Health Service Commissioner : second report for session 1977-78 : investigations completed December 1977-March 1978.

Report of the Health Service Commissioner

December 1977 to March 1978

London
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HEALTH SERVICE COMMISSIONER

Second Report for Session 1977-78

Investigations completed—December 1977 to March 1978

Presented to Parliament pursuant to Section 119(4) of the National Health Service Act 1977 and Section 48(4) of the National Health Service (Scotland) Act 1972

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1. Section 119(4) of the National Health Service Act 1977 and Section 48(4) of the National Health Service (Scotland) Act 1972 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.

2. The Appendix to this Report contains the individual reports I have issued during the months December 1977, and January, February and March 1978. Those for England have the prefix 'W'; those for Scotland starting on page 133 the prefix 'SW' and those for Wales starting on page 171 the prefix 'WW'.

I V PUGH
Health Service Commissioner

May 1978

APPENDIX
REPORTS ISSUED DURING FOUR MONTHS ENDED 31 MARCH 1978

Case No W309/76–77—X-ray examination of children without their mother's permission

Complaint and background

1. On 22 September 1975, a mother attended the outpatients department of a hospital with her two children, a boy aged 15 months and a girl aged 3. Her common-law husband complained to his Member of Parliament that a large number of x-rays were carried out on the children without explanation and without their mother's permission. The Member corresponded with the Regional Health Authority (the Regional Authority) about this and, because the complainant remained dissatisfied with the information they gave, he asked me to undertake an investigation of the complaint and the way in which the Regional Authority had dealt with it.

Investigation

The complaint about the x-rays

2. The mother told my officer that she had taken the children to see the family doctor so that he could look at the boy's feet which always seemed to be cold. She had also told him that she and the children had been visited by social workers (from the County Council Social Services Department), who had seemed to be implying that the children were being maltreated, and she had asked the doctor to examine them both. He had done so and had said that they were all right. But he had been concerned about the boy's cold feet and had said that the condition might be caused by a heart defect. He had said that he would arrange an appointment for him to see a specialist at the hospital. The boy was duly offered a hospital appointment but this had been for about 9.00 am and, because his mother could not get there so early, the health visitor agreed to take them; the social services department had provided transport and the mother said that she had taken both children with her to the hospital because there was no one to look after her daughter in her absence.

3. The mother went on to say that she was surprised when both children were examined at the hospital. The doctor who saw them, whom my officer later identified as a senior house officer (SHO), told her that he could not tell what was wrong with her son without an x-ray. After examining him, he had examined her daughter's legs and commented that she had a lot of bruises. She had told him that her daughter had been late in learning to walk and that she fell down a lot. She told my officer that she could not recall that the SHO had said anything about having her daughter x-rayed.

4. The mother had then taken both children to the x-ray department and had stayed with them. When it became clear that the radiographers were carrying out more than just chest x-rays on her son she said that she had protested strongly to them, but they had continued and had x-rayed virtually the whole of his body. The mother told my officer that after this the radiographers had asked

her to put her daughter on the x-ray table, but she had refused to do so. A radiographer had then told her that the note from the SHO said that he wanted her daughter's legs to be x-rayed because of the bruises, and she had allowed this to be done. The mother said that when she had realised that the radiographers intended to x-ray her daughter's whole body she had 'played hell' with them but they had ignored her protests and had x-rayed her daughter all over. The complainant told my officer that he believed that the social workers, by suggesting that the children had been ill-treated, were responsible for both the children being x-rayed so thoroughly. He felt that the examinations and the way they were carried out were unwarranted.

5. The consultant paediatrician ('the consultant') at the hospital told my officer that on 9 June 1975 the family doctor had written to her about the girl because he was concerned about her slow progress in speech and had asked for her advice. Two appointments had been offered to the mother for her daughter, but neither had been kept. On 30 June, the family doctor had referred the boy to her because he had been found to have cold hands and feet. The consultant told my officer that the mother was offered two appointments for him but these also were not kept. She explained that slowness in talking and cold extremities could be indicative of deprivation in childhood. On 18 August, the consultant wrote to tell the family doctor that the outpatient appointments he had requested for both children had not been kept, and she had suggested that if he was still worried about them another appointment could be made and transport arranged.

6. The appointment was arranged for 22 September but, before this, the social services department had been in touch with one of the consultant's colleagues and had registered their concern about the children. The consultant said that the mother and the children had been seen by the SHO; because of the interest of the social services department the SHO had asked her to see the children and she had agreed that they should be x-rayed to exclude any possibility of non-accidental injuries. Indeed, she thought it would have been negligent not to have done so. She had no recollection that the mother had made any objection in her presence but had noticed later that the SHO had recorded on the case notes that she had been upset by the proposal to x-ray her daughter.

7. When the SHO met my officer, he could remember very little about his examination of the two children, but referred to the detailed notes he had made at the time. He said that he was sure that the mother had understood that not only her son was to be x-rayed, because he had entered on the girl's medical notes (which I have seen) 'mother upset on hearing x-rays being done to see if she's any broken bones "The social services have been at you have they?" '. The SHO told my officer that his own feeling was that the mother's explanation of how her daughter's bruises had occurred seemed quite reasonable, but because the social workers were concerned about the children and because of their slow development, he had thought it advisable to have them x-rayed in detail. He had also asked the consultant to see them.

8. The SHO told my officer that he thought the mother must have accepted the need for x-rays because she had taken the children to the x-ray department. He said that he did not tell her how many x-rays would be carried out because he did not know how many would be needed for a full skeletal examination.

9. My officer spoke to the two radiographers who had x-rayed the children. Neither of them could remember the family, and they thought that, if the mother had protested strongly, they would have remembered her because the incident would have been unusual. The superintendent radiographer, to whom my officer also spoke, said that if parents asked why x-rays were being done, they were told that it was at the doctor's request. Any further query would have to be referred back to the doctor.

