible; the complainant was under the impression that he meant a bed in a nursing home. He said that the AHA(T), by placing his brother's name on the waiting list at hospital A, a hospital for mental illness, were in effect diagnosing him as mentally disturbed without examining him. The complainant thought that the British Legion declined to offer accommodation for 'someone in your brother's condition' because the Asst AA might have told them that his brother needed psychiatric treatment. The complainant did not believe that the AHA(T) had any direct correspondence with the Australian authorities and he therefore took exception to the Chairman's assertion that they had medical information which was at variance with the information given in his letter to them. He alleged that they merely considered the November 1977 letter from the MHV (paragraph 15) and disregarded earlier correspondence which indicated that his brother's return to the UK was entirely feasible. The complainant added that there appeared to be no co-operation between the various UK departments and agencies involved.

21. The Asst AA in his written comments to me on the complaint and in discussion with my officer said that the AHA(T) did not accept *responsibility* for providing hospital accommodation for the complainant's brother. He knew of no regulational procedures which entitled British nationals living abroad to be put on the waiting lists of hospitals in the UK; on the other hand he knew of none that prevented this. From the outset, therefore, they tried to make arrangements to help the family; and they had arranged inclusion on the waiting list. He agreed, however, that, with the benefit of hindsight, the AHA(T) might have been too optimistic about finding a hospital bed and thereby raised the family's hopes too high.

22. The Asst AA said that they acted on a request from the DHSS who gave details of the case and asked them to make arrangements for the admission of the complainant's brother for assessment by a psychiatrist and/or a geriatrician. Because of the links the complainant's brother had with the area through prior residence and through relatives in the area, the Asst AA thought that the AHA(T) should try to help. Their original intention had been to arrange admission of the patient for assessment at hospital A, after which he would have been transferred to a residential home or to day care or, as seemed the most likely on the medical evidence, remained where he was.

23. Waiting lists are controlled by consultants and it is for them to decide priorities and the allocation of places. In this particular case, however, the Asst AA said he gave at the outset an estimate of a two year waiting period because he knew that it was likely to take that length of time to achieve the rationalisation of anomalies in catchment area boundaries affecting the number of beds available at hospital A for patients from the area in which the complainant lived. He said that hospital A served three catchment areas outside the AHA(T)'s boundary which together took up approximately 170 beds out of the total of more than 1000 at the hospital. The problem of arranging for the two AHA's responsible for these areas to provide beds for their own patients who were already accommodated in hospital A was complicated by the fact that one of them had a commitment to provide some beds for patients from other areas, including the AHA, who in turn had a commitment to provide beds for patients from the area in which the complainant lived: it was a vicious circle which was taking much longer than expected to break. The Asst AA went on to explain that despite many attempts by the AHA(T) to achieve a solution, including unilateral action to refuse admission to patients from other areas, the problem remained and it was unlikely to be before the end of 1980 that admissions to hospital A from two of the areas outside the AHA(T)'s boundaries would cease and the commitment for patients from the area in which the complainant lived be accepted.

24. In general comment on the points made by the complainant the Asst AA told my officer that he had no direct communication with the Australian authorities; his Chairman's reference to medical reports being at variance with the contents of the complainant's letter to which the latter took exception related only to a different interpretation of the reports the complainant himself had provided to the AHA(T). He had said in his letter of 6 May 1979 (paragraph 19) that his brother's life could have been saved if he had been allowed to reunite with him and his sister earlier, but the AHA(T) did not place that interpretation on any of the reports they had seen. He did not accept the complainant's views regarding the priority that should have been given to his brother but in general thought the AHA(T) had been right in trying to help the family and explained that they had put the complainant's brother on the waiting list because it was thought there was a possibility of providing a bed. The Asst AA stated categorically that he had no contact whatsoever with the British Legion over the complainant's brother.

25. The SCM(SS) who arranged the placement of the complainant's brother on the waiting lists told my officer that he had no direct control over the allocation of beds; that was the responsibility of the consultants. In many cases the choice open to them was either to admit someone to an 'acute' bed (ie a bed designated for a patient suffering from an acute condition) and risk blocking it in the event of the individual not requiring long-term hospital care and the social services department being unable to provide alternative accommodation, or to put the individual's name on the waiting list. At the time the name of the complainant's brother was placed on the waiting list, a wait of four years was not uncommon; but it was thought at that time that agreement on resolving the catchment area problem might be reached in a much shorter space of time, thus releasing a block of beds at hospital A for patients from the area in which the

complainant lived. The SCM(SS) was in no doubt at all that the complainant's brother was in need of hospital care and said that his rapid deterioration and death confirmed that view. He added that in this country care for the confused elderly had come traditionally from psychiatrists and that senile dementia was classified as a psychiatric condition. It was appropriate therefore that he should have looked to a mental illness hospital for the care of the complainant's brother.

26. The AHA told me that, when he was first approached, the consultant psychiatrist at hospital B controlled nine acute male beds for patients from the area in which the complainant lived but no psycho-geriatric beds. Only in very exceptional cases were psycho-geriatric patients admitted to the acute beds because they were in great demand for younger men; the consultant relied on beds for psycho-geriatric patients being made available by his other medical colleagues and, in fact, he shared a waiting list with one of them. The AHA said that when the situation was reviewed in May 1978 (paragraph 18) five of the eleven men on the consultant's waiting list were residents of the area in which the complainant lived. Between that date and March 1979 when the complainant's brother died four patients, all from that area were admitted from the waiting list. The consultant confirmed that the complainant's brother had moved up to seventh place by the time he died but doubted if, had he lived, a bed would have been available for him until early in 1980. The consultant explained to my officer that once a person's name was on the waiting list other names added would not be given priority, although in any case where urgent admission became necessary the patient would be taken into the admissions ward, where he might well stay for six months or longer until a long-term bed became available. He added that the waiting list was reviewed at regular intervals but after May 1978, no further information about the complainant's brother was received on which to base a review of his case.

Findings and conclusions

27. The complainant's brother remained a British National after taking up residence in Australia in 1948 and the complainant regarded this and his brother's wartime service as entitling him to care and treatment in a hospital in this country when it was required. The complainant was unable to accept that others born abroad but now resident here had a better claim on the hospital resources available in this country. But the DHSS guidance to health authorities makes it quite clear that the National Health Service in England and Wales is available to anyone normally living in the United Kingdom, regardless of nationality. Furthermore that guidance placed no obligation on the AHA(T) or the AHA to offer or arrange facilities for the care of the complainant's brother before he returned. Despite this, the AHA(T) tried to assist in view of the family's association with the area.

28. The complainant has contrasted a statement made by the MHV in March 1976 that his brother was not a mental patient with the sole consideration that was given to providing care for him in a mental illness hospital. The complainant has questioned whether such a hospital was appropriate for his brother. But I have seen that the medical officer in Australia in charge of the case said in May 1976 that senile dementia had been diagnosed and that it required placement in

a hospital with nursing supervision. In this country senile dementia is classified as a psychiatric condition and, traditionally, care is given to the confused elderly in psychiatric hospitals unless a special unit for dementia is available, which is not the case in the AHA(T). The SCM(SS) decided on the basis of the medical evidence from Australia that it was appropriate to seek a place for the complainant's brother in a mental illness hospital – a decision he was entitled to take in the exercise of his clinical judgement and one which I am not empowered to question.

29. The complainant attempted to get the estimated waiting period of two years reduced but without success. The AHA(T) were not prepared to give the case priority and bearing in mind that the patient was already being cared for in hospital, albeit far from his family, I make no criticism of that decision. Following the review of the case in mid-1978, the name of the complainant's brother was added to the psycho-geriatric waiting list at hospital B and I am satisfied that he progressed up the list as patients above him were admitted. Sadly, the two year estimate proved to be over-optimistic and I think that a contributory factor was the delay in resolving the catchment area anomalies (paragraph 23). The AHA(T) actively pursued this question from their side and I have found no grounds on which I could criticise them for the delay.

30. In this case it is clear that the AHA(T) were over-optimistic in their estimate of the waiting period and they regret that that was so. But I have found no cause to criticise the AHA(T) or the AHA for their action in trying to place the complainant's brother in a suitable hospital bed. I recognise that to the relatives the waiting time must have seemed excessive, but reasonable funds were said to be available for private nursing care and I have noted that the AHA(T) in December 1977 offered to put the family in touch with private nursing homes if that was their wish. Even though earlier the same month, the complainant had written that his brother would not have been a burden on the ratepayers because all expenses were to come from his estate, I have found nothing to suggest that the family took up the AHA(T)'s offer. That was of course entirely a matter for them to decide.

Case No. W.118/79–80 – Handling of complaint by Family Practitioner Committee

Background and complaint

1. On 3 April 1979 the complainant wrote to her Family Practitioner Committee (the FPC) complaining about the treatment given to her mother by her family practitioner (the FP) She was not satisfied with the way in which her complaint was dealt with and with the FPC's response and subsequently complained to me.

Jurisdiction

2. Paragraph 19(2) of Schedule 13 to the National Health Service Act 1977 precludes me from investigating action taken by a Family Practitioner Committee in the exercise of its functions under the National Health Service (Service Committees and Tribunal) Regulations 1974 (the 1974 Regulations) in dealing with complaints against doctors, dentists, pharmacists or opticians. I made

enquiries of the FPC and established that they had dealt with the complaint informally and outside the 1974 Regulations and I therefore decided to proceed with an investigation of the action they had taken. The action of the family practitioner himself is not within my jurisdiction as I explained to the complainant at the outset.

Investigation

3. During the investigation I obtained the comments of the FPC and I have seen the relevant correspondence. I am sorry to record that the Administrator of the FPC (the Administrator) died soon after he had given his initial comments on the complaint. My officers however took further evidence from the Chairman and the Assistant Administrator of the FPC; one of my officers also met the complainant.

4. I know from previous investigations I have undertaken that Notes of Guidance have been issued by the Department of Health and Social Security about the way Family Practitioner Committees deal with complaints against family practitioners and other independent contractors. These Notes refer not only to the procedure under the 1974 Regulations, known as the formal Service Committee procedure, but also to an informal procedure under which a lay member of the Family Practitioner Committee, assisted as necessary by a medical member, provides support to the FPC Administrator with the purpose of clearing up minor grievances, a procedure which in turn is not intended to prevent the FPC Administrator from achieving informal reconciliation of difficulties between a patient and a family practitioner when that is possible. It is clear from the Notes of Guidance that a complainant and the doctor should be informed at an early stage whether it is proposed to deal with a complaint under the informal or formal procedure; that neither party is obliged to accept the informal procedure; and that a right to an investigation under the formal procedure remains. As regards the time limit in which a complaint can be made the Notes of Guidance explain that when a complaint is dealt with under the formal procedure, it must normally be received by the Committee within eight weeks of the event which gave rise to the complaint – the date on which the complainant became aware of a possible breach of terms of service not being regarded as relevant. Under the formal procedure the Notes expect an Administrator to seek the complainant's reasons for the delay in making a complaint and, if a FPC concludes a complaint is out of time, the complainant has a right of appeal to the Secretary of State and the Notes again anticipate, in accordance with the requirements of the Regulations, an Administrator informing the complainant of that right. But under the informal procedure, where a member of the Family Practitioner Committee is appointed to assist in resolving difficulties, the Notes of Guidance explain that the appointed member need not be inhibited from taking up a complaint because it would be out of time under the formal procedure or because it discloses no reasonable grounds for alleging that terms of service have been breached. Unless a complainant indicates that he does not want his complaint investigated formally, it has to be referred, in the case of a complaint against a family practitioner, to the Chairman of the Medical Service Committee for action under the 1974 Regulations. The Notes also show and the Regulations require that it is the Chairman of the Service Committee

who has to decide whether the complainant discloses any reasonable grounds of complaint and these are said to exist where the facts alleged by the complainant, if true, show a breach of the practitioner's terms of service. The Notes of Guidance make the point that the doctor's failure to reach a correct diagnosis does not in itself constitute a breach; the question depends on the degree of care and skill exercised by the practitioner in arriving at the diagnosis.

5. In her letter of 3 April to the FPC the complainant explained that her mother visited the FP a year previously complaining of pain in the lower back and stomach, and was prescribed medication. She returned to the FP on several occasions, still in pain, and received further treatment. The complainant said that the FP later gave her mother an internal examination of the bowel, and that, later still, her mother returned to the FP because of increasing pain and insisted on being given a hospital appointment. This was arranged three weeks later, and when she was seen at the hospital, she returned the next day for further examination. Some days later she was admitted for tests and it was discovered that she had a large tumour of the bowel requiring major surgery. The complainant approached the FPC about the failure of the FP to refer her mother to hospital earlier and wrote of the FP's general reluctance to refer patients to hospital for tests, supporting her point by reference to her husband's similar experience.

6. The Administrator replied on 27 April informing the complainant that complaints against a family practitioner should, in accordance with Regulations, be submitted to the FPC within eight weeks of the event which gave rise to the complaint. He asked her whether the situation of which she complained occurred within the time limits prescribed by the Regulations, ie after 8 February 1979, as her letter did not include any dates of the incidents mentioned. She replied, giving only the date of her mother's operation – 19 March 1979. On 4 May the Administrator again asked for the dates of all the incidents she had included in her letter and on 11 May she wrote again giving the date of her mother's first visit to the FP – 2 January 1978 – and the date of the last visit on 17 February 1979 when her mother requested a hospital appointment. She also gave details of the dates of the events after that appointment. On 21 May the Administrator replied to the complainant stating that incidents prior to 8 February 1979 would normally be considered out of time and indicated that his comments would therefore be restricted to her mother's visit to the FP on 17 February and subsequent events. The letter went on to explain that the Committee could only investigate a complaint against a doctor if the circumstances indicated that the doctor concerned might not have complied with his terms of service. The Administrator concluded that the doctor had in fact seen the complainant's mother, provided treatment and medication and had referred her to hospital. The complainant's response on 30 June was to point out that it was not possible to have made the complaint any earlier than she did, since it only became evident to her after her mother's hospitalisation that a referral to the hospital should have been arranged much earlier. She alleged that the FP had made little attempt to discover what was wrong with her mother. She added that since the Committee were unwilling to do anything about the events prior to 17 February 1979 she intended to write to me enclosing the correspondence. No further substantive action was taken by the FPC at that stage.

7. The complainant told my officer that not only did she disagree with the FPC's view that the main substance of her complaint was out of time, but she was also upset by the unsympathetic and unhelpful nature of their replies.

8. When the then Administrator gave his comments on the complaint he explained that as the complaint was initially to be treated informally, it was pointed out to the complainant that with regard to the recent events her mother had in fact been seen by her doctor who had provided her with the necessary introductory letter to hospital and that she had received appropriate treatment following an operation. He added that in view of these facts it did not appear that the doctor could be considered in breach of his terms of service. Had the complainant any further comments to make the Administrator suggested that it would have been expected that she would have replied to the Committee's letter of 21 May but that no such reply had been received when my officers first discussed the case with him. Subsequently the FPC received the complainant's letter of 30 June and in the light of the information that she had passed the complaint to me her letter was only acknowledged. He pointed out that throughout the correspondence the complainant had referred to the family practitioner's mis-diagnosis but that failure to diagnose correctly was not necessarily a breach of a doctor's terms of service. The Assistant Administrator who was closely involved with the then Administrator in handling this complaint said that at that time they normally dealt with complaints together. The Assistant Administrator usually drafted letters to complainants which were vetted by the Administrator before despatch; he remembered that although the Administrator was unwell at the time they followed this procedure with this complaint. He was sure the complaint was not referred to the Chairman of the Medical Services Committee and the present Administrator has confirmed this. The Assistant Administrator explained that they were waiting for further details from the complainant before doing this, and for the same reason she had not been advised of her right of appeal to the Secretary of State. He said that the letter of 21 May was not a rejection of her complaint but one seeking more information from her. He added that although her correspondence had been dealt with informally up to the time it was referred to me, the FPC had not regarded her case as a minor cause of dissatisfaction but rather as a complaint.