10. I have seen from the hospital records that the family doctor did request appointments for the girl on 9 June 1975 (because of suspected deafness and poor motor co-ordination) and for the boy on 30 June (because of cold extremities), but that the appointments offered were not kept. In her letter of 18 August the consultant told the family doctor of this, and in his reply the family doctor said that the health visitor had confirmed that the mother felt unable to take the children to hospital without transport and had also reported that she had told her that the children had suffered bruising from falls; he added that he had asked the social services department to investigate the situation and to see if they could provide transport and that they had agreed to do so. I have also seen a copy of the letter the health visitor wrote to the consultant on 6 September in which she says that she could see no evidence of the children having been maltreated but was concerned about their development. On the children's case notes there is recorded a telephone message from the social services department about their concern that the children might have suffered from neglect or non-accidental injury. The notes record that neither of the children had any broken bones. The letter of complaint which the mother wrote to the hospital on 4 October 1975 makes it clear that both children were taken to the hospital for examination as the family practitioner had asked for a specialist's opinion on the boy's feet and on the girl's speech difficulty.

11. On the evidence I have seen it is clear that the appointment on 22 September was for both children. It is also clear that the reason the SHO and the consultant wanted a comprehensive x-ray examination made of both children was because of the concern of the family doctor and the social services department about their welfare. The examinations were made partly to exclude the possibility of non-accidental injury; and the x-rays showed no evidence of this. In view of the representations which had been made to them, I think the hospital had no option but to carry out these examinations. I cannot say precisely what explanation the SHO gave to the mother about the extent of the x-rays, but I think it doubtful that she was told that there was to be a complete skeletal survey of both children. I have no reason, however, to doubt the accuracy of the SHO's entry in the case notes (paragraph 7) and I think the mother must have been told that both children were to be x-rayed. There is evidence that the mother objected to the x-ray examinations at the time but there is a conflict which I cannot now resolve, about how strong her objections were. Had the mother refused absolutely to have the children x-rayed I would have expected the radiographers to have followed normal procedure and to have referred her back to the doctor.

The complaint about the way the Regional Authority handled the representations to them

12. The Regional Authority's general administrator, who had dealt with the Member's complaint, was on sick leave when I began my investigation and

subsequently retired from service; my officer did not therefore interview him. But I have seen the papers held by the Regional Authority and my officer spoke to the district general administrator (DGA) of the Area Health Authority, who was concerned with the complaint at district level.

13. The complaint was made in the first instance on 4 October 1975 by the mother, who wrote to the hospital asking who had given the doctor permission to carry out mass x-rays on her children. The DGA sent her a preliminary reply on 17 October saying that his initial impression was that it was not usual for consent to be required for x-ray procedures which were part of 'the diagnostic investigations carried out by a practitioner in the detection and treatment of patients referred to them'. And in a later reply of 10 November he said that the x-rays were part of the normal diagnostic examinations carried out by the paediatric department. On 1 November, the complainant got in touch with his Member of Parliament and asked him to find out who had arranged for the children to be x-rayed, why the examinations had been carried out, and what the outcome was; and the Member did this on 6 November when he wrote to the Regional Authority.

14. On 8 December the regional administrator acknowledged the Member's letter and apologised for the delay; and on the same date information was sought from the health district. The DGA replied to the Regional Authority on 11 December enclosing a copy of a report which had been provided by the consultant in response to the mother's original complaint and saying that as there had been a suspicion of baby battering it was his view, and that of the consultant, that 'any approaches should be dealt with in very low key' because of the continuing need for the family to receive support from the social services department.

15. On 19 January 1976, the Member asked the Regional Authority for a reply to his letter of 6 November 1975 and on 20 January the regional administrator responded by saying that the case was 'not without some complication' and that he hoped to be able to reply by the end of that week. His further reply dated 2 February gave the original reasons for calling the children to hospital (paragraph 6 above), and said that, in the boy's case, 'x-rays were ordered partly to assess his bone age, which is in fact compatible with his chronological age. In addition the pictures show no evidence of fracture'. In the girl's case, x-rays had been taken because of 'bruises and also again to look at the bone age'. The letter also mentioned the need for the hospital service to be fully alert to the possibility of the mis-treatment of children.

16. The Member was not satisfied with the answer and wrote to the Regional Authority on 16 February saying 'As I understand it . . . the appointment for [the boy] concerned his feet and for [the girl] her speech. I find it extraordinary that the children were x-rayed for the reasons given in [your] letter. Are you really trying to tell me that it is normal to x-ray people looking for evidence of fractures who make appointments concerning their speech'. He went on to say that it seemed obvious that the hospital authorities had connived with the local authority and had taken advantage of the hospital visit to have the children x-rayed even though the complainant and the mother had made it quite clear that they objected to this. He also complained about the delay in replying to his first letter.

17. The regional administrator promptly apologised for the delay which, he said, had been caused by pressure of work. He suggested that since he had had to refer to the health district of the Area Health Authority for reports on the case, the Member might prefer to deal direct with them. He also said that there had been a possibility that the staff at the hospital had been dealing with a 'battered baby' and explained the responsibility of the staff in such circumstances and the guidance that had been given by the Department of Health and Social Security. He asked the Member to treat in confidence the information he had been given.

18. The Member wrote again to the Regional Authority on 26 February saying that in view of the parental opposition to the x-rays, it would surely have been better to follow a correct procedure instead of taking advantage of the children's visit to the hospital for another reason. He also asked why the information he had been given should be withheld from the parents. The Regional Authority's general administrator immediately asked the DGA for further information and he received a reply on 10 March. The regional administrator next wrote to the Member on 3 May. He said that there was no record of the mother having objected to the x-rays and, indeed, she had accompanied the children to the x-ray department. After reviewing the position, he felt that the paediatric staff had acted responsibly, and he pointed out that the hospital staff have a wider responsibility in dealing with children than with adults. He concluded by saying that the consultant and the DGA would be happy to see the Member or the mother to discuss the matter further.

19. The Member again wrote to the Regional Authority on 11 May asking for a written answer to all the points he had raised, including the involvement of the local authority. He also pointed out that it had taken two months to reply to his letter of 26 February. The regional administrator, after consulting the health district, replied on 20 May giving what information he could about the involvement of the social services department but explained that he could do so only informally since it was another public service for which he had no responsibility.

20. On 28 May the Member raised what he saw as a number of inconsistencies in the Regional Authority's letters. On 2 June the regional administrator replied saying that he had been dependent entirely on the reports he had had from the health district and he thought it would be best if the DGA could meet him at any convenient time at the House of Commons to explain the case, as he thought this would be a more satisfactory way of dealing with the matter than by correspondence. The Member declined this offer and, on 8 June, asked for a full written reply. After obtaining, from the district, information in response to the Member's questions the regional administrator wrote to the Member again on 21 June giving a detailed reply. On 12 August, after speaking to the complainant and the mother, the Member wrote again to the Regional Authority, raising queries on several points, notably about who had initiated enquiries about the girl's bruises and the fact that the children had been x-rayed despite their mother's objections.

21. On receipt of this letter the Regional Authority's general administrator asked the DGA for his comments. The Member sent a reminder to the Regional

Authority on 28 September and a further one on 18 October. The DGA eventually sent his comments to the Regional Authority on 19 October and these were sent on to the Member on 20 October.

22. There is no doubt that there were several unnecessary and inordinate delays on the part of the Regional Authority in replying to the Member's letters, but I have seen that the regional administrator apologised to the Member for each delay. The DGA told my officer that, when the Member's letter of 12 August was received, he was on holiday, and on his return he had decided to re-examine all the points which had been raised throughout the correspondence, and this had taken some time. Even so, I think a reply should have been sent more promptly.

23. As regards the content of the letters to the Member it seems to me that the Regional Authority, who recognised the delicacy of the matter, tried to handle it tactfully and initially avoided saying that the examinations which had been carried out were partly to exclude the possibility of non-accidental injury. I can understand their reticence but, in dealing with it as they did, they appeared to be evasive, and I think it would have been better if, at the outset, they had told the Member fully and frankly the reasons for the examinations and the events that had led up to them. I think they should have realised that the Member would not be satisfied with anything less than an unambiguous statement of what had occurred but, when they did so, I think they did their best to make amends by offering him a meeting with the consultant and the DGA and, later, by sending detailed letters to him on 21 June and 20 October.

Conclusion

24. I have not upheld the complaint about the examinations of the children. It is not for me to say whether the concern of the family practitioner and the social services department was justified, but I think the hospital would have been failing in their duty if, after receiving the information they did, they had not sought to exclude the possibility of non-accidental injury to the children. Because of the conflict of evidence I have not been able to establish precisely what the mother was told by the hospital staff before the x-ray examinations were carried out or what she said to them. I have dealt at some length with the correspondence between the Member and the Regional Authority. There were some unnecessary delays and their original responses were evasive. I can understand his and his constituents' annoyance about this. The Regional Authority have asked me to apologise on their behalf to the Member and the complainant for the way in which their representations were dealt with.

Case No W314/76–77—Standard of hygiene in a maternity unit and failure to change an oxygen cylinder

Complaint and background

1. On 2 December 1975, the complainants' first child was born in the maternity unit of a hospital, and on 10 December mother and daughter were discharged. On 12 December the child became unwell and was taken back to the hospital and admitted to ward X, but her condition deteriorated and on 13 December she died of orbital cellulitis caused by a staphylococcal infection.

2. The complaints are that:—

(*a*) the standard of hygiene in the maternity unit was low;

(*b*) skin infections of both mother and baby were not noticed by the staff;

(*c*) the child's weight was not properly monitored;

(*d*) umbilical cord powder was not given to the mother when she left hospital on 10 December;

(*e*) on 13 December the nurse looking after the baby in ward X allowed an oxygen cylinder supplying the incubator to become empty; and

(*f*) they were dissatisfied with the response to their complaints by the consultant paediatrician (the consultant) in whose care the baby was placed, and the Area Health Authority (the Authority).

Investigation

(*a*) *The complaints about the standard of hygiene*

3. In his letter to me the father said that following his daughter's death the consultant spoke to his wife and himself and told them that she had contracted an infection of staphylococcus aureus which had caused her death. He said the consultant told them that the particular strain of the infection which the child contracted is very rarely found outside a hospital environment and he thought the maternity unit had been the source of the infection.

4. The father said that he and his wife had been anxious to find out how their child had picked up the infection, and they thought that one source might have been her hair, which had been very soiled at birth, but had not been washed until she was five days old. The consultant had told them that it was the normal policy to wash babies' hair on the third day, but that the bacteria which caused the infection would not grow in the hair. The mother still believed that the child's hair might well have harboured the infection, and she told my officer that she had spoken to a nurse about the state of the child's hair within two or three days of her birth, but nothing had been done about it. She also said she noticed that the nurses did not wash their hands between handling babies and that neither her daughter's cot nor any others were ever cleaned despite possible soiling when babies' nappies were changed.

5. A note of a meeting between the complainants and the consultant records that the consultant explained to them that although there was no hard and fast rule about the washing of babies' hair, it should not be subjected to 'vigorous' washing during the first few days of life but there was no reason why it should have remained soiled for five days. The consultant told my officer that he did not tell the complainants that the organism contracted by their child would not grow in hair.

6. The present Divisional Nursing Officer (Midwifery) (DNO), who took up her post after the child's death, told my officer that the normal routine is to wash babies' hair on the fifth day following birth but this can be done earlier if it is considered necessary. She could not say whether, when the mother was a patient, the nurses washed their hands between handling babies, but all nurses are trained to do so. She also said that each baby is nursed in one cot only, so

as to minimise cross-infection dangers, and that cots are cleaned 'between babies' and at other times if they become soiled. None of several nurses who had worked in the maternity unit in December 1975 could recall discussing with the mother the washing of the child's hair. All of them said that they always washed their hands between handling babies.

7. There is some doubt about the instructions which were in force at the time the child was born regarding the age at which a baby's hair could be washed, but instructions have now been issued to the nursing staff that if the baby's condition is satisfactory the head may be washed immediately after birth or at any time following if this is found to be necessary.

8. There is no corroborative evidence about the need for the child's hair to be washed earlier than it was, or about lapses in the standard of hygiene practised in the maternity unit. I cannot therefore reach a conclusion on these complaints.

(*b*) *The complaint about the failure to notice the skin infections*

9. In his letter to me the father said that a septic area had developed on his wife's right breast and had not been observed by the nursing staff. He also said that he and his wife had noticed that their child had a red mark on her right eye and a cut in her left armpit, which had not been treated.