9. The FPC Chairman – whose role is not to be confused with that of the Medical Services Committee Chairman – acknowledged that the complainant was not advised of her right of appeal to the Secretary of State; he thought the letter of 21 May should have mentioned this. But although the Chairman expressed regret that the complainant felt fobbed off by the FPC, he too considered that their letter was not meant to be seen as the final word. The FPC were he said trying to gather further information from the complainant on which to decide whether or not her complaint could be entertained. Nonetheless, neither the Chairman nor the Assistant Administrator thought a decision to reject as out of time that part of the complaint relating to events before February 1979 could be considered as harsh, given the Notes of Guidance.

Findings and conclusions

10. In his first reply of 27 April to the complainant the Administrator made no reference to the possibility of a Service Committee considering out of time

complaints nor did he ask for the reasons for the delay in submitting the complaint. When she provided dates, the Administrator said that these incidents before 8 February 1979 'would normally be considered out of time' and he restricted his comments to events thereafter. Furthermore by dividing the complaint in this way, the Administrator concluded that the doctor did not appear to be in breach of his terms of service. But the complainant's original complaint, in addition to the diagnosis of her mother's illness also concerned the reluctance of the family practitioner to refer patients to hospital for tests and the complainant cited her husband's experience in support of this. This rather more general complaint was not answered and I think it would have been prudent for the Administrator to have sought advice on that point. The Chairman of the FPC and the Assistant Administrator both told my officer that they regarded the Administrator's letter of 21 May as seeking further information but I can see no basis at all to support that line of argument. I find it hard to believe that any reasonable person would interpret the letter as seeking further information and I can fully understand why the complainant felt the matter was closed and that the replies had been unhelpful.

11. The Administrator told me that the complainant's correspondence was to be dealt with informally (paragraph 8), but the procedures that were adopted fell a long way short of those that good administrative practice requires. In another case I investigated I accepted that there is often scope for clearing minor grievances without recourse to investigation under the Regulations. But I do not regard the complaint as coming within that category and the Assistant Administrator has also confirmed that the complainant's correspondence was not regarded in that way. The conciliatory procedures therefore were not appropriate. And what is more the complaint was never dealt with in accordance with either the formal or informal procedures set out in DHSS guidance. Since I have found no evidence that the complainant ever intended to withdraw her complaint, I criticise the FPC for the way they handled it. Furthermore, she was denied a right of appeal to the Secretary of State (a matter which was never even mentioned in the correspondence) because the complaint was never considered under the 1974 Regulations and I believe the complainant was fully justified in complaining to me.

12. In upholding the complaint I have taken into account the Chairman's statement that the then Administrator was ill at the time and I can imagine the stress that this placed on his office as a whole. However I am pleased to record that the Chairman and the present Administrator have taken a constructive approach in that they have revised informal reconciliation procedures and I am equally pleased to record that the present Administrator wrote to my Office to say that all the complainant's correspondence was to be placed before the Chairman of the Medical Service Committee. I learned subsequently that the correspondence was placed before the Committee under the formal Service Committee procedure required by the 1974 Regulations. I hope the complainant will feel that the final outcome of my investigation has given her what she wanted in the first place – a proper consideration of her original complaint. I was very sorry to learn that the complainant's mother died earlier this year and extend my sympathy to the complainant in her loss.

Case No. W.164/79–80 – Waiting time for operation

Complaint

1. On 17 May 1978 the complainant was placed on the waiting list for a sterilisation operation at a hospital (hospital A). On 19 June 1978 she was told that her proposed admission to hospital A on 21 June had been cancelled. Various postponements followed until her eventual admission to another hospital (hospital B) on 1 January 1979 where the operation was carried out.

2. She complains of the time she had to wait before her admission to hospital and she is not satisfied with the replies made by the Area Health Authority (the AHA) to the representations on her behalf by her Member of Parliament.

3. During the investigation I obtained the written comments of the AHA and I have examined these and other relevant documents. One of my officers interviewed the staff involved. I was also given written evidence by a doctor who was abroad.

Background

4. In his letter of 17 July 1978 to the Area Administrator (the AA) of the AHA, the Member advised him that the complainant had been due to be admitted to hospital A on 21 June but on 19 June she had received a telephone call cancelling her admission. Afterwards she had been informed that she had been transferred to another consultant's list as the consultant, in whose care she had originally been placed, was shortly to retire. As a consequence it would no longer be possible for her to be admitted to hospital A as the new consultant had not been allocated operating time there. Instead she would be admitted in due course to another hospital (hospital C). The Member said that the complainant wanted the operation to be carried out at hospital A and in order that this might be done she was quite prepared to be placed on another consultant's waiting list.

5. On 8 August the AA replied to the Member that as was usual practice the new consultant took over the patients of the retiring consultant but as he carried out the particular operation which the complainant needed only at hospital C, all his other patients at hospital A waiting for the same operation would likewise be admitted there. The AA explained that if the complainant wished her operation to be carried out by another consultant so that she could be admitted to hospital A she would need a fresh referral from her family practitioner. He also pointed out that the operating theatres at hospital A were due to be closed shortly for at least three months and this being so it would perhaps be advisable for the complainant to accept the admission at hospital C when it was offered.

6. The Member wrote a further letter to the AA on 6 November. In this he referred to correspondence which the complainant had had with the district administrator (the DA) and he outlined the sequence of events, as he understood it, since he had last written. He said that the DA had indicated in his letter of 19 September to the complainant that she might be admitted on 23 October but

that did not prove possible and on 3 November the DA had written that equipment necessary for the operation was expected to be delivered 'about this month.' The Member asked to be told the latest position and concluded his letter by commenting that there seemed to him to be a most unfortunate saga of delay.

7. On 29 November the AA replied to the Member that the complainant's situation had been extremely unfortunate and that matters had been further complicated as the consultant had broken his arm and was unable to carry out any surgery for the time being. He referred to the gynaecological ward at hospital C having had to be closed on account of an extreme shortage of nursing staff but said that in view of this, arrangements had been made for the complainant's admission to hospital B where the consultant had other gynaecological beds. However equipment needed for the operation had not been available at that hospital and its order had been expedited. There then had followed an industrial dispute at that hospital involving maintenance supervisors when all but emergency and extremely urgent admissions were cancelled including that of the complainant. The industrial action had since ended and efforts had been made to obtain all the necessary equipment. The AA said that it was hoped to review the situation in four weeks, by which time the consultant was expected to have fully recovered and to be in a position to offer the complainant a date for admission. He referred to the whole situation as having been surrounded by a very unusual and unfortunate catalogue of events.

8. On 10 January 1979 the complainant wrote to the Member informing him that she had been admitted to hospital B on 1 January and had undergone her operation on the following day. Although she was relieved to have had the operation she said she found it incredible that there had been a delay of over six months from the time her first admission had been cancelled and she asked him to refer the case to me for investigation.

Investigation

9. My investigation has been handicapped as I have been unable to obtain first-hand information from those principally involved in the case. Shortly after I started the investigation the consultant who had retired, died. I then learned that the registrar who initially put the complainant on the waiting list for admission and who called for her admission on 21 June had returned to Australia. I also learned that the complainant herself had emigrated to the United States of America. In a written reply to my enquiries the registrar said that he was unable to recall specific details of the case. But he explained that when he had been in post at hospital A, in order to utilise fully the available theatre time and to improve bed utilisation rates in the private ward which also accommodated amenity beds, patients on the waiting list were offered an amenity bed either when they were first put on the list or when the bed became available. He said that this was how the complainant would have been called so quickly, only a month after she had been put on the list. The complainant's admission for 21 June had then had to be cancelled because of a shortage of nursing staff. The registrar said that shortly afterwards his consultant retired, he himself moved to another unit and the complainant was transferred to the list of the new consultant.

10. It is relevant to explain the terms 'amenity patient' and 'amenity bed'. An amenity patient is a part-paying patient who receives all medical, surgical and ancillary services free of charge, his or her only payment being towards the cost of accommodation. Provision for such is made by Section 63(1) of the National Health Service Act 1977 which states *inter alia:*

> 'The Secretary of State may authorise the accommodation described in this section to be made available, to such extent as he may determine, for patients who give an undertaking (or for whom one is given) to pay such charges for part of the cost as the Secretary of State may determine, and he may recover those charges. The accommodation mentioned above is:
>
> (*a*) in single rooms or small wards which is (*sic*) not for the time being needed by any patient on medical grounds;
>
> (*b*) at any health service hospital or group of hospitals . . .'

I have established that according to the complainant's pre-admission form, which was completed when she was first placed on the waiting list, she indicated her interest in such accommodation if it was available when her turn came to be admitted and that she was prepared to accept admission at two to three days' notice.

11. In an interview with my officer the consultant obstetrician and gynaecologist (to whom I shall now refer as 'the consultant') to whose list the complainant transferred when he took up his appointment on 3 August 1978 said that he had found a long waiting list for operations and his efforts to reduce this had been frustrated by events including theatre closures, staff shortages, an industrial dispute and a lack of modern equipment. To make matters worse he had broken his arm and had been unable to carry out surgery for about three weeks during November 1978. He said that he himself did not know why the complainant had been offered the amenity bed in June and as far as he was concerned she only wanted sterilisation for social reasons which he did not consider warranted her being given an earlier admission. He had seen the complainant on 9 September when she had asked him for immediate admission but he had had to decline her request for this very reason. He pointed out to my officer that between his date of appointment and the date of the complainant's eventual admission to hospital he had carried out only three other primary sterilisation operations solely for contraceptive reasons. These operations had taken place in December 1978 and all three patients had been waiting for admission between 9 and 10 months. The consultant said that the offer of admission in October had only been made to the complainant in a bid to stop 'harassment' of himself by the administration who had been repeatedly asked by the complainant when she might expect to be admitted. He admitted that by so doing the complainant had jumped the waiting list and that he had at the time chosen what he considered to be the easy way out of the situation.

12. I have established from the AHA's records that the private ward (which housed the amenity beds) at hospital A was closed from 19 June 1978 until 9 July 1978 due to staff shortage and that the theatres there began closing for upgrading and redecoration on 21 August 1978 and it was not until 19 March 1979 that they were all fully operational. The gynaecological ward at hospital C was closed on 1 July 1978 because of shortage of nursing staff and still remains

so. According to one of the district's officers this is because, in addition to a national shortage, the hospital also experiences difficulties in attracting nursing staff on account of its relative isolation from any larger centres and its poor residential accommodation.

13. Commenting on facilities at hospital B, the hospital to which the complainant was eventually admitted, the consultant in a report, dated 10 October 1979, on the state of his waiting list said that he found that one of its theatres was deficient in modern gynaecological equipment and that there were no specialist x-ray facilities in the theatre. He said that he understood that his predecessor had had to carry out operations needing this equipment at hospital C. He himself however had asked and it had been agreed that £5,500 should be spent on bringing the theatre at hospital B up to modern standards.

14. I have established that the industrial dispute referred to earlier was part of a national campaign involving maintenance supervisors and it affected the district's hospitals from 18 September until 21 November 1978. During this period emergency cases only were dealt with. In the meantime most of the equipment ordered by the consultant had arrived and by 18 November its delivery had been completed. Operations however had had to be further delayed on account of the consultant's own accident. In his report the consultant stated that he had reviewed the complainant's case when all the equipment had arrived, but he had concluded that as the operation was not urgent and for purely social reasons he did not consider he could give her preference over others whose cases were more urgent or who had been waiting longer. His report shows that only three primary sterilisation operations for contraceptive purposes were carried out by him before the complainant had her operation on 2 January 1979. Of these the first was carried out on 7 December, the patient having been on the waiting list since 5 April 1978, the second on 14 December the patient having waited since 1 March 1978, and the third was carried out on 28 December the patient having waited since 19 April 1978. (The complainant was placed on the waiting list on 17 May 1978.)

15. I have also examined the Regional Health Authority's statistical summaries for patients on in-patient waiting lists. On 31 March 1979 these show that in the region as a whole out of a total of 7,016 patients for gynaecological operations for non-urgent reasons 818 (representing 11·5 per cent of the total) had been on the waiting list for more than one year. The corresponding figures for the AHA were 2,833 and 355 (this represents 12 per cent of the total).

Findings

16. The complainant has said that she could not understand why there was a delay of over six months from the time of her proposed admission on 21 June 1978 to the date when she was admitted for her operation on 1 January 1979. If the proposed admission had not been cancelled she would have had her non-urgent operation within one month of being put on the waiting list on 17 May. In the course of my investigation surprise was expressed at this early offer of admission and I have been unable to obtain an adequate explanation as to how it occurred but I am satisfied that the complainant was offered a priority to which she was not entitled. The provision of amenity beds for National Health

Service patients who choose them when placed on waiting lists is subject to the availability of this type of accommodation at the time of admission in accordance with their place on the waiting list for all National Health Service patients requiring similar treatment. If an amenity bed is available, as in this case, it ought to be offered to the next person on the waiting list irrespective of whether the patient chose an amenity bed or not and no charge is made in these circumstances to a patient who had not 'booked' an amenity bed. In the absence of any evidence to the contrary, it seems to me that this procedure which has been the general practice since the issue of relevant guidance in the former Ministry of Health circular R.H.B(51)66 was not followed when the complainant was offered the amenity bed for admission on 21 June. (I was surprised during my investigation to be informed by the Department of Health and Social Security that this circular had now been cancelled – "not on the grounds that it is wrong or superseded but because it was issued as advice needed in 1951 which we felt it was no longer necessary to keep 'alive' ".) Certainly as regards the occasion when she was next offered admission on 23 October the consultant has agreed that in making his decision he was influenced by the pressure being applied by the complainant and that she was incorrectly given preference over other non-urgent patients who had been longer on the waiting list.

17. In my report I have detailed the unfortunate saga of events which affected the waiting time for non-urgent gynaecological operations similar to the complainant's and which placed the AHA in a difficult situation. I consider in the circumstances that they did all they could to help her bearing in mind the nature of her operation. She may not have been aware that when she was first called for admission in June 1978 she was given priority–although wrongly in my view – and if this was so I can understand her disappointment at the delays which ensued until in the correct order of the waiting list she had her operation on 2 January 1979. The complainant waited seven months for her operation; she fared better than other patients as the statistics in paragraph 15 show and in my opinion in a time of scarce resources this was not unsatisfactory for a sterilisation for social reasons. I do not uphold this aspect of the complaint.

18. The AHA in their replies to the Member explained frankly the various difficulties they faced and the reasons why the proposed admissions had to be cancelled. I have no criticism of their handling of this complaint.

Conclusions

19. I have not upheld this complaint but in my investigation of it I found weaknesses in the management of the waiting list concerned and I am glad to record that the AHA have recently told me that they are reviewing their procedure for the use of amenity beds.

Case No. W.214/79–80 – Management of elderly patient's money

Background and complaint

1. In January 1974, the complainant's father then aged 80, was transferred from an old people's home to a hospital (the hospital) where he remained until his death in January 1979. His son complains that he is not satisfied with:

(*a*) the way in which the Area Health Authority (the AHA) managed his father's financial affairs and made purchases on his behalf; and

(*b*) the possessions he was told had been left by his father and which were returned to him after his father's death.

Investigation

2. During the investigation, I obtained the written comments of the AHA and examined the relevant documents. One of my officers interviewed members of the nursing, administrative and finance staff of the AHA. She also met the complainant.

(a) *The complaint that the AHA mismanaged his father's affairs*

3. The complainant told my officer that he had received a letter from the sector administrator (the SA) of the hospital in June 1975 advising him that, in the opinion of the consultant physician, his father was no longer able to manage his own affairs. He was asked, as his father's next of kin, to make arrangements through a solicitor for someone to be appointed to act on his father's behalf. As he was then fully occupied caring for his invalid wife he took no action on receipt of the letter.