10. The mother told my officer that she noticed the septic area on her breast within two days of the birth and, although she did not specifically point it out to anyone, there had been occasions when the nurses could have seen it. She added that she had mentioned to a nursing auxiliary the marks on the child's eye and armpit but that she had heard nothing more about them.

11. The DNO told my officer that the condition of the mother's breasts had been checked and recorded daily and had been found satisfactory. Her staff were trained to point out things like septic areas and, although a small spot might admittedly have gone unnoticed, she considered that the mother must have had ample opportunities to speak to a doctor about it. She added that a cut armpit had not been recorded in the child's clinical notes, but there had been a comment on the child's daily observation chart for 9 December—'sore under arms'. As far as the mark on the child's eye was concerned, the DNO said that all babies were cleaned each morning and her eyes had been recorded as clear on each of the seven days she was in hospital.

12. When my officer spoke separately to the two nursing auxiliaries who were on duty in December 1975, neither recalled a conversation with the mother about a cut in the child's armpit or a mark on her eye. They both said that had they been told by any mother of a cut or a mark on a baby they would have reported this to the nurse in charge. They also said that they would have reported or noted any septic area; and this procedure was confirmed by staff midwives and the ward sister. My officer also spoke to the nurse who, on 9 December, had recorded the soreness under the child's arms. She told him this meant that the skin had merely been red; had it been a cut or an open wound she would have said so specifically.

13. My investigations have not revealed the identity of the staff member to whom the mother says she spoke about the child's cut armpit or the mark on her eye, and the complainant acknowledges that she did not specifically mention the septic area on her breast to anyone. Apart from the entry about the redness under the child's arm the clinical records do not show any reference to the conditions mentioned by the complainants. On the evidence of the clinical notes, I think it likely that the child's eyes and armpits were inspected and that there was nothing there which was considered to warrant treatment.

(*c*) *The complaint that the child's weight was not properly monitored*

14. In his letter, the father said that at birth the child weighed seven pounds but on discharge she weighed only six pounds. He told me that when it was found that breast-feeding was inadequate for her, supplementary bottle feeds were given, but that there had been some dispute as to whether she had put on any weight after this, as her weight chart had been altered. The mother told my officer that a doctor had had difficulty in reading the weight chart and that, although she herself believed the child's weight loss to be high, the doctor had not considered it to be exceptional.

15. The DNO told my officer that the child's weight on 5 December was satisfactory, but on 8 December it had been decided that complementary feeding would be necessary. She did not consider that the weighing procedure had gone wrong and thought that, although the child's discharge weight was fairly low, her condition was such that the discharging doctor, after examining her, had been satisfied.

16. My officer spoke to the nurse who completed the first, but not the subsequent, entries on the child's test feeding chart. She said that the chart had not been properly completed in that only two of the five entries following her own showed the amount of both breast milk and complement which had been taken by the child at each feed during the test, and none of the entries had been signed.

17. The consultant has said that in his view the child's weight loss was not serious but I think that the lack of full information on the test feeding chart is regrettable and I criticise the inadequate recording.

(*d*) *The complaint about the umbilical cord powder*

18. The father said in his letter to me that when his daughter left hospital her umbilical cord had not separated and a supply of the powder used to dress the cord was not given to his wife for use at home. The mother told my officer that when the midwife called she was surprised at this.

19. The DNO told my officer that of the 70 babies discharged from the maternity unit each week about five left hospital with the umbilical cord still attached, and it was the practice in such cases for the mother to take a tin of powder for use at home. She expressed regret that in this case it had been overlooked.

(*e*) *The complaint about the oxygen cylinder*

20. The father told my officer that, on 13 December 1975, after his daughter had been admitted to the paediatric department, she had been placed in an

incubator which was supplied with oxygen from a cylinder. When he visited between 3.00 pm and 3.15 pm he noticed that the noise of the oxygen going into the incubator had stopped; and when he looked at the gauge on the cylinder he found it registering empty. He said he had drawn this to the attention of the nurse who was looking after the child and she had taken the empty cylinder out of the cubicle, and returned with a full one, which she connected to the incubator; and the noise had then resumed. He later told my officer that he thought the pointer on the dial of the old cylinder had been about one fifth of the way into the red segment (which gives warning that the oxygen content is running low) when he had informed the nurse.

21. My officer interviewed the nurse described by the father, and she told him that there had not been any problem with the oxygen supply to the incubator while she was responsible for the child, nor had she at any time changed the cylinder. My officer interviewed other nurses who, during meal breaks, had relieved the nurse responsible for the child's care. None of them could recall whether the oxygen cylinder had had to be replaced.

22. On examination of the records my officer found that, on the instructions of the doctor, the child was being nursed in an atmosphere of 30 per cent oxygen (normal atmosphere having an oxygen content of 20 per cent). He was told that the oxygen content in an incubator is monitored by the nurse responsible for the patient by means of an oxygen analyser fitted to the incubator and that the details are recorded on the observation chart. In this case this would probably have been done every 15 minutes, but no longer than 30 minutes. My officer enquired about the training which nurses undergo in the use of oxygen equipment. The Divisional Nursing Officer responsible for the paediatric department told him that, before student nurses working on the ward are allowed to go on night duty (when the staff cover is less than during the day), they are given training in the use of all the special equipment which they may have to use, and she confirmed that the nurse described by the father had undergone such a period of instruction before having a spell of night duty prior to the child's admission.

23. Two other nurses who had been on the ward when the child was a patient confirmed that they had been given instruction about the use of incubators and oxygen equipment. They said that, when they relieved a nurse who was 'specialling' a patient, they would automatically check the equipment as well as the condition of the patient; and if the oxygen in the cylinder appeared to be getting low, they would bring a full cylinder to the bedside before disconnecting the cylinder in use so that the flow of oxygen was only interrupted momentarily.

24. When a patient leaves hospital the observation charts that record the monitoring of the oxygen are destroyed by the medical records department in order to reduce the bulk of the records in store. I have not therefore been able to find any precise and contemporary evidence to show what happened on the afternoon of 13 December. But I have no reason to doubt that the complainant drew the attention of a nurse to the state of the oxygen cylinder and that it was then changed, though I cannot say whether, by then, it was absolutely empty. However, in view of the evidence I have obtained about the

training of nursing staff in the correct handling of oxygen equipment, I think it would be very surprising if the cylinder in use was disconnected before a full one was in place beside the incubator.

(f) The complaint about the Authority's and the consultant's replies

25. In his letter to me the father said that although, following his daughter's death, he and his wife had met the consultant and a member of the administrative staff to discuss their complaints, they thought a member of the nursing staff should also have been present. He said that he and his wife were dissatisfied with the answers they had been given to their questions and, in particular, they had been led to believe that all the nurses in the maternity unit had been given swab tests to try to establish the source of infection but they subsequently found that this was not so; and their complaint about the oxygen cylinder had not been answered at all.

26. My investigation has shown that after their daughter's death the complainants met the consultant on his own on 15 December 1975 and 23 January 1976, and with an administrator on 6 April 1976. It is true that at no time was a member of the nursing staff present at the meetings and I think that although the consultant gave all the information he could, there is no doubt that the presence of a senior nurse would have been of value in answering their questions about nursing care.

27. There is no evidence to show exactly what information the complainants were given about the results of the swab tests, and there are no written records of the number of tests which were carried out, but the Authority have told me that some 50 to 60 members of the staff were tested and, although this did not represent all the staff who worked in the maternity unit, they were the ones thought to have had some contact with either the mother or the child. None of those tested were found to have the strain of infection from which the child died. With regard to the complaint about the oxygen cylinder, I have found that although this was received by the Authority on 5 March 1976, it was more than a year before the nursing staff immediately concerned were interviewed about it.

28. Although the complainants were given a considerable amount of information about the care and treatment of their daughter and the cause of her death, it was inadequate in some respects, and I think it would have been appropriate, since some of the complaints were about nursing care, for a senior member of the nursing staff to have been present at their meeting on 6 April 1976, with the consultant and the administrator. On the question of the oxygen cylinder, I find that the seriousness of the complaint was not realised at the time it was first made and I think it regrettable that there was so long a delay before the Authority took steps to interview the staff immediately concerned.

Conclusion

29. There was insufficient evidence to enable me to uphold the complaints about the standard of hygiene in the maternity unit. But I am glad to report that instructions have now been issued about the washing of babies' hair and the reporting of skin infections to the medical staff. I have criticised the completion of the test feeding chart and I hope steps will be taken to stress to the nursing staff the importance of properly entering all the information which is required.

I have also criticised the Authority for the way the complaints were handled; and I think the Authority should review the arrangements for the retention of certain records such as the observation charts referred to in paragraph 24 of my report in cases where there is a possibility of questions being raised about events which took place during the patient's stay in hospital. I think the Authority owe the complainants an apology for the shortcomings revealed by my investigation.

Case No W315/76–77—Administrative inefficiency, failures in communication and lack of adequate information

Complaint and background

1. The complainant's husband was admitted to hospital A on 26 May 1976 for a prostate gland operation. He suffered a stroke during or after the operation on 27 May and following treatment was discharged on 26 June. He was admitted to hospital B on 2 August for further treatment and was subsequently transferred on 6 December to hospital A to undergo a carotid arteriogram, but this was cancelled. He returned to hospital B on 15 December and was transferred to hospital C on 29 December where he is at present a patient.

2. The complaints are of administrative inefficiency, failures in communication, and lack of adequate information about the husband's condition, treatment and care whilst a patient in all three hospitals between May 1976 and January 1977 as follows:

(*a*) on 21 May the complainant's husband made an abortive visit to hospital B as x-ray films required for an examination had not been forwarded from hospital A;

(*b*) when the complainant's husband arrived at hospital A on 26 May in response to a telephone instruction given the previous day, a bed was not ready for him;

(*c*) during an operation on 27 May the complainant's husband suffered a stroke but the complainant was not given an explanation and her family practitioner was not told the result of the operation. On 29 May the complainant was unable to see a doctor at the hospital to discuss her husband's condition;

(*d*) when the complainant's husband was discharged on 26 June he arrived home by ambulance. A promised wheelchair only arrived later by taxi after the complainant had telephoned the hospital asking for one;

(*e*) during the post-operation period whilst the complainant's husband was attending hospital A for physiotherapy his catheter was frequently found to be leaking, and he contracted a urinary infection;

(*f*) the complainant was not given proper advice on the administration of two drugs with which her husband arrived home on 28 July;

(*g*) on 2 August, a chiropodist who called at the complainant's home told her he had called at her husband's request. At that time her husband was unable to speak;

(*h*) on 6 December while the complainant's husband was a patient at hospital B he was transferred to hospital A for overnight stay for a brain scan which had been arranged for 7 December. Although the patient's consent had been obtained the brain scan had been cancelled without proper explanation and his personal property was not brought from hospital B;

(*i*) the complainant was told on 14 December that her husband had been returned to ward x, hospital B. On visiting there on 15 December she found he was not there and staff did not know where he was. Subsequent enquiries showed he was in ward y in the same hospital. On 16 December he was moved from ward y to ward x at hospital B and on 20 December he was moved to ward z. On 28 December he was moved to ward 1 of hospital C;

(*j*) the speech therapy treatment provided for the complainant's husband was inadequate;

(*k*) when the complainant's husband broke his glasses on 30 December they were sent to hospital A for repair, but on 29 January 1977 they were returned unrepaired because they were not National Health Service glasses;

(*l*) the Area Health Authority (the Authority) had failed to deal with her complaint adequately.

3. The complainant first raised some of her complaints with the welfare officer at her place of work, who was at the time vice-chairman of the Authority. At his request the patients' services administrator of the health district discussed the complaints with the complainant on 20 August 1976, and arranged for her to meet the registrar to the consultant responsible for her husband's care. The complainant remained dissatisfied with the action taken and wrote to me on 30 November 1976. Before I can carry out an investigation into a complaint I have to be satisfied that the health authority concerned have received full details and have been given an adequate opportunity to investigate and reply. The Authority told me they did not consider they had received a formal complaint so I advised the complainant that she should put her detailed complaints in writing to the area administrator and that if she was not satisfied with the reply it would be open to her to write to me again. The complainant wrote to the area administrator on 12 February 1977. She received a reply to her complaint from the health district on 1 July. She was dissatisfied with this and telephoned my office on 4 July. Following a visit by one of my officers to discuss aspects of the complaints with the complainant I decided to carry out an investigation.