4. The complainant wrote to the hospital in October 1978 asking for details of his father's financial position. The SA replied that he could not give details of the father's savings account but said that his father's pension was used in providing him with all the comforts he required such as cigarettes, talcum powder and soap.

5. He wrote again to the SA after his father's death asking for detailed records of his father's savings account and the money spent on comforts for him. The SA replied on 22 February 1979 setting out the average pension received each year by the father (which totalled about £727 over the five year period). He said that the average weekly expenditure (he must have meant 'income') over the period was therefore £2·79; that the total expenditure was £482; that in round figures the difference between all monies received and the total expenditure was £300 and, of this sum, £244·58 had been paid to him the complainant as next-of-kin. The balance of some £56 was spent on extras such as clothing and outings.

6. The complainant then referred the matter to the Area Administrator (the AA) as he considered the amount of money spent on his father's comforts to have been excessive. The AA replied to the complainant on 5 April 1979 that nothing further could be added to the explanation of his father's financial affairs already given to him by the SA, but said that 'the Sister [the Ward Sister of [——] Ward] maintains a record of her receipts and disbursements of all patients' moneys and these records are subject to regular audit by the District Finance Officer'. In a further letter dated 17 April, the AA said – 'I am satisfied that your father's financial affairs were managed conscientiously by the hospital', but on 19 April wrote to the complainant saying that premium bond prizes totalling £125 which were credited to his father's account whilst he was in hospital had not been included in the SA's letter of 22 February, and apologised for the omission.

7. The complainant was not satisfied with some aspects of the AHA's replies. For example, he was told that money had been spent on comforts such as cigarettes, yet his father did not smoke; and, as £125 income from premium bond wins had been omitted from the figures, an even greater amount of money

had been spent on comforts than he had first been told. From an examination of his father's savings account, he also noticed a change in his father's spending pattern after 1975, the year when he was informed that his father was incapable of managing his own financial affairs. Before that year, his father had deposited approximately one half of his pension in his savings account but after that time his whole weekly pension had been withdrawn and spent.

8. The complainant asked his Member of Parliament to investigate the matter and the Member approached the Department of Health and Social Security (the Department) on his behalf. The Department's reply of 24 July, he said, merely repeated what he had been told by the AHA in their letter of 5 April.

9. The hospital records show that £7·68 was transferred into the complainant's father's account when he was admitted from the Old People's Home. From 22 January 1974 to 29 January 1979 his income was £880·95 including premium bond prizes totalling £125. His expenditure during this period was £644·05 and, other than a payment of £21·55 made on his behalf by the hospital on 22 February 1974, this money was passed in weekly payments to the ward for him. His income less expenditure plus the money transferred when he was admitted, left a balance of £244·58 which was the sum paid to the complainant after his father's death.

10. The Department's memorandum HM(71)90 issued in 1971, *inter alia*, gives guidance to health authorities on the issue of personal allowances such as pensions to long-stay patients. In general, the Department say, patients should be encouraged to spend their full personal allowance apart from any amount they wish to set aside for purposeful saving. Where a patient deposits or accumulates more than £100 from all sources in his account, and maintains such a balance for over three months, an appropriate amount should be reserved for the patient's immediate needs and the rest deposited in an interest-earning account.

11. The memorandum states that arrangements for the payment of personal allowances and for patients' personal accounts, the hospital cash office and the hospital shop or trolley service should be the responsibility of the 'chief financial officer or Secretary' as appropriate and their staff. Where patients are so severely handicapped or confused that they are not able to decide on their own requirements, a nurse may need to *order* the goods which the patient is most likely to appreciate and the nurse in charge of each ward should maintain for inspection by a senior nurse, a simple record of all goods obtained for individual patients. All transactions relating to the custody, deposit, investment and disposal of patients' money should be subject to the supervision and overall responsibility of the 'chief financial officer'.

12. The patients' monies clerk at the hospital (the clerk) told my officer that a weekly list of entitlements and allowances was drawn up for all patients whose pension books were held by the SA and sufficient money was obtained to meet these requirements. Once a week, on Thursday or Friday, she visited the wards to distribute the patients' money. Those patients who were capable of managing their own financial affairs told her how much money they required and signed for it. The ward sister decided how much money was needed for each patient not capable of making purchases himself and she signed for his money. The

transaction was not witnessed. Any part of the weekly pension not required by a patient was credited by the clerk to the patient's savings account.

13. My officer examined the records of monies paid to patients and these showed that the sister of the Ward had signed for the complainant's father's money since his admission in 1974. She told my officer that she had signed for money on the father's behalf since his admission, mainly because of his poor eyesight. The money was used to buy him comforts such as boiled sweets, talcum powder, of which he used large quantities, magazines (as he enjoyed looking at large colourful pictures) and, as he had little contact with his family, birthday and Christmas presents – which had included on one occasion a watch purchased cheaply by one of the nursing staff. The watch, she said, had been given to another patient on his death. The sister said that although he had not wanted alcoholic drinks on his admission to the hospital, he had later enjoyed a little brandy and this had been bought for him. He was also taken on outings about twice a year for which he paid and raffle tickets for hospital fetes had been purchased for him. Some of his clothes, she said, were provided by the hospital but cardigans, slippers, socks and caps were bought for him.

14. My officer examined the ward sister's purchase records which were in an exercise book, a page being allocated to the purchases made for each patient. The date when money was received on behalf of a patient was recorded together with the pension due and, in some cases, the amount drawn by the sister when this differed from the patient's entitlement. The amount spent was also recorded. A very brief description of one or two items purchased each week was given. But on 27 occasions when the sister signed for money on the father's behalf no entry appears in the ward purchase book.

15. The sister told my officer that any part of the weekly pension of those patients for whom she undertook the responsibility for purchasing goods and which were not spent when the trolley visited the ward, was saved by her for more expensive purchases such as clothing; and the surplus money was kept in a locked cupboard in her office. The balance of the money saved for the complainant's father was not recorded in her purchase book but was kept in a labelled envelope and thus earmarked for his use. Wherever possible she encouraged relatives to take responsibility for the financial affairs of patients who were unable to handle their money. The sister believed that the father's other son (not the complainant) who had occasionally visited his father when he had first been admitted to the hospital, was approached but had been unwilling to be involved with his father's finances. The sister said that if she had had the opportunity to speak to the complainant she would have asked him if he would accept responsibility for his father's financial affairs.

16. The sister said that no guidance had been given to her on how a patient's money should be spent or on the maintenance of a ward record of purchases for patients. She admitted that the record book was a 'shambles' and that not all articles purchased for the complainant's father had been recorded. However, she said, all the money received on his behalf had been used for his sole benefit and none had been used for the general benefit of the other patients in the ward or for any other purpose. The sister said that, as a nurse, she did not want the responsibility of handling patients' money and, whilst she appreciated that the

records she kept were not adequate, she would be reluctant to maintain more detailed records if she were asked to do so.

17. A nurse who cared for the complainant's father told my officer that he had been quite lucid until the last year of his life and could tell the nursing staff what he wanted them to buy for him. The nurse said that a trolley came to the ward once a week and she obtained the items required for the patients who were unable to manage their own money. The tradesman gave the sister a list of the purchases of each patient and she paid him from the money she held on the patients' behalf. Only the sister and a charge nurse had access to the ward cash box and the other nursing staff only handled patients' money when it was required for purchases of clothes or expenditure on outings.

18. A charge nurse who had taken the complainant's father on hospital outings told my officer that, where patients were rarely or never visited by relatives, the nursing staff felt that the whole of the weekly pension should be spent on extra comforts for the patient rather than being saved.

19. My officer questioned a number of the other staff about the responsibility for safeguarding and accounting for patients' monies and I record their comments in this and the following paragraphs. The nursing officer who had been in post for three years and had previously been employed on the Ward was not aware that it was part of his duties to check the ward purchase book – which, in fact, he had never seen. No guidance had been given to the nursing staff on the maintenance of the ward account books nor could he remember having seen an AHA instruction on the handling of patients' money and property. Ward sisters, he said, had never been happy with the responsibility of looking after patients' money and, since my investigation began, had asked to be relieved of this responsibility. The senior nursing officer told my officer that she, too, was unaware that it was the responsibility of senior nurses to check the ward records of purchases made by nursing staff on behalf of patients in long-stay wards.

20. The SA told my officer that it was his responsibility to supervise the handling of patients' money and to provide the staff to carry out the duties of the patients' monies clerk. His authority was required when a large sum of money was requested from a patient's account; and he arranged for any balance over *£500* which had accumulated in a patient's account to be invested in the Post Office Savings Bank or, more recently, in a building society. He considered that it was the responsibility of the ward sister to record the amount of money spent on behalf of patients incapable of making purchases themselves; of a senior nurse to check the ward sister's records; and of the area treasurer's department to monitor the system. He said that any recommendations made by the auditors for a change in the procedure would be passed to him by the area treasurer and he would expect the nursing officer to inform him of any failures of the system operating on the ward. In fact, he said, he had not received any recommendations or criticisms. But he agreed that information given to the complainant in his letter of 22 February 1979 (paragraph 5) had been incorrect. He had wrongly referred to 'expenditure' instead of 'income'; the figures of both income and expenditure had been wrong as he had omitted the premium bond prizes; because of errors in his calculations he had had an unexplained expenditure of £56; and he was not aware that such items as clothes were provided from the money drawn weekly by the sister on the patient's behalf.

21. The acting district administrator (the ADA) told my officer that, in his opinion, it was the responsibility of the area treasurer to ensure that the procedures for the handling of patients' money within the area were in accordance with the recommendations of the Department, and of the area audit section to ensure that staff were carrying out these procedures. Although nursing staff were involved, no instructions had been issued about their, or the overall, responsibility. He told my officer that he was not aware that cash in excess of that required for a patient's day to day needs had been kept on the ward or that contrary to the Department's guidance, sums of up to £500 had been allowed to accumulate in patients' accounts before they were invested. The ADA said that any system devised had to strike a balance between ensuring that a patient or, where necessary a nurse on his behalf, had easy access to his money and providing the necessary safeguards to protect the patients' interests; but the system which had operated on the ward was such that the AHA could not prove that it had not been abused. He told my officer that, as a result of my investigation, the system for handling patients' money had been changed. The nursing staff no longer handled the money of those patients incapable of looking after their own financial affairs. Instead, nurses now sent a list of the patients' requirements to the SA and his office ordered them and arranged for the cost to be debited to the accounts of the patients concerned. More expensive items, such as clothing, were ordered through the supplies office.

22. The district finance officer (the DFO) was abroad at the time of my investigation and my officer saw the assistant district finance officer (the ADFO). He told my officers that the DFO was responsible for the financial management of the district, comprising the provision of financial control and ensuring that the systems and procedures required by the area treasurer were in operation. In response to the question as to why the district finance staff had not discovered that adequate ward records were not being maintained, the ADFO pointed out that only the DFO and himself were actually employed in the district and it was unrealistic that they personally should be required to check individual ward records. It was accepted that once systems had been specified by the area treasurer/DFO it was the responsibility of the staff concerned (in this case the SA) to ensure that these were complied with and it was the function of the internal audit section periodically to ensure that all financial systems were satisfactory for the purpose intended and were complied with although, with only a small staff, in many cases test checks only would be applied. The ADFO would, of course, do anything within his own resources to cope with any financial problems brought to his notice. The DFO, he said, did not have access to the weekly print-outs of the balances of patients' savings accounts which were prepared on NCR machines and forwarded by the AHA's central accountancy headquarters to the sector administrators with a summary to the area treasurer's office. He would not, therefore, be aware of any failure to invest patients' monies.

23. The chief internal auditor (the CIA) told my officer that he prepared the audit team's schedule of work in consultation with the area treasurer and on the advice of the district finance officers. The team had reviewed instructions to staff about the handling of patients' money and property and an area instruction on the subject, based on the Department's guidance had been drawn up, in consultation with the district finance, administrative and nursing staff, following

an audit of patients' property accounts carried out in 1976; this had come into operation on 5 April 1979.

24. The handling of patients' money was, he said, the responsibility of the SA and the medical and nursing staff, but the audit section had a responsibility to review systems in operation to see if they were adequate and, where necessary, to recommend new procedures. With such a limited staff, it could not be expected that the audit team could examine every account book kept by each hospital. The CIA said he had no record of an internal audit being carried out on patients' money on this particular ward since 1975 when his records first began, although spot checks had been carried out on other wards at the hospital in 1979. His assistant had, however, made a cursory examination of the ward sister's purchase book when the complaint had first been received. And the Authority's reply to him had been based on his assistant's findings. In a report submitted to the area treasurer by the CIA in January 1979, details had been given of 24 accounts held in respect of patients at the hospital where sums of over £100 had accumulated in their accounts and, in contravention of the Department's guidance, had not been invested. Steps were taken immediately to open building society accounts for the patients in question.

25. The area treasurer (the AT) told my officer that he had overall responsibility for the financial affairs of the Authority and he discharged his duty by organising procedures to meet the requirements of the Authority and the Department. An instruction on the handling of patients' money, based on the Department's guidance, had been circulated to sector administrators for distribution within hospitals and it was their responsibility to ensure that all the staff concerned received copies of it and for administrative and nursing staff to ensure that it was being complied with. The instruction clearly laid the responsibility for the day to day management of patients' money on the administrative staff and for the checking of ward records on the senior nursing staff. The regular monitoring of hospital systems to ensure that area procedures were being followed was, he said, the responsibility of the senior administrative and nursing staff in the district, *not* that of the audit team, whose main function was to advise whether the systems in operation were the most appropriate for the purposes for which they were being used.

26. The AT said that although there had been a complaint about the use of the complainant's father's money, he considered that this was an unimportant matter compared with the other investigations being carried out by the audit team where much larger sums of money were involved; and that he had to deploy his limited staff in areas of greatest risk. Even if more staff were available to the audit team and district finance department, he would not consider it necessary for an officer to be employed on regularly checking the patients' accounts and he doubted whether any authority carried out regular checks on all their financial procedures. The AT said that he had not been aware that patients' money was being kept on the wards by the nursing staff or that sums of money over £100 had accumulated for some time in patients' accounts without investment.

Findings

27. I can well understand the complainant's concern about the management of his father's affairs by the AHA as the replies he received to his complaint

were inaccurate and misleading. I find the letter from the SA of 22 February 1979 particularly inept and I cannot understand why he did not give the complainant the information which was readily available in the records of his father's account.

28. I have been unable to establish whether or not the father's money was properly spent on his behalf because of the inadequate ward records; but I have been assured by the ward staff that it was used only for his benefit. From the evidence I obtained it was clear that the ward staff were concerned for his welfare and I think it very likely that they purchased for him the items that he required or that they thought he would appreciate. But with little description of the items purchased and, in certain instances, weekly payments received on the father's behalf not accounted for, the system which prevailed when he was a patient was such that it was open to abuse. The system in operation at the time offended the basic accounting principle that the duties of those who disburse monies should be separated from those who account for them. And furthermore it contravened the Department's guidance, which had it been followed, would have prompted investment of the complainant's father's savings from 1976.

29. The AHA's instruction based on the Department's guidance of 1971 did not come into effect until April 1979 but I found in my investigation that even then the nursing staff interviewed had not seen it. I have been unable to identify any officer who was considered to be responsible for co-ordinating the functions of the nursing, administrative and finance staffs in relation to the handling of patients' monies. And although the AT did agree that he was ultimately responsible he thought that the matter was relatively unimportant. I accept that the amounts of money concerned are small, but I think the AHA have a clear duty to safeguard the monies of those patients who are not capable of doing so themselves. As the ADA admitted, the system on this ward was such that the Authority could not prove that it was not being abused. I conclude that the AHA did not pay sufficient attention to this matter. I criticise them for this, and I invite them to monitor the present procedures to ensure that they are working satisfactorily. Having said that, I have no reason to doubt the integrity of the ward staff and I think that, especially since the complainant's father had no visitors, it was entirely reasonable of them to have obtained for him such items as he could afford in order to make his last few years in hospital as comfortable as possible.

(b) *The complaint about the possessions returned after his father's death*

30. The complainant told my officer that new pyjamas, dressing gown and slippers were purchased for his father to take with him when he transferred from the Old People's Home to the hospital in 1974. He said that he could not understand why these new clothes were not included in an inventory of possessions when his father was admitted to the hospital; why clothes purchased for him during his residence at the hospital were not added to the inventory; and why no clothing, except for a cap, was returned to him after his father's death. He was not satisfied, he said, with the explanation given in the AA's letter of 17 April 1979 that the absence of a record of any items transferred from the home was sufficient indication that nothing had been transferred and that clothes purchased on the father's behalf while he was at the hospital had worn out. The hospital,

he said, should have asked him if he wanted his father's clothes whatever their state – even though he would probably have left them for the hospital's use. The complainant said that he thought the articles returned to him after his father's death must have been taken from a storeroom; they included an old paperback 'Western' (although his father, who, he said, had been a member of the Salvation Army, would not have read such a book even if his poor eyesight had permitted it), six tablets of soap, 1 lb mixed sweets, two tins of talcum powder, one cap and a new toothbrush.

31. I have seen the list of property made up on the death of the complainant's father and certified by the SA which is as follows: '£3·90, various sweets, talc – etc., soap and juice'. The sister told my officer that these articles were the contents of the father's bedside locker. She had not returned his father's clothes to the complainant, she said, because they had been in a poor state and she had given the inexpensive watch to another patient. She added that no record would have been taken of the clothes transferred to the hospital with the father or purchased by her on his behalf as the hospital only maintained an inventory of valuables brought with a patient on admission.

Findings

32. The AA provided the complainant with incorrect information about the hospital's procedures; she assumed that a record would have been made if his father had brought anything with him when he was transferred. As the complainant knew that his father had taken new clothes with him to the hospital, it is not surprising that he was not satisfied with the explanation he was given and I can also understand his concern that a cap was the only item of clothing returned to him after his father's death. The disposal of a patient's possessions should not be at the discretion of the hospital staff and I find that the complainant should have been offered his father's clothes. I think it disgraceful that his watch was given arbitrarily to another patient. However, I have found no evidence that the articles returned to the complainant were not the contents of his father's bedside locker.

Conclusions

33. Other than the failure to invest the complainant's father's money, I have been unable to establish, so unsound and rudimentary were the procedures, whether or not the way the AHA managed his financial affairs and made purchases on his behalf was satisfactory. But I have criticised the AHA's general management of the money of patients who were incapable of handling their own affairs. I am glad to record that as a result of my investigation the hospital procedure has been changed. Nurses have been relieved of the burdensome necessity of handling and accounting for cash and larger purchases are made through the supplies office. I have upheld the complaint about the return of the father's property and I consider they should offer him an *ex gratia* payment for the value of the watch they failed to return. The replies of the AHA to the complainant's enquiries following his father's death were inaccurate and misleading; the AHA have told me that they will be writing to the complainant shortly to apologise for this and that they will consider making an *ex gratia* payment to him.

Case No. W.263/79–80 – Wrongful information regarding outcome of operation

Complaint and background

1. The complainant's husband was admitted to hospital (the hospital) on 27 August 1978, and on 29 August he had an operation on his left lung. He was discharged on 10 September.

2. She complains that on Sunday 3 September a doctor (the first registrar) told her that a malignant tumour had been removed from her husband's lung, that his death was inevitable, and that he would live for about two years. However, in March 1979 she found out that this was wrong; a benign cyst had been removed; and that although the hospital had known in September 1978 that the cyst was not malignant she had not been told. She states that these failures in communication have caused her great distress and had serious repercussions on her domestic life.

Investigation

3. During my investigation I saw copies of the clinical notes and my officer obtained evidence from the complainant, her brother, and members of the medical and nursing staff at the hospital.

4. The actions of family practitioners are outside my jurisdiction and I cannot comment on them. However, I obtained information from a family doctor (the FP) with whom the complainant discussed her husband's health between September 1978 and March 1979.

5. In correspondence and in conversation with my officer the complainant said that she and her husband were living apart and until 2 September 1978 she had not known he was in hospital. She had telephoned the hospital that day, and on 3 September she went with her brother to the hospital and saw the first registrar, whom she described as about 6 feet tall, 14 stones in weight, with black hair.

6. She said he had told her that another doctor (the second registrar) had performed her husband's operation, but he would tell her about her husband's condition as the second registrar was operating. She said that the first registrar had then said her husband had had a major operation which had gone well. He had read from a yellow paper in the clinical notes which she could see (and which she described in detail to my officer) that 'a malignant tumour 5 centimetres in diameter had been removed from the left lung'. He had then said he regretted to inform her that her husband's condition was terminal. She had then asked if her husband had cancer and he had said yes.

7. She said that the first registrar had told her that her husband would not be told the diagnosis, and if he had to return to the hospital he would be told it was for something minor. He had also said that her husband could live between one and five years, but in view of his previous medical history he would probably live between 18 months and two years providing he did not relapse during the first year.

8. The complainant said that the first registrar had neither said that the diagnosis was not definite nor mentioned any further tests. He had not given her

any advice about whether she should continue with divorce proceedings. As she thought her husband would die, she had let him return to live with her, and her divorce had been delayed for a year.

9. She said that on the day of her husband's discharge she had told a charge nurse (the charge nurse) that she knew her husband's diagnosis and had drawn the charge nurse's attention to the yellow paper in the notes.

10. In March 1979 she had spoken to the FP, who had said that on 15 September 1978 a letter stating that a non-malignant cyst had been removed from her husband's lung had been sent to the family practitioner with whom her husband had then been registered.

11. The complainant said she had then written to the hospital asking to see the first registrar or her husband's consultant (the consultant). She had seen the consultant by appointment on 10 April 1979. When she told him what had happened he had apologised and explained that the first registrar had been wrong and her husband did not have cancer. She told my officer that on 10 April she had again seen the yellow page in the notes.

12. The complainant's brother told my officer that he had been present when his sister met the first registrar, whom he described as about 5′ 7″, of medium slim build and blond. The interview had not taken place in an office. He, the first registrar and his sister had sat in a row on chairs along the corridor. He said that at the start of the meeting the first registrar had said that his brother-in-law could live twelve months to two years providing he did not smoke or drink, but in the first registrar's opinion he would not last 12 months. The first registrar had also said that he had performed the operation himself.

13. The complainant's brother said his sister had then been shown a pink paper in the case notes and the first registrar had said a one-inch long malignant cancer had been removed. He had also said that they were waiting for results of some final tests. He said the first registrar had explained that his brother-in-law would not be told the diagnosis in view of his past medical history, and that he had told him he would not have to return to the hospital. He said the first registrar had not said anything about further treatment or having to go back into hospital. However, the first registrar said that when his brother-in-law had asked if he would have to come back he had replied, 'Put it this way [——] I shan't be seeing you again'. He also said that the first registrar had told his sister that she would be foolish to proceed with her divorce as she would be a widow within twelve months.

14. The first registrar, who is tall and thin with brown hair told my officer that the second registrar had performed the operation but he had been asked to see the complainant as he was on duty. He had seen her in the side room of a ward. Her brother had not been present. He said she had asked what was wrong with her husband and he had said a small tumour or mass had been removed from his lung but that they did not know what it was. When the complainant had asked if it was cancer he had said that cancer was a possibility but they could not say until they knew what the tumour was. He told my officer that the histology report, which would explain what the tumour was (the report) was not available when he saw the complainant. He said he never gave an estimate of how long patients could live, even when pressed. He may have discussed her

husband's smoking as it was so important in lung diseases but had not mentioned any other matters relating to his previous medical history. Nor had he discussed what her husband would be told if he needed further treatment.

15. The first registrar said he would have taken his information from the doctors' notes, and the operation note if it had been typed and added to the clinical notes by then. He had not shown the complainant the notes and did not know what the yellow paper could be that she had mentioned to my officer.

16. The second registrar did not remember the complainant's husband, but confirmed after seeing the clinical notes that he had removed a tumour, which he had thought was probably cancer.

17. A locum was acting for the consultant pathologist (the pathologist) during the relevant period but the pathologist was able to explain what had happened to the specimen from the records available. She said that it had been sent to the pathology department (the department) on 29 August and tests which showed it to be a cyst, not a cancer, had been completed on Friday, 1 September. She explained that as it had been a routine report the department would have sent it to the secretaries in the cardio-thoracic unit, whose job it was to establish which ward a patient was in and send on the report. (She explained that as patients frequently changed wards the department did not send routine reports directly to the ward.) She said that as the unit secretaries would have gone home before the report arrived it would have been sent to the correct ward on Monday 4 September.

18. The pathologist said that without the report the first registrar could not have given an estimate of how long the patient had to live, as different types of tumour responded differently to treatment.

19. The consultant told my officer that when he saw the complainant on 10 April 1979 she had told him that the first registrar had said her husband had cancer and would die. He had had to accept this because he had not had the opportunity to seek the first registrar's view, but he now knew that the first registrar denied saying this. The consultant did not know what the yellow paper was to which the complainant had referred, but was certain that nothing had been removed from the medical notes.

20. The charge nurse could not remember the complainant's husband or speaking to the complainant about the diagnosis on 10 September, and none of the other nurses to whom my officer spoke was able to help.

21. The FP told my officer that the husband had registered with his practice on 15 December 1978 and the complainant had told him on 12 March 1979 that her husband had cancer. He had told her there was a letter on the notes which indicated that he did not. He told my officer that it would be unusual for a hospital doctor to say any more than that a patient's condition was serious and that he thought the complainant had heard what she expected to hear.

22. I have examined the clinical notes, which show that when he attended the consultant's clinic on 15 August a provisional diagnosis of 'probably a tiny cancer' was made. This provisional diagnosis is also shown on the slip dated 29 August requesting histological examination. However the report which is dated 1 September (which would not have been available for the first registrar at the

time of the interview) did not confirm this provisional diagnosis. The nursing record shows that the complainant saw the first registrar on 3 September and that she 'does not wish anyone else to be told of her husband's diagnosis please'. There is no record of the interview in the doctor's notes.

23. None of the papers in the clinical notes fits the description of appearance or content given by the complainant. The operation note is on pink paper and the doctors' notes are on white paper; in both cases the sheets are bigger than the complainant described.

Findings and conclusions

24. It is clear from my investigations that the histology report was not available when the first registrar saw the complainant. The first registrar has said that he told her that he would not know what was wrong with her husband until the test results were available, and that he did not give her any estimate of her husband's life expectancy. The pathologist has said that without the histology report any estimate of life expectancy is impossible even if a patient is known to have cancer. The complainant's account of her interview with the first registrar varies considerably from his account, and is also very different from the one given by her brother, who the first registrar says was not present. On the basis of the evidence I have obtained I must conclude that the account given by the first registrar is the most credible and I accept it. I dismiss this complaint.

Case No. SW.11/78–79 – Care and treatment prior to patient's death

Background and complaint

1. After being taken ill at her home the complainer's mother, age 83, was admitted on 8 July 1977 to hospital (the hospital) where she died on 25 July.

2. The complainer and her sister wrote to the Health Board (the Board) on 28 December 1977 complaining that:

(i) her mother's admission to hospital was unnecessary;

(ii) she was detained in hospital and treated against her will; and

(iii) she was subjected to unnecessary and excessive treatment; and the complainer also mentioned

(iv) poor communication between staff and relatives;

(v) contradictory explanations about the treatment given;

(vi) some aspects of her mother's care; and of

(vii) difficulty in getting to see the consultant physician (the consultant) responsible for her mother's care.

3. The complainer was not satisfied with the Board's reply of 19 March 1978 nor with the outcome of a subsequent meeting she had with medical staff of the board on 18 April. She says that she had not had satisfactory explanations concerning the excessive number of needle marks on her mother's arms and a particularly large bruise on her wrist on 14 July; needle marks on her mother's

neck which were noticed near the time of her death; a statement that her mother had Parkinson's disease; and the need to walk her up and down the ward to her distress so that 'she would not get infection on her lungs'. She also believes that a statement made by the consultant at the meeting on 18 April that her mother had required hospital treatment because she had a cardiac arrest was untrue.

4. My predecessor informed the complainer that he could not look into those aspects of her complaint concerning the decision to admit her mother to the hospital and the medical treatment she received there as the Act does not permit him to investigate the actions of family doctors nor clinical action taken by a hospital doctor in connection with the diagnosis or treatment of a patient's illness. He agreed however to look into the remaining aspects of her complaint.

Investigation

5. In the course of my investigation I have obtained the comments of the Board and examined relevant documents from their files including the clinical notes. My officer has interviewed medical and nursing staff responsible for the patient's care and treatment. Unfortunately all those principally concerned had left the hospital and the need to contact them led to my investigation taking much longer to conclude than I would have wished. I refer to the complainer's mother's medical condition and treatment in my report only in order to set the complaints in context. The complainer's evidence, taken mainly from her twenty-four page letter to the Board is given in the initial paragraph(s) of each of the following sections, except section (e).

(a) *Detention in hospital and enforced treatment*

6. The complainer suggested that he mother was taken into hospital and treated against her will. She said that although her mother wanted to go home the relatives were told by the ward sister (the sister) that she was not allowed home because there was no one to look after her. The complainer also suggested that the family should have been notified and permission sought before treatment was 'forced' on her mother 'against her will'.

7. The house physician (the houseman) told my officer that the complainer's mother had never indicated that she objected to having been brought into hospital; nor had she ever refused treatment or indicated that it was being given against her will. This was confirmed by the sister who told my officer that although the complainer's mother had been in a very drowsy state during most of her stay in hospital she had, until about the last week, been quite able to communicate with the staff. The sister thought that the complainer's mother had been frightened by her experience in being taken ill at home and had been grateful for being looked after in hospital.

8. In the houseman's view the complainer's mother would have had to come in to hospital for at least a few days when she was taken ill even if she had been living with relatives who could look after her. He recalled that on 13 July he discussed with the relatives the question of taking her home. He told my officer that at that time she had not been medically fit and the outlook was rather bleak, but her blood pressure had been brought down and there was not really much

more they could do for her in the way of active treatment. Therefore provided she could be adequately cared for they were prepared to let the relatives take her out. The sister said that when the decision was made to allow her to go to her daughter's home she had tried to be as helpful as possible. She had had a number of discussions with the complainer about the transfer and had made various enquiries and arrangements on her behalf. She told the complainer that if they had difficulty she would escort the patient herself on her day off, but unfortunately her condition had deteriorated on 18 July and thereafter there had been no real question of her leaving the hospital.

9. In written reports the consultant said that when the daughters saw him after their mother's death they expressed the view that she should not have been admitted to hospital and treated without prior consultation with them. He explained to my officer that the complainer's mother had been an emergency admission with her blood pressure at a dangerously high level and that tests and examinations had also indicated a heart condition of some long standing. I have seen that in a letter to the doctor who had seen her at home (the FP), he said that despite her years active measures were necessary to bring down her blood pressure to protect her from a major cerebrovascular accident or renal damage. In his written report to the district medical officer (DMO) he expressed his view that admission to an acute medical ward was the correct management and that it would have been negligent not to have treated her very severe and persistent hypertension, especially as her previous good health gave grounds for hope that her well-being could be restored.

10. The FP told the Board that his opinion had been that the complainer's mother required urgent admission to a hospital, and that the arrangements made for her to attend the hospital had been made with her agreement.