Investigation

(*a*) *The complaint that x-ray film was missing*

4. In her letter to the Authority the complainant said that her husband attended hospital B by appointment at 9.45 am on 21 May 1976 but that an x-ray film which had been taken a few days before was not available. The consultant urologist who examined the complainant's husband had said it would be fetched by taxi from hospital A. However, at 12.00 noon he said that the film had not been traced and that he could not recommend treatment until he had

seen it, but promised to let the complainant's husband know when he had examined it. In her reply of 1 July, the deputy sector administrator (DSA) stated that the complainant's husband first attended hospital A on 14 May 1976 for an x-ray which had been arranged through his family practitioner (FP). The FP telephoned the hospital on 17 May to make an urgent appointment for the complainant's husband to attend the urology outpatient clinic, which at that time was being held at hospital B, the outpatient area at hospital A being closed for up-grading. The DSA suggested that the reason why the film was not available in advance of the appointment on 21 May could have been a failure on the part of the FP to inform the receptionist that the complainant's husband had had an x-ray examination, or the fact that the receptionist had not seen the FP's letter of 17 May to the consultant urologist, which referred to the examination. She apologised for the non-availability of the film at that time but said the consultant urologist nevertheless felt the visit was helpful as it had offered an opportunity to discuss the arrangements for the operation.

5. I have seen a report to the DSA by the director of the department of diagnostic radiology in which he stated that x-ray films for hospital A clinics being held at hospital B were usually requested a few days in advance and taken to hospital B by the outpatient receptionists. Those required urgently were normally requested by telephone and sent to hospital B by taxi. There was no record that such a request had been received on the day in question or that there had been any difficulty in finding the films at any time when they were requested. A statement by the principal administrative assistant in the patient's services office accepted responsibility for the fact that the film was not available when required, but, in the absence of any recollection of the incident, could not offer a positive explanation.

6. The consultant urologist responsible for care of the complainant's husband at hospital A told my officer that he did not know whether the FP's referral letter was posted or handed to the patient to bring. Had it been sealed and addressed to him personally the receptionist would not necessarily have read it to check whether documents such as x-ray films should be obtained. He could not recall the detailed circumstances but remembered that by the time he had left the clinic at noon the film had not turned up, and as it could have been 11.00 am before he had seen the complainant's husband, there would have been little time for it to be found and sent from hospital A to hospital B. He drew attention to the disruption caused by the temporary transfer of surgical clinics to the other hospital. Had the clinic been held at hospital A, the film could have been fetched by the receptionist. He had no reason to believe it was not in the x-ray department and remembered that it was available when he sought it on the following Monday (24 May). He confirmed that his normal practice in such circumstances would be to tell the patient that he would be notified if and when a further consultation was required.

Findings

7. The Authority have accepted that the x-ray film should have been made available for the consultation and have apologised to the complainant. I have been unable to establish the reason for the error, but I suggest the Authority should examine its procedures to ensure that receptionists responsible for fixing appointments are given all the information they need so that films are requested in good time for the clinics.

(*b*) *The complaint about the delay in admission to hospital A*

8. The complainant's letter to the Authority said that on 25 May 1976 she telephoned the consultant urologist's secretary to find out what action was being taken to admit her husband. The secretary later confirmed that he was to be admitted at 6.30 pm on 26 May but this was subsequently changed to 9.30 am so that tests could be carried out. The complainant claimed that because a bed had not been ready her husband was kept waiting for two hours before he was admitted to ward a at 11.30 am. In her reply the DSA apologised for the delay in admitting the complainant's husband to the ward. She said that at the time, ward a had its full complement of urology patients, but the complainant's husband had been allocated to a bed of a patient due for discharge that morning. She explained that the hospital provided a 24 hour emergency service and the availability of beds changed from hour to hour. The time taken to adjust to such changes could lead to delay. Attempts were currently being made to stagger admission times so that some patients reported during the afternoon rather than in the morning, although there were some disadvantages to this arrangement. She realised it could be very distressing for relatives and patients to have to wait for admission, especially as patients were understandably apprehensive.

9. The health services information officer told my officer that a patient admitted as an emergency case, such as the complainant's husband, would be allocated to a vacant bed irrespective of the specialty. The normal admissions procedure was for the bed bureau to obtain a daily bed-state return from each ward at 8.30 am. Nursing staff were also asked whether they would have any vacant beds that day. If the daily statement revealed no vacancies, the registrar concerned with the case would be asked to find a bed during a ward round, and the patient would have to await the result, although he did not feel this should normally take more than an hour. He said that admissions from the waiting list were normally arranged between 9.00 am and 12.00 noon, with the result that there could be a large number of patients waiting in the admission hall at that time. Efforts had been made to stagger admission times, but some doctors had found it difficult to carry out the necessary investigations on patients admitted later in the day. This applied particularly to patients needing surgical treatment. He said that the consultant urologist dealt personally with admissions instead of following the normal procedure of delegating this duty to his registrar, and in this case gave instructions for admission without reference to the bed bureau.

10. The consultant urologist confirmed that he had given instructions for the complainant's husband to be admitted as an emergency. It was essential that he be admitted on the Wednesday for an operation the following day, and be brought in early enough for tests to be carried out. He therefore did not regard reference to the bed bureau as appropriate. He did not consider the two-hour wait in finding a bed to be excessive in the circumstances; delays of this kind were the price to be paid for a high rate of bed occupancy, the alternative being an extension of waiting lists.

Findings

11. I accept that at a time of high bed occupancy it is difficult, because of unforeseen emergency admissions, to predict the availability of beds for cases from the waiting list. But since the consultant had instructed that it was essential

for the complainant's husband to be admitted the following day, action should have been taken to ensure that a bed was ready for him by the time when he was asked to arrive. The Authority have apologised to the complainant for the inconvenience she and her husband suffered but I think they should review their admission procedures so as to prevent similar occurrences in the future.

(*c*) *The complaint concerning inadequate information given to the complainant and her family practitioner about her husband's condition*

12. The complainant told the Authority that when she visited her husband on the evening of 27 May, she was unable to talk to him and said that 'water drainage was in process'. Although she had telephoned the hospital three times the following day she had not been properly informed of her husband's condition, since when she visited him that evening, 28 May, she had noticed that he had suffered a severe stroke and was unable to speak. On 29 May she had asked her family practitioner's partner to obtain information from hospital A. He had arranged for her to talk to a doctor at the hospital during visiting hours that afternoon. The complainant said she waited on the ward but no doctor arrived even though a nurse had told her that a doctor would come to see her. She also said that although her husband had been discharged on 26 June the FP when visiting him between 29 July and 1 August disclosed that he had not been advised of the success of the operation.

13. In her reply the DSA said that although the complainant's husband's immediate post-operative condition was satisfactory, he subsequently bled into his bladder and it was therefore necessary for him to be taken back to the theatre to remove the blood clot. The house surgeon had kept a close check on him and at 10.00 pm that night became concerned about his slow recovery from the anaesthetic. By the following morning it was confirmed that the complainant's husband had a right-sided paralysis. The DSA said that when the complainant visited on the evening of her husband's operation there was at that time no indication that he had suffered a stroke, and that the sister had previously explained that, after his operation, he would be fitted with an intravenous infusion set and catheter. The DSA had been unable to find out why the complainant had not been informed earlier of her husband's stroke. She suggested it would have been unfeeling for nursing staff to have given the news over the telephone, but accepted that the complainant should have been advised of her husband's condition before she had seen him, and apologised for the omission. She promised a review of the hospital's arrangements for giving information of this kind. She also apologised for the fact that the complainant had not been able to speak to the house surgeon as arranged by her family practitioner's partner, saying that the hospital doctor concerned could not remember making the arrangement.

14. The Divisional Nursing Officer said it was the initial responsibility of the sister in charge of the ward, rather than a doctor, to explain a patient's post-operative condition to relatives and to inform them of events such as a stroke. To relay such information over the telephone could cause relatives distress, but she felt it would probably have been better if this had been done in this case. Certainly the complainant should have been told the news on arrival at the ward and before seeing her husband.

15. The sister in charge of ward a informed my officer that she could not recall the complainant having difficulty in seeing a doctor. Normally when a relative asked for an interview a nurse would call the doctor by 'bleep' and let the relative know when they could expect to see him.

16. The consultant urologist told my officer that he would have explained the nature of the operation to the complainant's husband before obtaining his consent. As the complainant's husband was able to understand and pass on the information to his wife, he would not have spoken to the complainant prior to the operation. He agreed that the complainant should have been informed of the complications that arose after the operation, and on the morning of 28 May had mentioned this to his house officer, who would have asked the sister to inform the complainant accordingly. Whether or not the request from the family practitioner had been received, he thought it should have been possible for the complainant to see a doctor on the afternoon of 29 May, even if the house officer were not available. He did, however, see the complainant himself subsequently and discussed her husband's condition with her.

17. I have seen a copy of the detailed clinical abstract sent on 13 July 1976 to the family practitioner, and a copy of a letter from the FP to the DSA confirming that he had received it. I note from the Authority's reply to the complainant that since the events complained of arrangements have been made for brief details of treatment and drugs prescribed to be sent to the FP immediately on a patient's discharge, followed later by the full summary.

Findings

18. I am told that nursing staff are reluctant to give relatives bad news about a patient's condition over the telephone since to do so may cause them unnecessary distress. This is a matter for professional judgment according to the circumstances of the case, with the possibility of causing distress having to be weighed against the effect on the relatives of being kept in ignorance of an important development, or even, as in the present case, of observing the deterioration without being prepared for it in advance. The DNO has agreed that the complainant should have been told about her husband's condition and the DSA has apologised to her on behalf of the Authority for the way in which she found out about her husband's stroke. I am pleased to note that the hospital have decided to review the way in which such information is communicated. I have been unable to establish the reason why the complainant was unable to see a doctor on 29 May, but this was a regrettable lapse for which the Authority have also apologised. I have established that the FP was informed on 13 July of the outcome of the operation and am unable to support the complaint in this respect. I am glad to note, however, that revised arrangements have been made to ensure that essential information is provided to FPs more promptly in future than in this case.

(*d*) *The complaint that the complainant's husband was sent home without a promised wheelchair*

19. The complainant told the Authority that when her husband was discharged on 26 June 1976 he was sent home by ambulance without his wheelchair. She had telephoned the sister on ward a who had arranged for a wheelchair to be

sent by taxi. This arrived later in the day. The DSA replied that the ward sister had arranged with the physiotherapy department for a wheelchair to be provided for the complainant's husband but the ambulance was unable to take it, so she had arranged for it to be sent on afterwards. The complainant told my officer that she could not understand this reply as her husband had a wheelchair on the ward which could have accompanied him.

20. In a memorandum dated 28 April 1977, the senior nursing officer (SNO) at hospital A (SNO) reported that the ward sister had arranged with the physiotherapy department for a wheelchair to be provided for the complainant's husband to take home but it had not arrived on the ward by the time the ambulance came to collect the complainant's husband.

21. I have seen a copy of the form asking for transport for 26 June for the complainant's husband and note that this does not contain a reference to a wheelchair. My officer was told by a physiotherapist that a list of the patient's requirements on discharge, including a wheelchair if necessary, was normally drawn up with the ward sister but neither was able to recall what happened in this case. I have seen a copy of the nursing notes which confirmed that the complainant's husband had the use of a wheelchair on the ward.

Findings

22. As the complainant's husband was immobile without a wheelchair, I consider that greater care should have been taken to ensure that he had one with him when he was discharged. I am glad to note that the omission was rectified promptly when the complainant informed the ward sister. But I think she is entitled to an apology.

(*e*) *The complaint that a catheter leaked and that the complainant's husband contracted a urinary infection*

23. The complainant told the Authority in her letter that, whilst her husband was attending for outpatient physiotherapy in June and July 1976, his catheter was constantly leaking and he needed treatment for a urinary infection.