Findings

11. I am satisfied that the complainer's mother was not detained in hospital or treated against her will and I believe that had she wanted to object to her treatment she would have been capable of doing so, certainly until the latter part of her time in hospital. I have seen that the hospital staff were prepared to co-operate with the relatives in their wish to take the patient to her daughter's home until her condition deteriorated to the point where they considered it would have been completely unreasonable and irresponsible to have allowed her to leave the hospital. Accordingly I dismiss this aspect of the complaint.

(b) *Communication between staff and relatives*

(i) *Failure to inform next-of-kin of admission*

12. The complainer said that after her mother had been seen at home by the FP she was taken to the hospital by a neighbour. However the hospital did not inform the next-of-kin of admission and it was only that afternoon when the neighbour's wife attempted to telephone the complainer's sister (and in fact spoke to her son), that the relatives were eventually informed.

13. The hospital records show that after the complainer's mother had been examined in the accident and emergency department she was admitted to ward

25 (the ward) at noon on 8 July. The sister recalled that when the patient arrived on the ward she was still accompanied by the neighbour who had taken her to the hospital. While the nurses were getting her settled the sister spoke to the neighbour who confirmed that the patient had daughters. He said that he did not know their telephone number, but his wife had it at home and that she would telephone the relatives and let them know the situation. Sister asked him to let the ward know whether they had contacted the relatives and about an hour after he had left the ward he telephoned to say that his wife had telephoned the complainer's sister's number and had left a message with her son as both his parents had been out. The neighbour also gave sister his own and the complainer's sister's telephone numbers for future reference. The sister thought that it was not very long after this when the relatives telephoned the ward.

14. The sister acknowledged that she should have asked the complainer's mother for relatives' telephone numbers, but she explained to my officer that the ward had been busy at that time and the patient was being examined. Therefore the neighbour's offer to telephone the daughter had seemed an entirely satisfactory arrangement, given the safeguard that the neighbour was to let her know whether the relatives had been contacted, which he did.

Findings

15. I think it reasonable that in a busy hospital ward the sister should have accepted the neighbour's offer to telephone the relatives. As in any case the sister would presumably have waited until after the complainer's mother was settled and had been examined before she asked about relatives' telephone numbers, I do not think that any significant delay occurred because of this, and I do not uphold this complaint.

(ii) *Refusal to allow relatives to visit on* 8 *July*

16. The complainer said that when her sister telephone the hospital she said that she and members of her family would travel by car straight away and would arrive at the hospital about 10 pm. She asked if she could see her mother then, but was told that it would not be allowed until 3 pm the following day.

17. The sister was unable to recall whether the complainer's sister had spoken to her or to one of the other nurses when she telephoned on the afternoon of 8 July. She told my officer that she had not previously heard of the allegation that the relatives were refused permission to visit that evening. She said that she would not have refused such permission and she could not imagine any of her nurses doing so. She recalled that at that time there had been 'open' visiting on the ward between 3 and 8 pm daily, but she explained that as they cared for quite a number of heart patients from outwith the area they were quite used to relatives who had to travel a long distance arriving outwith normal visiting times and it was not their practice to turn away such visitors. The sister suggested that if the relatives had merely enquired about when they could visit they would have been told the normal visiting times. This possibility was also suggested by the houseman who agreed with other staff interviewed that visiting times were not strictly adhered to on this ward.

Findings

18. I have been unable to identify the person to whom the complainer's sister spoke but as visiting arrangements on the ward were flexible I think the enquiry about visiting could, as the sister and houseman suggest, have been misunderstood. I do not uphold this complaint.

(iii) *Contradictory statements by staff*

19. The complainer said that when her sister visisted the hospital on 9 July she found their mother 'sitting bolt upright in bed with her face a white mask and her eyes shut. The complainer's sister asked a nurse if her mother was sedated and was told that she was not. However, shortly afterwards the complainer's sister's husband, who had been out of the ward, asked another nurse if the patient was sedated and was told that she was.

20. As the complainer arrived to visit on 13 July her mother was having her urinary catheter reinserted. The houseman subsequently explained that they had been going to take the catheter away but that the complainer's mother had been unable to pass water without it. However, the complainer said that the sister later told her that her mother needed the catheter because of her incontinence.

21. I have seen that there is no record in the medical notes of any sedation being given and the houseman confirmed that the complainer's mother had never been sedated. He told my officer that she had never required it. The sister was unable to account for the allegation that the complainer's sister's husband had been told by a nurse that the patient was sedated and she had no idea who the nurse involved might have been.

22. The consultant confirmed that the complainer's mother had been catheterised to relieve her bladder, not because of incontinence, and the sister told my officer that she had never told the complainer otherwise. She recalled one occasion however when they were discussing the possibility of the patient travelling to her daughter's home by car and she had advised that it would be better to keep the catheter in for the journey in case of incontinence. She suggested that it might have been this that led the complainer to believe she had been given contradictory information about the need for the catheter.

Findings

23. I accept the assurances I have been given that the complainer's mother was not sedated and that if a nurse informed the complainer's sister's husband otherwise she was mistaken. The evidence also shows clearly that the patient had required catheterisation because of her inability to pass urine and I think that the complainant's belief that the sister had given her a contradictory explanation could only have arisen from a misunderstanding of what the sister had said. I do not uphold this complaint.

(iv) *Offensive remark made by staff nurse*

24. The complainant said that on 12 July a staff nurse came over to the relatives at the bedside and in a most offensive manner said, 'Your mother did not want to be hospitalised; she wanted to go home; she would not co-operate;

we soon put her in her place; we soon made her see what it meant to be hospitalised'. The complainer was upset that anyone, and especially a nurse, should speak to the relatives like that and within earshot of her mother.

25. The staff nurse named by the complainer (who now works at another hospital) told my officer that she had not previously heard of this allegation. She denied that she would have said any such thing and said that apart from the fact that she would not dream of making such remarks about an 83-year-old lady, it would be more than any nurse's job was worth to be so tactless. The staff nurse told my officer and other members of staff confirmed to him that the patient had just seemed to give up although she was constantly encouraged by the nurses to eat, drink and walk. She said it was possible she had mentioned that the patient was not co-operative in this way but she had certainly not intended to be offensive.

26. The staff nurse recalled that the complainer had complained about her alleged rudeness on one occasion but she said that this had related to a telephone conversation on 16 July when the complainer had enquired how her mother was. She said that after she had informed the complainer that there was no change and that her mother would not drink the complainer asked what they were going to do about this. In an effort to be helpful she explained that they might have to put the patient on a drip to prevent dehydration. The staff nurse said that the complainer had 'gone berserk' at this and had screamed that they were not going to use her mother as a guinea pig. The staff nurse terminated the conversation by saying that the complainer would have to discuss this with the doctor when she visited that afternoon. The complainer apparently complained to the sister that afternoon that the staff nurse had been rude to her. As a result the staff nurse was interviewed by the nursing officer (the NO) and gave her version of events. The staff nurse told my officer that she did not feel she had been rude. She also said that on other occasions she and other nurses had experienced problems because of the reluctance of the relatives to let them do things for the patient; she thought they had felt that the patient should have been left alone and were not prepared to accept that the nurses were doing things for her good.

27. The sister recalled that a complaint had been made about alleged rudeness on the part of the staff nurse but she was unable to remember details of it. Her impression of the incident was that whatever remark had been complained of it had certainly not been intended in the way it was taken. She said that the staff nurse did have a rather brusque manner and the relatives may have misinterpreted her efforts to encourage the patient to do things for herself. The NO recalled that he had been asked by the sister to see the relatives mainly because she was concerned about their dissatisfaction with what was happening to their mother. He said that he had a long talk with the complainer to try to reassure her about her mother's nursing care and she had seemed satisfied with his explanation.

28. The NO said that the question of the staff nurse's attitude had arisen during this interview, but he was unable to remember details. He thought he had probably apologised for the nurse's manner and explained that she was inexperienced. He told my officer that the staff nurse who had qualified only a few

months previously did sometimes have an unfortunate manner; she could be brash and sharp-spoken which he thought may have been attributable at least in part to her nervousness in talking to people, and about which he had given her guidance on a number of occasions including, he thought, the one in question. However, the NO was certain that the complainer had said nothing to him about the staff nurse saying anything untoward to or about her mother. If she had he would have taken the matter further. He believed the staff nurse was too good a nurse and too intelligent a girl to have said anything out of place. He told my officer that the staff nurse had not been tactless in what she said; her problem had been in the way she said things.

Findings

29. It seems from the evidence I have gathered that relations between the relatives and some members of the nursing staff were not as good as they might have been and that this may have led to a certain amount of friction. I believe that the complainer took offence at the attitude of the staff nurse which she may have felt was not as sympathetic as it should have been. I am unable to reach any firm conclusion about whether a specific remark was passed which caused offence but if it was I believe that it was entirely unintentional.

(c) *The complaints about the patient's care*

(i) *Lack of supervision*

30. The complainer said that when the relatives visited on the afternoon of 15 July her mother was in a most distressed state. She had slipped down in her chair and her nightdress was above her knees. After covering up her mother's legs the complainer's sister looked for a nurse but could not find one in the ward.

31. The sister said that no complaint had been made about this at the time. However she said that with the best will in the world they could not avoid such things happening occasionally in a busy ward with a fair number of elderly patients. The staff nurse also held this view. She said that in their very busy medical ward they might have up to a dozen elderly ladies recovering from strokes and it was possible that a patient might slip down in her chair with her clothing dishevelled and remain unobserved for a little time. The sister could not understand why the relatives should have had difficulty in finding a nurse. Although the nurses would try to keep out of the way during visiting time there should always be a nurse on duty at the nursing station and other nurses would have been somewhere nearby. The sister said that sometimes at the start of visiting time she held a tutorial for the younger nurses and it was common for nurses to talk in the day room to patients who did not have visitors of their own. The staff nurse suggested it was possible that at such times there might briefly appear to be no nurses in sight if the nurse keeping an eye on the ward had to leave the duty station to attend to a patient behind screens.

Findings

32. There is no evidence to suggest that this was other than an isolated incident and while it is regrettable that such incidents should occur I accept

that they are sometimes unavoidable when dealing with confused elderly patients and I do not consider that they necessarily indicate lack of care on the part of the nursing staff. While a nurse may not have been immediately in view at the time I have no reason to believe that nursing staff were not readily available in the vicinity had they been required.

(ii) *Failure to give drinks*

33. The complainer said that there were sometimes three cups of cold tea lying beside her mother which no one had helped her to drink. She said that the relatives started to take in a flask of tea which her mother drank. They also took in orange juice and oranges which they asked a nurse if someone could squeeze. The oranges were returned with their mother's personal belongings after her death. The complainer said that after her mother went on the drip and when it was too late all the nurses were helping her to drink.

34. The sister denied that the nursing staff had neglected to give the patient drinks. She said that in fact they had great problems in getting her to drink and this was one of the areas in which she had required a great deal of encouragement. It was because they could not get her to drink enough that she had eventually to go on a drip. The staff nurse also said that they had problems in getting her to drink and that the nursing staff had not failed to supply her with drinks but she would not take them.

35. I have seen the nursing reports which record that on 11 July the patient was 'eating and drinking well' and that on 12 July she was 'tolerating small amounts of fluids'. However from 14 to 16 July, when she went on the drip, there are a number of references to her requiring a lot of encouragement and to her reluctance to drink. Entries from 17 July onwards make various references to fluids taken by her and to her continuing reluctance to drink.

Findings

36. The evidence shows that nursing staff were fully aware of the patient's reluctance to drink and that they tried to encourage her to take fluids. The records indicate clearly that on occasion she would only tolerate small quantities of fluids. Accordingly I do not uphold this aspect of the complaint.

(iii) *The insertion of the catheter*

37. The complainer said that on one occasion when they visited screens were round her mother's bed but they saw the houseman and several young nurses with her as the urine catheter was being reinserted. The houseman later told her that they had been going to take the catheter away but that her mother had been unable to pass urine without it. The complainer expressed doubts whether this was in fact what had been happening as she said it seemed to be law in ward 25 'that bed patients had those contraptions'. She wondered if the young nurses were practising inserting the catheter into her mother.

38. None of the staff interviewed could remember the particular occasion when the complainer's mother was re-catheterised. However the nursing records show that the catheter was removed at 6 am on 15 July but that she was re-catheterised that afternoon after having failed to pass urine despite being toileted two hourly.

39. The houseman told my officer that there had never been any question of the patient's catheter being removed or inserted solely for teaching purposes. He said that student nurses working in the ward would assist in such procedures as part of their practical training but no student would be brought into the ward just to observe. The sister acknowledged that it was possible that the patient was attended on this occasion by student or pupil nurses. She pointed out that a large proportion of the ward staff were nurses in training and the only way they could get experience was to undertake normal ward nursing duties under supervision. However there was no question of the patient being catheterised purely for training purposes. The sister also explained that it could sometimes be helpful to have three or four nurses present during this procedure.

Findings

40. I am completely satisfied that the complainer's mother was not catheterised for teaching purposes but because it was found that she was still unable to pass urine. Accordingly I do not uphold this aspect of the complaint.

(d) *The complaint of difficulty in seeing the consultant*

41. The complainer said that she and her sister did not get to see the consultant until after their mother's death. She said that they kept asking the sister when they could see him but she made all kinds of excuses about not being able to contact him. The complainer said that after her mother's funeral she telephoned the ward on 30 and 31 July and on 1 August and was told that the consultant could not be found. When she telephoned on 2 August she was told that it was the consultant's day off and that his secretary was on holiday. They eventually saw the consultant on 3 August when they just visited the ward and asked to see him. The complainer said that he told them he was unaware that they had been asking to see him and that 2 August had not been his day off.

42. In his reply on behalf of the Board the community medicine specialist (the CMS) told the complainant that their report suggested that the sister had asked the complainant to let her know what would be the most suitable time for such an interview but in frequent contacts with junior nurses subsequently the issue became confused and the agreement did not materialise. The complainant told my predecessor that this was a 'downright lie'.

43. The CMS's comment was based on a report from the consultant in which he said he had been surprised to learn that any relative had experienced difficulty in seeing him. The consultant told my officer that he had spoken about this to the sister who told him that the daughters had expressed a wish to see him but that they had been surprisingly evasive about coming to any arrangement about a definite appointment. The sister had also told him that they were very impatient with ward staff and tended to change tack in the middle of conversations. The consultant said that he had also made some enquiries about why they had apparently experienced such difficulties in contacting him after the patient's death. He found that they had enquired at a clinic which he did not take on that particular day and were told that he was not there although he had been elsewhere in the hospital at that time.

44. The sister told my officer that she only remembered the relatives asking her on one occasion about an appointment with the consultant. She said that

she mentioned this to the consultant during his ward round the following day and he told her to ask the relatives to get in touch with his secretary to arrange an appointment. Unfortunately the sister forgot about this and she went on leave for the following two days having omitted to leave a message for the relatives. She acknowledged that this had been a mistake on her part for which she was sorry. She told my officer that on the day she returned to duty the complainer telephoned the ward to ask about the appointment. She asked the nurse who had taken the call to explain that she had forgotten about this and that the complainer was to get in touch with the consultant's secretary. The sister understood that the nurse had then asked the switchboard to transfer the call to the secretary.

45. The sister told my officer that the relatives did not ask her again about an appointment and she did not realise until after the patient's death that they had not seen the consultant. She said that on the day the complainer saw the consultant she spoke to her on the ward and the complainer told her that when they had tried to contact the consultant's secretary there had been no one there or they had been 'fobbed off'. The sister said that when the consultant spoke to her about this complaint she told him the same as she told my officer.

46. The consultant's secretary told my officer that she was certain that neither the complainer nor her sister had contacted her about an appointment. As far as she was aware the normal practice was for ward staff to pass any request for an interview direct to the consultant. This was confirmed by the NO who said that he had never known of relatives experiencing problems in obtaining an interview with the consultant at a mutually convenient time. Other staff interviewed by my officer were unaware of any request by the relatives to see the consultant.

Findings

47. It is not disputed that the complainer did ask the sister about an interview with the consultant and the sister has acknowledged that she was responsible for some delay and expressed her regret over this. However in view of the time that elapsed before the complaint was made and the contradictory evidence of those involved I have been unable to resolve what went wrong thereafter. I cannot discount the possibility that the way in which the relatives approached staff may have contributed to this; but it seems to me that the failure of procedures within the hospital were mainly responsible for the complainer's request not being met, and to that extent I uphold this complaint.

(e) *The complaint about the board's reply and unsatisfactory explanations*

48. The complainer told my predecessor that she considered that the Board's reply to her complaint was dishonest and unsatisfactory. She said that when she intimated her dissatisfaction to the CMS he said he would try to arrange a meeting for her with the consultant, the professor of geriatrics (the professor) and a representative of the Board. In the event the meeting which took place on 18 April 1978 was attended by the consultant and the community medicine specialist of the district involved (the district CMS) and the complainant said that she was unable to get answers to her questions from them and she specifically referred to the matters I have summarised in paragraph 3.

49. The consultant told my officer that when he first saw the daughters on 4 August 1977 they told him that they wanted to satisfy themselves about their mother's care and treatment. They indicated their concern that she had been admitted to hospital and treated without their consent and the consultant understood that their view was that she should have been left in peace as the various things done to her in hospital had only made her miserable and her condition worse. The consultant said that he tried to reassure them of the appropriateness of their mother's treatment. Because of the daughters' concern and their criticisms of their mother's treatment the consultant reviewed all the medical and nursing records and made the management of the case the subject of detailed discussion at a joint meeting of physicians, junior staff and students of the medical wards at the hospital. He also asked the professor to review the management of the case. I have seen the case study and the correspondence with the professor.

50. When the complainer made her written complaint to the Board the CMS sought a report from the DMO who in turn discussed the matter with the consultant and obtained a written report from him. The DMO told my officer that he had not sought a report from the nursing side as it had seemed at the time that the complaint mainly concerned the patient's medical treatment and the consultant had already obtained information from the sister. A report was also obtained from the FP who had sent the patient to the hospital.

51. In his reply to the complainer the CMS explained the diagnosis reached by the FP which had led him to consider that the patient required urgent admission to hospital. He pointed out that in view of the time which had elapsed it was difficult to answer in detail the numerous points she had raised, but regarding the specific issue of the patient's treatment he pointed out that:

(i) emergency admission to an acute medical ward was the correct treatment;

(ii) the medical treatment subsequently carried out was based on careful assessment and observation;

(iii) not to have treated a very severe and persistent hypertension would have been negligent, especially as the patient's good previous health gave grounds for hope that her previous well-being could be restored;

(iv) the patient's subsequent withdrawal, inability to help herself and Parkinsonism were due to the nature of her disease;

(v) the sole aim of all the treatment instituted was to help the patient; and

(vi) it was much regretted that the treatment had failed, but this failure was not felt to justify an allegation that no attempt should have been made to treat.

Among other matters touched upon by the CMS was the confusion over arrangements for an interview with the consultant (see paragraph 42) and the reference to Parkinsonism (see paragraph 56). He concluded by saying how sorry all concerned were that she had been so distressed by the circumstances of her mother's death, and assuring her that all the matters she had raised had been carefully considered.

52. The consultant told my officer that when he and the district CMS saw the complainer on 18 April 1978 she did not raise anything new but went over the same ground again. She was not prepared to listen to explanations and her 'questions' mainly consisted of allegations of the nature 'why were they allowed to do experiments on my mother?'. These allegations were denied and it was explained to her again what had happened. The consultant said that the complainer had also gone on at some length about how well her mother had been and what she had been doing before she was admitted to the hospital and he had to explain to her that this was irrelevant as the onset of her illness had been rapid. In a memorandum to the DMO written immediately after the interview the district CMS confirmed the consultant's recollection and said that the complainer was not really interested when explanations were being given since her mind was already made up.

53. The consultant recalled that he had been mystified when the complainer raised the question of needle marks on her mother's neck. He said that he did not know what she was talking about and he was unaware of blood having been taken from this unlikely site or of injections having been given there. The sister told my officer that the complainer had asked her about the marks when she came to collect her mother's belongings some days after the patient's death. The sister also said she had no idea what the complainer was talking about and was at a loss about what to say. She therefore replied something to the effect that she had not seen any such marks. Other members of staff interviewed by my officer knew nothing of this and it was variously suggested that as the patient's skin had been very fragile the complainer might have seen small pressure marks caused by the pillow or scratch marks.

54. The consultant confirmed that the patient had been given a number of blood tests. He explained to my officer that she had to be regularly assessed for renal function; to see if her electrolytes were being adequately controlled; and to see if different forms of treatment were necessary. He said that at his initial meeting with the daughters he explained to them that sometimes blood leaks from the puncture site, particularly with older people whose veins have deteriorated, and causes a bruise. While this looks awful it is not painful for the patient. The houseman in agreeing with this account acknowledged that he might have forgotten to mention a single injection as the relatives had been asking about the marks on the patient's arms which were mainly attributable to blood withdrawal.

55. The sister told my officer that the patient had been in a drowsy condition and would have been quite happy to have stayed in bed all the time. However in order to try to avoid the onset of pneumonia which often develops in immobile elderly patients the nurses had tried to walk her in the ward and had sat her out of bed in a chair. The relatives had been told the reason for this but had nevertheless considered it 'cruel'.

56. The consultant said that he explained to the complainer that her mother did not have Parkinsons' disease but that stemming from the nature of her illness she had developed symptoms akin to Parkinson's disease. The houseman told my officer that he was unable to recall what he had said to the relatives but he was certain that he would not have said the patient had Parkinson's disease. He thought that what he had explained was that some of the patient's symptoms

were suggestive of Parkinson's disease. The sister who had been present when the houseman spoke to the relatives was unable to remember what, if anything, he said about Parkinsonism or Parkinson's disease.

57. The consultant denied that he had at any time mentioned cardiac arrest to the complainer. He told my officer however that examination of the patient at the time of her admission had shown evidence of a heart condition of some long standing and I have seen that this is confirmed by the notes made at the time by the examining doctor.

Findings

58. I have seen that the complaints were taken very seriously indeed, particularly by the consultant who was concerned that the relatives were so unhappy about the patient's treatment and even before a formal complaint was made had arranged for the management of the case to be reviewed to see if anything could be learnt from it. I have been very impressed by the objectivity and self-critical analysis of the consultant's case study.

59. It is understandable that in making his enquiries into the complaint the DMO should have taken the view that the complainer was principally concerned about her mother's clinical care as at various points in her long letter of complaint she returned to her view that her mother's admission was unnecessary and referred to her treatment as 'monstrous', 'horrific' and 'inhuman'. I am satisfied that in explaining the need for admission and treatment the CMS accurately represented the clinical views of the doctors involved.

60. However I think that the Board were at fault in failing to obtain the views of the nursing administration on this complaint. It was clear from the complainer's letter that she was dissatisfied with some aspects of her mother's nursing care and if the nursing staff had been formally asked for comments at the time it might have been possible to obtain clarification on certain points of the complaint, for example the difficulty in arranging an appointment with the consultant. Also, although I consider it would have been unrealistic to have expected the Board to reply in detail to every point made in the complainer's letter, they failed to mention several points which she had specifically queried such as the marks on her mother's neck and the bruising on her arms.

61. I believe that at the interview on 18 April genuine attempts were again made to satisfy the complainer regarding her principal causes of concern, namely her mother's admission and treatment.

Conclusion

62. I believe that the complainer and her sister did not at the time appreciate how very ill their mother was. From the evidence I have seen it is clear that there was great concern for the patient among the staff at the hospital and I am satisfied that their efforts were directed wholly towards helping her. I am surprised that the complainer and her sister should have been so little able to appreciate this or to express any gratitude for what was attempted.

63. On the other hand the difficulties they encountered in obtaining an interview with the consultant and some omissions in the Board's written reply to the complaint deserve some expression of regret and this the Board have asked me to convey to the complainer and her sister on their behalf.

Case No. SW.30/78–79 – Nursing care following operation

Background and complaint

1. The complainer's husband underwent an appendicectomy on 16 August 1976 at a hospital (hospital A). Ten days or so after the operation he developed a thrombosis in his left leg and on 13 September 1976 was transferred to another hospital (hospital B) for recuperation. The condition of his leg deteriorated and on 5 October 1976 he was transferred to a further hospital (hospital C) where his left leg was amputated below the knee.

2. The complaint concerns:

(*a*) lack of courtesy and poor communication on the part of the medical and nursing staff at hospitals A and B who failed to inform the complainer (i) of the reasons for her husband's transfer to hospital B; (ii) of a heart attack suffered by him at hospital B; and (iii) of the deteriorating condition of his left leg for which the houseman at hospital B incorrectly told her that effective treatment could be given.

(*b*) poor nursing care which failed to take account of the husband's previously known circulatory troubles and which allowed bed sores to develop at hospital B; and

(*c*) insufficient supervision of junior medical staff.

3. The complainer approached the district medical officer (the DMO) for the district of the Health Board (the Board) but remains dissatisfied with his replies which she feels have not answered many points of her complaint.

Investigation

4. During the course of the investigation my predecessor obtained the Board's comments which I have examined together with correspondence from their files and other relevant documents. One of my officers interviewed the complainer and her husband, medical and nursing staff involved in his care at hospitals A and B and the DMO.

The complaint about lack of courtesy and poor communication

5. The complainer told my officer that she had received no advance warning of her husband's transfer from hospital A to hospital B. On the day of the transfer, just as she was preparing to visit her husband, she was told of it by a telephone call from the ward sister (the hospital A sister). The only explanation she ever received, she said, was that it was felt that this move would help his recuperation. In her letter to the DMO the complainer stated that she considered continuity of care under the same staff would have been better for her husband.

6. The complainer said that when she visited her husband at hospital B on the evening of 21 September she found him in a very distressed condition as he said he had had a heart attack that morning. He told my officer he could not remember telling his wife about the heart attack but he said that his memory was rather vague about a large part of the time he spent there. The complainer told my officer that the ward sister (the hospital B sister) had confirmed that

her husband had had a heart attack but had added that it was nothing very serious. She thought that the houseman had also told her about it although she could not remember when. She felt she should have been told when the attack occurred and not left to find out for herself later in the day.

7. The complainer said that after her husband developed the thrombosis in his left leg the hospital A sister told her that 'he had not been getting up enough' and she had assumed that the leg would recover with bed rest. She first became aware of the true condition of her husband's leg when she visited on 22 September and she found the curtains drawn and a group of staff around her husband's bed. She then saw his leg uncovered and his foot blue and she was concerned that no one had thought it necessary to see her and explain. She asked to see the houseman who assured her that treatment would be given. In her letter to the DMO the complainer stated that her daughter telephoned hospital B the following morning and was assured that special treatment was being arranged. However, when the complainer visited later that day the only treatment she could see was the application of water bottles to his right leg. She asked the houseman to see her daughter and son-in-law on 24 September and he explained then to them that several things could be done. This buoyed up the complainer's hopes, but when she herself saw the houseman on 25 September he informed her that he knew nothing about circulatory troubles and the methods could only be used on a younger man. She was informed the next day that her husband's foot would have to be amputated.

8. The complainer said that she was asked to see the nursing officer (the NO) on 25 September and she told my officer she believed this was because the NO had become concerned about all the telephone enquiries from relatives and thought that there might be trouble. The complainer said that she found this interview distressing as the NO had offered no explanation about her husband's condition or prognosis, but had seemed concerned merely about the questions the relatives had been asking and the possibility that there might be a complaint in the offing. The following day the houseman apologised to the complainer.

9. The consultant surgeon (the consultant) responsible for the husband's treatment told my officer that his transfer to hospital B had been routine as at that time hospital A dealt with acute surgical cases and hospital B convalescence and elective surgery. The decision to move the complainer's husband had been taken by his registrar in the light of the bed situation and the patient's condition at the time. The NO who had been responsible for surgical wards at both hospital A and B told my officer that transfers from hospital A to hospital B were a frequent occurrence during this period and it was the duty of the ward nursing staff to inform relatives when it was decided to move a particular patient. The NO said that such decisions were usually made at short notice and it was unlikely that relatives would have had advance warning of the move. As the policy was expected to be short-lived there was no mention in the patients' handbook of the possibility of such a move. The consultant told my officer that this practice had now ended as all surgical beds had since been transferred to hospital A.

10. The hospital A sister told my officer that transfers to hospital B were usually made on the day the decisions were taken and she normally telephoned the relatives to inform them. She could not remember speaking to the com-

plainer but said that her usual practice was to explain that the patient was to be transferred for convalescence because of pressure on beds and because the patient was considered the fittest to be moved. She recalled that the complainer's husband had not been very pleased at having to move.

11. The medical notes show that the complainer's husband was seen by a doctor at hospital B when he complained of chest pains on 21 September and was given a chest X-ray and an ECG. Although the houseman was not the examining doctor on this occasion he told my officer there was nothing in the notes to indicate that the complainer's husband had suffered a heart attack. The houseman could not remember speaking to the complainer that evening but as he did not believe that her husband had suffered a heart attack he said he would not have told her so, although he might possibly have said that her husband had had an ECG to *rule out* the possibility of a heart attack. In the houseman's view the husband's condition had not necessitated the relatives being informed specially, a view shared by the hospital B sister who told my officer that she did not think there had been any cause for concern. She recalled that the ECG and other tests, which had been done at once, had not indicated a heart attack. She was sure she had not mentioned a heart attack when she saw the complainer later that day, but had simply told her that he husband had had chest pains.

12. The consultant told my officer that it was possible that the complainer's husband had suffered a mild coronary on 21 September, but he too did not think that the relatives should have been informed immediately: if the patient's condition had deteriorated and given cause for concern he would have expected the relatives to have been notified, but in this case there was no cause for alarm and it was reasonable for the staff to wait until they saw the relatives who were expected to visit later in the day.

13. The consultant explained that the complainer's husband had a history of circulatory problems but the thrombosis which he developed while in hospital A was separate from them and was something which could develop in any not very mobile patient post-operatively. In his view the thrombosis had been treated quickly and correctly. The subsequent deterioration in the husband's foot at hospital B had however been due to his circulatory problems. An entry in his clinical records on 21 September observes that his left foot was 'blue and slightly mottled – always been colder than right'.

14. In a written statement for the DMO's enquiry the hospital B sister said that the complainer had seemed satisfied with the information given and that she had said that she understood what was going on. The hospital B sister told my officer that she had spoken to the complainer at least twice before 21 September and although her husband's thrombosis was mentioned the conversation had mainly been about his general condition as his leg was not the main cause for concern at that time.

15. In her statement for the DMO the hospital B sister said that the complainer had arrived for afternoon visiting on 22 September while her husband was being examined. She was seen at this time and given the latest information regarding further management. The hospital B sister subsequently told my officer that she did not know what the houseman told the complainer as she was not

present at this interview, but she thought that she had spoken to the complainer later to ensure that she understood what was going on. The houseman could not remember what he had said to the complainer but he told my officer that he would have told her of the treatment they were trying.

16. The hospital B sister also stated that on 23 September she was informed by the NO of the patient's daughter's concern about her father's condition and in particular about his foot. The daughter had been told that another doctor had seen her father and had ordered the bandages to be removed at once saying something to the effect that this was not the correct treatment. The hospital B sister said that she discussed this with the houseman and they decided that as information reaching the relatives was incorrect or was being misinterpreted the relatives should in future be seen only by them.

17. In her statement, the hospital B sister said that when she and the houseman saw the patient's daughter and son-in-law on the evening of 24 September they said that they had been led to believe that the bandages had not been removed from the patient's leg since his transfer to hospital B and that they assumed that his present condition was related to this. It was pointed out to them that the bandages had been removed daily and that several types of bandage had been tried because of the patient's discomfort. The hospital B sister told the DMO that the houseman explained that the arterial occlusion from which the complainer's husband was then suffering was different from the thrombosis and outlined the current management and mentioned other possibilities including the question of amputation. The hospital B sister told my officer that in discussing the treatment the houseman said that he did not know what the outcome would be as he was not an expert in that field.

18. The houseman was unable to recall details of what was said during this interview, but he told my officer that he would have explained the patient's condition and told the relatives of the treatment being tried and warned them that amputation was a possibility. If he discussed other possible treatments this would only have been in very general terms and he agreed that in this context he might have said that he was no expert in this field.

19. The NO, in her statement to the DMO, said that she saw the complainer on 25 September as the hospital B sister thought that she did not appreciate how ill her husband was and that his relatives seemed to be getting incorrect information about his condition and treatment. The NO recalled that at the interview she had told the complainer just how ill her husband was and that the complainer had been extremely emotional and had said that she had not been told before about her husband's illness. The NO confirmed that she had asked the complainer if she wished to make an official complaint. She said she had done so with the thought that if a complaint were to be made it would be better made then so that it could be investigated while events were fresh in everyone's mind. However, the complainer had not wished to make a complaint.

20. The houseman could not remember details of his meetings with the complainer on 25 and 26 September. He told my officer that he had not been aware of what had been said during the complainer's meeting with the NO. He surmised that if the hospital B sister told him that the complainer had been upset during the interview he might subsequently have told her that he was sorry she had been upset. He recalled that he had felt very sorry for her and had

sympathised with her obvious concern about her husband. He thought that he had bent over backwards to try to help her and that his mistake might have been that he had been too forthcoming because in retrospect it seemed that she had misinterpreted just about everything he had said to her.

Findings

21. The geographical separation of the surgical wards was not ideal, but such arrangements are sometimes unavoidable and in this case it was a temporary expedient which has since been discontinued. However as it was common at the time, I think that patients and relatives should have been forewarned of the possibility and the confusion and anxiety which may arise when a patient is transferred unexpectedly at short notice thus avoided. The actual decision to transfer the complainer's husband was taken by a doctor after he had considered his fitness for transfer and this I consider to be a question of clinical judgement on which I may not comment. The information about her husband's transfer was relayed to the complainer without delay and although I have been unable to establish exactly what was said I am satisfied that she was advised of the reasons.

22. It is clear that whatever the complainer's husband suffered or complained of on the morning of 21 September in the opinion of the doctors and nurses his condition was not serious enough for the relatives to be informed immediately: and it is possible that had the complainer been telephoned at the time she might well have been caused unnecessary alarm. I do not uphold this aspect of her complaint.

23. I have been advised that the complainer's husband's foot began to show signs of deterioration on 21 September and despite the treatment which was begun on 22 September it continued to deteriorate until by 26 September amputation was indicated. The complainer may have been stunned by this rapid deterioration and misinterpreted the houseman's endeavours to explain in general terms possible treatments. I am fully satisfied that the staff involved tried to keep the relatives informed of the patient's condition, treatment and prognosis and that the main purpose of the NO's interview was to establish that the complainer understood the seriousness of her husband's condition. I think it was reasonable for her to ask if the complainer wished to make a formal complaint because a complaint can most satisfactorily be resolved if it is made promptly. I concur with the houseman's opinion that the complainer misinterpreted his explanations and, although this is a risk which is run when doctors are trying to be particularly informative, I commend his attitude. I do not uphold this complaint.

The complaint about poor nursing care

24. In her letter to the DMO the complainer stated that she had been told by the hospital A sister that the thrombosis had developed because her husband had not been getting up enough. She felt that with his history of circulatory trouble he should have had special attention, physiotherapy and good nursing. She told my officer that she was convinced that poor nursing attention at hospital B had led to her husband developing bed sores. She said that the nurses at the limb centre, which her husband subsequently attended, had commented that they had never seen anything like it and that it was a disgrace to the nursing

profession. The husband told my officer that he could not remember having any treatment to his pressure areas whilst at hospital B.

25. The consultant told my officer that the circulatory problem from which the complainer's husband suffered was very common among men of his age often to a greater degree than in this case. No special treatment was given to such patients beyond the usual modern practice of mobilising them as soon as possible after their operations.

26. The hospital A sister told my officer that the nursing staff there knew the complainer's husband and were fully aware of his previous history as he had been a patient on the ward a few months earlier. She recalled that after the appendicectomy he had been very quiet and withdrawn and had not wanted to be bothered. He had been very reluctant to get out of bed and take exercise despite being encouraged to do so. She recalled that when he was got out of bed so that it could be made he would get straight back in again immediately the nurses had finished. She said that after the thrombosis developed she had explained to the complainer that her husband had not been getting up enough and that while mobilisation was important for all patients it was particularly so for a patient suffering from peripheral vascular disease. The NO recalled that the complainer's husband was reported as being particularly 'disinterested' in mobilisation after his operation.

27. The divisional nursing officer (the Div NO) told my officer that the husband's pressure areas had received regular attention while he was at both hospital A and B. She had spoken to the sister at the limb centre who told her that the complainer's husband had some 'ruffled' patches of skin on his bottom when he arrived there. The Div NO said that these were not bed sores and that they would have been noted had they been present at hospital B. She thought that they would have developed immediately following the amputation as patients were required to be kept very still for a time after this operation.

28. The NO and the hospital B sister confirmed that the complainer's husband had received regular care to his pressure areas in hospital B. In her written statement to the DMO the hospital B sister said that after a small blister had appeared on the husband's right hip, which was thought to have been caused by micropore tape, he was nursed on a ripple mattress. His left foot was blistered but the skin was intact. She said that none of her staff had any recollection of any pressure sores. The patient's pressure areas had been treated two hourly and he had been very annoyed because he was being turned that often.

29. The nursing records at hospitals A and B confirm these statements. The nursing report completed on the patient's transfer to hospital C refers to a superficial sacral sore and to his blistered foot. The records of hospital C on 6 October note 'pressure areas on back very sore', then 'must lie off back, but not keen'. The notes record that despite two hourly pressure care the skin on his sacrum was broken by the time he was transferred to the limb centre on 11 October.

Findings

30. I consider that the staff at hospital A were aware of the husband's circulatory problems and that in accordance with good nursing practice they

did try to encourage him to get out of bed as soon as possible after his operation. There is also ample evidence that regular and careful attention was paid to his pressure areas at hospital B and that such problems as did arise were properly recorded. I therefore dismiss the complaint of poor nursing care.

The complaint about insufficient supervision of junior medical staff

31. The complainer told my officer that for a great deal of the time that her husband was in hospital B the consultant had been away and that as there were never any senior doctors about the young houseman had appeared to be in complete charge. She stated that when she asked what was going on around her husband's bed on 22 September (see paragraph 7) she was told that the assistant to the specialist in circulatory troubles happened to be in the ward and saw her husband's foot. She was upset that her husband should be seen 'just by chance' by someone from the appropriate specialty. She was also convinced there was a row going on at her husband's bedside on this occasion as the sister had left the examination red-faced, and the houseman had been sent away to telephone for something. She said that her husband had told her at the time that there had been a row over his treatment although he told my officer that he could not now remember the incident.

32. The consultant agreed that he had been away a lot of the time but he denied that there was inadequate supervision of junior staff. He told my officer that his absences had been covered either by a locum consultant surgeon or by his senior registrar, and that although the consultant surgeons were not based at hospital B they visited as required and there was a surgical registrar permanently based there.

33. The houseman told my officer that he had never felt that he was left without adequate support from senior staff. He explained that the ward was shared by the patients of three consultant surgeons so in addition to being able to contact the consultant or his deputy by telephone he could always if necessary seek advice or assistance from members of the other surgical teams using the ward. One of the consultant surgeons using the ward had a special interest in vascular surgery (the second consultant) and it was his registrar (the registrar) who saw the complainer's husband on 22 September. The houseman denied however that the registrar had seen the complainer's husband 'by chance'. He said that he specifically asked the registrar to look at the husband. (This was confirmed by the hospital B sister.) The houseman said he might well have told the complainer that the registrar was the assistant to the specialist in circulatory problems, but if he used the expression 'happened to be in the ward' he did not mean to indicate that the patient had been seen merely by chance. The houseman said that he had telephoned the consultant about the deteriorating condition of the husband's foot and the treatment recommended by the registrar. He recalled that the consultant had approved the registrar's treatment and had not considered it necessary to make a special trip to hospital B himself.

34. Neither the houseman nor the hospital B sister could recall any sort of 'row' at the patient's bedside on 22 September. The houseman said that there might have been some discussion about the proposed treatment, and the hospital B sister's recollection was that the registrar had recommended treatment and said that he would ask the second consultant to see the patient when this

could be arranged. The hospital B sister said that at the end of the consultation she had left to prepare the infusion which the registrar had recommended.

Findings

35. I have been assured that the consultant's absences were adequately covered and that the houseman had ready access to senior staff at both hospital A and hospital B. I am satisfied that the houseman asked the registrar to see the patient on 22 September and the consultant was advised of the patient's condition and the proposed changes in his treatment were reported to and agreed with him. He decided in the exercise of his clinical judgement, on which I cannot comment, that he did not need to see the complainer's husband himself. I do not uphold the complaint that there was insufficient supervision of junior staff.

The complaint about the Board's handling of the complaint

36. The complainer wrote to the DMO on 26 March 1977 complaining of her husband's treatment at hospital A and hospital B as outlined in the earlier paragraphs of this report. She suggested dates when her son could accompany her if the DMO wished to arrange an interview.

37. The DMO replied on 30 March and asked her to telephone his secretary to arrange a mutually convenient time for an interview. I have seen that he then sought the comments of the consultant and the district nursing officer who, in addition to giving her own and the Div NO's comments on the complaint, also submitted detailed written statements from the two ward sisters and the NO. After completing his enquiries the DMO met the complainer and her son on 15 April.

38. The complainer told my officer that she was dissatisfied with this meeting because she felt that the DMO had simply denied everything and not attempted to give explanations for what had happened. She said she had received no explanation about the lack of special care in view of her husband's circulatory problems, and when she asked the reasons for his transfer to hospital B she was merely told that they had stopped doing it now. She said the DMO had denied that the houseman would have given contradictory information and had also denied that the complainer's husband had had bed sores. She felt that the DMO had been splitting hairs about this last point by arguing that bed sores were much more serious than anything the complainer's husband could have had.

39. While the DMO could not remember in detail all that had been said at the interview his recollection also was that it had not been very satisfactory. The complainer and her son had seemed very upset and had tended to make accusations rather than listen to the explanations he tried to give them. The DMO said that at the end of the interview he still did not know what they had wanted from it.

40. The DMO recalled that when the complainer asked about her husband's treatment he replied that this would be better answered by the clinicians involved and offered to make an appointment with the consultant. However the complainer declined saying that she would in any case be seeing him at her husband's next clinic appointment.

41. The DMO said that in the course of the interview he also explained the chain of medical responsibility and that although the houseman was the immediate point of contact there was no barrier to their seeing senior doctors, including the consultant, if they had so requested and that what they had taken to be contradictory information from the houseman was probably an attempt by a young doctor to explain the situation compassionately. He also explained that at the time the surgical beds at hospital A were under heavy pressure and that it had been normal practice to transfer patients to hospital B for convalescence but that this practice had since stopped. The DMO said that while he had not actually denied that the complainer's husband had bed sore she had explained to them that according to the information received from the limb centre the husband had developed some blistered areas and that a bed sore was more serious than this.

42. Following this interview the complainer's son wrote to the DMO on 2 May requesting a written statement detailing the steps taken to inform his parents of the treatment for his father's condition and the possible complications; a policy statement by the Board on whose responsibility it was to inform relatives of extremely ill patients; a list of the doctors who were in charge of his father's care with the periods of actual attendance given; and a written record with dates of the total post-operative treatment given to his father while at hospital A and hospital B. He suggested that the records were either falsified or deliberately misleading in respect of his father's bed sores. He further requested that 'in view of possible further action' he be informed of the steps the DMO had taken arising from their interview.

43. The DMO acknowledged receipt of this letter on 16 May and following the receipt of a reminder dated 30 June informed the son on 5 July that he had referred his original letter to the legal adviser to the Scottish Health Service.

44. After receiving the advice of the legal adviser the DMO wrote to the son on 14 July stating that it appeared that despite his investigations and the subsequent interview the misunderstandings still remained and that he considered that he could not do anything further to rectify the situation. He expressed his belief in the assurance given by the consultant that his father's treatment was, despite the unfortunate series of complications, carefully and correctly managed and he rejected the allegations that the treatment and care were in any way negligent. The DMO also said that at all stages of her husband's treatment the complainer and other relatives had been given the opportunity of discussing the case with those responsible for his treatment. He had no doubt that the consultant would still be prepared to see the complainer and her husband to clear up any misunderstandings which still remained and he himself was prepared to take part in further discussion if it would serve any useful purpose. However the DMO made it clear that he was not prepared to arrange the extraction of detailed information from records for 'unspecified and futile purposes' but he did offer to make these records available to an independent consultant appointed by the complainer. The DMO told my officer that he had sought advice from the legal adviser as he had judged from the son's letter of 2 May that the family were considering taking legal action against the Board.

45. The son wrote to the DMO again on 19 August saying that the family emphatically disputed that they had been given the opportunity of discussing the case with those responsible; that neither his mother nor father were told that exercise was crucial after the appendicectomy; and that the reasons for the move to hospital B were not explained to his parents. He also stated the the family were given irrelevant information by the houseman and that the Board had failed to answer the points of complaint.

46. The DMO replied on 5 September again offering to arrange an interview with the consultant and himself to discuss the misunderstandings which still remained. He reiterated the offer of full co-operation to any independent consultant instructed to look into the matter on behalf of the complainer and her husband.

47. The complainer replied to this letter on 1 October restating the points of the complaint and the DMO replied on 14 October that he could contribute little more towards clearing up the misunderstandings other than by the suggestions he had made in his last two letters to her son.

48. The consultant told my officer that he did not personally see the complainant's husband at his clinics for some time after the initial complaint was made. When he eventually did see him neither he nor his wife raised the subject of the complaint and he thought that the matter had been dropped.

Findings

49. I have seen that on receipt of the original letter of complaint the DMO commenced his investigation into the matter without delay and quickly arranged an interview as suggested by the complainer. Although at this distance in time and in the absence of any written evidence it is not now possible to establish exactly what was said during the interview I believe that the DMO did try to answer the various points of the complaint although both sides agreed that the complainer was not satisfied. As her concern was about her husband's care I think it sensible and constructive of the DMO to suggest that the question should be discussed with the clinician concerned. It was unfortunate that the complainer did not accept this offer as it was some time before she and her husband actually saw the consultant, although this was no fault of his.

50. I think that the DMO's offers to arrange further interviews or to make the records available to an independent consultant were reasonable responses to the subsequent letters from the complainer and her son. Although there was a delay before the complainer's son received a substantive reply to his letter of 2 May this was because the DMO understandably sought legal advice as the wording of the letter implied that legal action was possible. I do not uphold this aspect of the complaint.

Conclusion

51. I sympathise with the complainer and her husband in their distress over the latter's serious illness. But I believe that the staff were greatly concerned and sympathetic and did their best to explain matters. Nevertheless, there were misunderstandings or misinterpretations of what was said. I have been unable to uphold any of the complaints, but I hope that my report will reassure the complainer that her husband was given proper and considerate care and attention. attention.

Case No. WW.51/78–79 – Delay in arrival of ambulance

Complaint

1. The complainant's four-year-old nephew was taken seriously ill on the morning of 27 November 1978. An emergency call was made to the police who asked for an ambulance to call at the house; the complainant's nephew died before it arrived. The complainant says that there was an unacceptable delay before the ambulance arrived and he is not satisfied with the explanation given him by the Health Authority (the Authority).

Investigation

2. During my investigation I obtained the written comments of the Authority and one of my officers interviewed the staff concerned in the complaint. He also met the complainant.

3. The complainant, acting on behalf of the parents, approached the secretary of the Community Health Council (the CHC) about the delay in the arrival of the ambulance and the CHC secretary wrote on 18 December 1978 to the Area Administrator (the AA) of the Authority giving the following details. A 999 call was made to the police at 05.55 on 27 November from the telephone box nearest to the nephew's home. The complainant was also called and when he arrived at the house at 06.15 the family practitioner had already arrived and said that the nephew was dead. He told the complainant that he could have died as a result of inhalation of vomit but that a post-mortem would be required. The ambulance did not arrive until 06.31, although the ambulance station is less than half a mile from the house. The complainant was told by the ambulance crew that one driver (the first ambulanceman) had been alerted to the emergency by his wife when he arrived home at 06.05. He had then returned immediately to the ambulance station collecting his colleague (the second ambulanceman) who was not on the telephone, on the way.

4. The CHC secretary told the AA that the complainant was not claiming that his nephew's life could have been saved if the ambulance had arrived sooner but felt that in some circumstances it could have been a matter of life or death for the patient. The CHC thought it inconceivable that an ambulance driver could be on call at home and yet not have a telephone; and they felt the Authority should ensure that ambulancemen were more readily available at night. In his letter to me the complainant explained that he was motivated by the need to ensure adequate provision of an ambulance service in the region; he thought his nephew's death had revealed a serious lack of organisation in that there were men working on standby duty without a telephone and that there were no other ambulancemen available 16 miles from the town who could have been called in the absence of the local drivers.

5. The complainant had previously complained in person to the area general administrator (operational services) and had met the AA and the area chief ambulance officer (the ACAO) on 13 December. The AA wrote on 15 December to the complainant. He expressed sympathy at the nephew's death but said that the medical advice he had received was that he had suffered from a fulminating meningococcal infection which had progressed quickly and had led to rapid circulatory failure and death. Although the family practitioner had arrived at the house very quickly, the complainant's nephew had already died; thus no

action the ambulancemen could possibly have taken could have saved his life. He admitted there was a delay in the arrival of the ambulance which, he said, was due primarily to the failure of the Post Office to instal a telephone in the house of the second ambulanceman. Three requests had been made to speed up the installation but there had been a delay of ten weeks. The absence of a telephone had been the crucial factor; if it had been installed, the ambulance would probably have been at the house by 06.10. (This could have been achieved by the second ambulanceman taking out the vehicle single-handed – a procedure adopted occasionally in any emergency such as this in order to get breathing apparatus to the patient as quickly as possible.) The second cause of the delay was the time taken to get in touch with the first ambulanceman on his way home from the previous call. The AA promised that the Authority would press the Post Office to give greater priority to the needs of ambulancemen and that the ACAO would negotiate with ambulancemen in the region to improve the response from personnel on standby by their carrying shortwave radios in their cars and by taking ambulances home when on call. There would also be continuing efforts to make improvements in the duty rosters.

6 When my officer met the complainant he said that he was not convinced by the AA's assurances that nothing could have been done to save his nephew's life. He said one boy of whom he had heard had suffered from the same condition and had survived following an emergency ambulance journey. Nor could he accept the excuse he had been given about delays in the Post Office installing the second ambulanceman's telephone since he understood that the ambulanceman had reported his change of address in June 1978 and that the telephone had been installed the day after the nephew's death. He also understood that another ambulanceman had been working on standby since December 1977 without a telephone. But he said he accepted that, with the ambulancemen carrying portable radios in their cars, the call-out time should be improved

7. The Authority responded to the CHC's complaint on behalf of the complainant by saying that the Chairman had approved the convening of a panel of inquiry. Two members of the Authority and a member of the CHC interviewed ambulance officers and studied the relevant records and correspondence. The members reported that they were satisfied beyond reasonable doubt that, whatever had been the ambulance response time, the nephew would have died. They agreed that there had been an unacceptable delay in response by the ambulance service but that, within the limits of the existing arrangements, no blame could be attached to any of the individuals concerned. They said that a refusal of ambulancemen on standby duty to take vehicles home and the delays in installing telephones in the homes of ambulancemen were two elements which had contributed to the delay. They made four recommendations which were directed towards eliminating needless delays. They recommended first that the ACAO should consider adopting a procedure whereby, if for any reason a standby crew could not be alerted, the crew on station duty would be mobilised straight away; secondly, that a meeting be arranged between officials of the Telephone Manager's office and members of the panel to discuss priority arrangements for the installation of ambulancemen's telephones; thirdly, that portable two-way radios be obtained for use by ambulancemen without telephones and lastly that ambulancemen in the region be asked to agree to take ambulances home when they were on standby duty, as was the practice in other sectors of the

Authority. Copies of the panel's report were given to the CHC on 2 February 1979, and they advised the complainant (who was not provided with a copy of the report) to ask me to investigate the complaints.

8. I have seen a record of the discussion between the family practitioner and the Authority's specialist in community medicine. The family practitioner reported that he believed the complainant's nephew had been quite well up to the night before his death when he had showed some minor signs of illness. The doctor visited, immediately on being called soon after 06.00, and on arrival he found him dead. His opinion was that there was nothing the ambulancemen could have done even if they had arrived earlier. The specialist in community medicine stated that the post-mortem examination confirmed the family practitioner's opinion that the nephew had died from a fulminating meningococcal infection. There would have been few warning symptoms or signs, but a rapid progression into profound circulatory failure and death.

9. The two ambulancemen concerned explained to my officer that they had completed their shift at the local ambulance station at 02.00 and had gone home to their standby addresses. They had afterwards been called out and when they had completed the call they had returned to the ambulance station and had notified ambulance control and switched off the radio at 05.56. The first ambulanceman, who lives some four miles from the ambulance station, said he had then driven home and had been met by his wife who told him that ambulance control had telephoned her about the emergency call for an ambulance for the complainant's nephew. He had driven back to the ambulance station, calling for the second ambulanceman on the way, and they had mobilised the ambulance and arrived at the nephew's home at 06.31. The second ambulanceman said that when they arrived they were met by the family practitioner, and a police sergeant who had been abusive towards them because of the delay. Though they felt it was not their fault they had been extremely upset. The ambulancemen estimated that if they had been on duty at the ambulance station it would have taken less than three minutes to arrive at the house.

10. The ambulance control officer who had been on duty told my officer that he had taken a call at 06.01 from the police headquarters in the town requesting an ambulance for a child with breathing difficulties in the region. Although he knew that the two ambulancemen on standby at the ambulance station had radioed shortly before this to record they were leaving the station he had tried to contact them both by radio and telephone in the hope that they were still on the premises. At 06.03 he had telephoned the house of the first ambulanceman whose wife told him her husband had not arrived home; and he asked her to ask him to telephone immediately he arrived. He did not know at the time that the first ambulanceman lived some four miles from the town but he did know that the second ambulanceman could not be contacted by telephone. At 06.10 he had a second call from the police confirming the emergency, which he realised would have come from the police officer at the scene of the incident. At 06.15 the first ambulanceman had telephoned (it seems unlikely that he could have arrived home at 06.05, as stated by the complainant) and had left immediately for the ambulance station. The next message he had recorded was that the ambulance was mobilised at 06.29 and had arrived at the house at 06.31. He said he had been extremely concerned at the length of time it was taking the

crew to get their ambulance mobile and he had considered calling out the ambulance crew on station duty elsewhere. However, he did not think that, even with a trouble free drive to the town (a distance of some 16 miles), the other ambulance would have arrived at the house before the local crew.

11. The ACAO told my officer that in his opinion the personnel involved in the early morning of 27 November had acted correctly. He thought the ambulance control officer had been right in his judgement not to call out the other ambulance crew. Subsequent events proved that the other ambulance would not have arrived more quickly than the local ambulance and calling out the other crew would have left the whole of the region without cover. He said that one of the results of the Authority's panel of inquiry was that a directive had been issued to ambulance control officers to the effect that if the standby crew could not be contacted at any time the next nearest crew should be called out on duty. If this had been in effect on 27 November 1978 the other ambulance would automatically have been mobilised. The ACAO said that, though this would not have been helpful on this particular occasion, he felt it was an additional safeguard to have such an instruction in force.

12. With regard to the problems of contacting the local crew on standby the second ambulanceman told my officer that he had informed the ambulance control officer at headquarters that he was moving house and had been asked to let the ambulance service know the completion date. He had done so and informed the officer that the telephone line had been taken out of his house by the Post Office. He had heard nothing more until the incident and, as he recalled, a telephone had been installed either on 27 or 28 November. The ambulancemen said that, following the recommendation of the panel of inquiry, the Authority had provided radio handsets to be carried in the ambulancemen's cars and that these had improved the communication with crews travelling between the ambulance station and their home addresses.

13. The ACAO confirmed that the second ambulanceman had notified the ambulance service of his proposed change of address in time for an order to be placed in writing to the Post Office for a telephone to be installed at the new address. This order had been followed up at intervals by the ambulance officer in charge of communications but the Post Office response had been slow. Though it had been realised that it was not ideal for the second ambulanceman to be on standby without a telephone, it had been felt necessary to use him as the number of ambulancemen was limited in the town. The system whereby the second ambulanceman's crew mate called for him when necessary at night had generally worked reasonably well. Following the nephew's death the officer in charge of communications had immediately telephoned and written to the Post Office and the telephone had been installed the same day. A meeting had been held with senior staff of the Post Office and, the ACAO said, they had been unable to provide a reasonable excuse for the failure to supply the second ambulanceman with a telephone earlier. It had been agreed that a higher priority would be given to ambulancemen in future and that it would be standard procedure, on appointment of ambulancemen, to check with the Post Office to see if a line was available for a telephone installation. But in one case the Post Office had given an estimate of three years for the installation of a telephone which had made it necessary for the man concerned to have a portable

radio by the side of his bed, switched on throughout any night he was on standby duty. The ACAO confirmed that, following the panel of inquiry, portable radios were carried by duty ambulancemen in the region in their cars and he thought that this should improve the response times.

14. I have seen copies of correspondence between the Authority and the Post Office. The order for the installation of the second ambulanceman's telephone was made on 14 September 1978. The ambulance officer in charge of communications has stated that telephone calls were made to chase progress on 4 October and 23 November 1978. The officer wrote to the Post Office on 27 November asking for the matter to be treated as urgent in order that there should be no recurrence of the delay which had occurred that morning. On 30 November he wrote again expressing concern that certain ambulancemen were on shared telephone lines and explaining that after normal working hours ambulance personnel responded to emergency calls direct from their homes. The Post Office responded to both these letters; to the first on 11 December explaining that though orders for telephones at the homes of ambulancemen on call were usually completed quickly, in certain cases delay was unavoidable for technical reasons; and to the second on 21 December when they offered to give special priority to ambulance personnel to exempt them from sharing telephone lines, provided that the Authority rented all telephones requiring such exemption. The Authority agreed to do this.

15. Following a meeting between ambulance officers and Post Office officials on 23 February 1979, the Post Office eventually wrote to explain that the delay between ordering and provision of the second ambulanceman's telephone had been a little over two months and this at a time when resources were stretched because of a backlog of work following the settlement of the Post Office Engineering Union's industrial dispute. Also there had been difficulties in parts of the town because the existing cables were working to capacity and it had taken some time to arrange a suitable shared line. The Post Office pointed out that in ordinary circumstances provision of a home telephone for an ambulanceman does not carry priority as he would be only one of a number of men who could be called out. However, in the special circumstances in the county which, the Post Office said, had been caused by the decision of the Authority to close ambulance stations at 2 am, it had been agreed locally to give a degree of priority to provision of new telephone lines for ambulancemen. The Post Office said that they had only learnt of the change of organisation from the letter of 30 November 1978 from the ambulance officer.

16. The ambulancemen told my officer that they were unhappy with the arrangements for providing an ambulance service in the town at the time the complainant's nephew died. Before 1 January 1978 the local station had been manned 24 hours a day, seven days a week, and they felt that anything less was inadequate in view of the problems of contacting crews on standby at home. Though the Authority has agreed temporarily to revert to the former arrangement, the ambulancemen were disputing with the Authority the arrangements in the town because they felt that the people there had, and would probably again have, a dangerously reduced service. The ACAO told my officer that the arrangements for night cover in ambulance stations in the county were the subject of lengthy discussions by the joint working party on ambulance services.

He said that the reduction in the cover provided in the town on 1 January 1978 had been the result both of criticism by the auditors for overspending on the ambulance budget and of pressure from the ambulancemen's trade unions to reduce the amount of overtime worked in the region and to standardise pay levels in the county as a whole. The arrangement in the region had been a compromise agreement and there had been problems in that the region's ambulancemen were reluctant to take ambulances home whilst on standby duty, although the ambulancemen in other districts of the county had done so for several years. He said the problem was still unresolved and, though the Authority had temporarily agreed to revert to 24-hour cover at the local ambulance station, negotiations at both national and local level were still proceeding and the result of these would determine the eventual pattern of ambulance cover in the region. He said that the auditor had again criticised the amount the Authority spent on night cover for the region and he could see no possibility of the Authority increasing funding to provide the service the ambulancemen in the town wanted.

Findings and conclusions

17. I have confirmed the medical opinion that the nephew's life could not have been saved even if the ambulance had arrived sooner. Although this clinical opinion is not for me to comment upon, I hope the complainant and his nephew's parents will draw some consolation from it. As the Authority have already done, I extend my sympathy with the relatives on this untimely death.

18. Nevertheless, it is a matter of concern that there was such a delay and I uphold the complaint that it was unacceptable. The Authority agree, but have come to the conclusion that no blame rested on the individuals concerned on the morning of 27 November 1978. I agree with that conclusion.

19. The complainant was told by the AA that the crucial factor in the delay was a failure on the part of the Post Office who have said that they had not been informed of the ambulance arrangements in operation in the region at night. I am unable to establish satisfactorily the precise reasons for the delay in installing the second ambulanceman's telephone because the Post Office is not within my jurisdiction. But I think that, in view of the importance of the need to communicate quickly with the ambulancemen on standby duty, the Authority should have made a greater effort to persuade the Post Office that any necessary work should be carried out quickly or should have made alternative arrangements if that was impossible. I recognise the difficulties the Authority were faced with when trying to rationalise the ambulance service arrangements in the county but I do not think that the emergency cover provided by the ambulance service in the town at the time of the nephew's death was satisfactory. I am glad that the Authority themselves have recognised this and that measures have been taken to reduce delays in the response to emergency calls during the early hours of the day. I have established that, of the four recommendations of the panel of inquiry, three have been implemented and improvements have been made in procedures and communications. Unfortunately the question of ambulancemen taking their vehicles home with them remains the subject of dispute, but, as a temporary measure, the local ambulance station is being manned 24 hours a day.

20. The complainant received an explanation for the delay from the Authority in the AA's letter of 15 December. This letter very briefly outlined the problems and the proposed improvements to the service. The complainant heard nothing more from the Authority, although a thorough investigation was carried out and a detailed report issued by the Authority's panel of inquiry. I have reached conclusions largely similar to those of the panel and I think that their recommendations were practical and sensible. But although the CHC had taken up the complaint, I think that the complainant should have been told that a panel of inquiry was to be convened and informed of the extent to which their findings and recommendations had been implemented. I think the relatives' natural distress might have been alleviated, if only in a small way, by knowing how seriously the Authority had taken the incident and being told of the detailed measures they were taking to minimise ambulance delays. The Authority accept this shortcoming and they have told me that they will be writing to the complainant to express their regret and apologies for this.

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