24. In her reply the DSA said that during his operation the complainant's husband had an in-dwelling catheter fitted. It was removed after two weeks but because he was unable to control his urinary flow it was re-fitted. When he was discharged the medical staff decided that the catheter should be left in until he was better and able to walk. The DSA said she had been informed by medical staff that a catheter might leak because the tap on the bag was not turned off properly or because it had become accidentally disconnected. It could also fall out because of failure of the balloon which retained it within the bladder. The risk of infection in patients with in-dwelling catheters was recognised as an unavoidable problem but was usually controlled by antibiotics. I have checked that the reply given by the DSA correctly conveyed information given to her by the consultant urologist, who told my officer that it had been reasonable to re-fit a catheter in the circumstances.

25. The complainant told my officer that on 3 July 1976 she informed the hospital that her husband's catheter was leaking and on 5 July she had received a note to say it had been replaced. When she put her husband to bed that night the catheter had fallen out. On the advice of her family practitioner she did

not have it replaced and bought a bottle for her husband's use. She informed the physiotherapy department what had been done and received a promise that if he took the bottle with him it would be offered to him every half hour. On 25 July she visited the department and found him sitting in a pool of urine. I observed from notes made by the patients' services administrator at the time that she raised this point with him at the interview in August 1976.

26. The physiotherapists to whom my officer spoke did not remember the occasion described by the complainant but one recalled that the complainant's husband had had problems with his catheter and another remembered him being wet when he arrived at the department on one occasion. They said that the facilities in the department for dealing with incontinence were normally adequate and that special care was taken with patients who were unable to ask for help. My officer was unable to speak to the superintendent physiotherapist who had been primarily responsible for the care of the complainant's husband as she is no longer resident in this country.

Findings

27. I have not been able to determine whether there was any exceptional factor which caused the complainant's husband's catheter to leak or become detached more often than normal. Failures of this kind clearly cause discomfort to the patient and distress to the relatives, and I can well understand the complainant's concern. I have not been able to corroborate the complaint about the failure of physiotherapists to offer her husband a bottle as promised. I have been informed by the consultant that urinary infections are an associated hazard in the use of a catheter; the decision whether or not to leave a catheter in place is a matter for clinical judgment and I do not question it. I believe the catheter was left in place for what was considered to be the appropriate medical and nursing management of the patient's condition and not for reasons of nursing convenience.

(*f*) *The complaint about inadequate advice regarding the administration of drugs*

28. The complainant told the Authority she had had a telephone call from the physiotherapy department on 29 July 1976 saying that her husband was uncooperative and almost violent. She was later told that he had been sedated and would be sent home. He arrived with two bottles of drugs and a note stating that tranquillisers were to be given every four hours and capsules every six hours. After taking a capsule he experienced considerable pain. When the family practitioner was called he told the complainant that a large quantity of water should have been taken at the same time.

29. The DSA's reply said it was not usual for patients to be told that the capsules could be taken with water. She understood that the family practitioner had diagnosed the complainant's husband's abdominal pain as possibly due to inflammation of the oesophagus caused by an ampicillin capsule and that he had advised taking future doses with a glass of water, which would have had the added effect of increasing the fluid intake. I have seen a copy of a letter from the family practitioner and a statement by the urologist, from which the DSA obtained the information she gave in her reply.

Findings

30. I can understand the complainant's concern at the pain her husband experienced after taking an ampicillin capsule, but I am told that it is not normal practice for doctors to amplify the instructions given on the container for this type of drug, which I understand does not necessarily have to be taken with water.

(*g*) *The complaint that a chiropodist made an unnecessary call at the complainant's home*

31. The complainant told the Authority that a chiropodist had called at her home at 5.30 pm on 2 August 1976 claiming that he had come at her husband's request, but she disputed this, since her husband was unable to talk. The complainant's husband had been readmitted to hospital at 10 am the same day. In her reply the DSA said that the chiropodist had called at the request of the district nurse, and the visit had taken place on 27 July. She further said that a card was normally sent in advance asking the patient to notify the chiropody office if the proposed appointment was inconvenient but no such message had been received and when the chiropodist called as arranged he was told that his services were not required.

32. The district nurse told my officer that she had requested chiropody for the complainant's husband, and remembered that the complainant had shown her the appointment card she had received prior to the visit and did not question the need for chiropody at the time. I have seen a photocopy of the record of the visit, dated 27 July, on which the chiropodist quotes the complainant as saying that her husband had excellent feet, and that she did not wish him to 'mess about with him'. The chiropodist told my officer that he had called between 11 am and 1 pm and not at 5.30 pm as alleged and that the complainant had spoken rudely to him and slammed the door in his face.

Findings

33. On the balance of the evidence I believe the complainant is mistaken about the time and date of the chiropodist's visit since I can find no record of a visit on 2 August, although one is documented as having taken place on 27 July. I cannot determine whether the chiropodist said he had called at the request of the complainant's husband but I have established that chiropody treatment was requested by the district nurse because she thought it necessary and I do not question her professional judgment. I cannot therefore uphold this complaint.

(*h*) *The complaint that a brain scan was cancelled without proper explanation, and that there was delay in transferring his personal effects between hospitals*

34. In her letter to the Authority the complainant said that her husband was sent from hospital B on 6 December to ward b, hospital A, for an overnight stay to undergo a brain scan. He was kept there for three nights without any action being taken, and, unable to communicate or walk, was accommodated in a single-bed room. She had been advised by the consultant neurologist that, although her husband's consent had been obtained (by a doctor at hospital B), he felt the relatives should be informed of the danger of the proposed probe, and that it would not improve the patient's condition. The complainant also said that her husband's personal effects had not been sent to hospital A until she had asked the sister to arrange this.

35. The DSA's reply to the complainant said that the consultant neurologist had suggested, in view of her husband's failure to make progress, that a carotid arteriogram be performed to make certain the precise cause of the stroke. Facilities for the procedure were available only at hospital A and the complainant's husband's restlessness necessitated a general anaesthetic. His consent had been obtained by a 'mark', witnessed by the complainant, and he was transferred to hospital A on 6 December. The DSA said that after a further examination, the consultant neurologist decided he needed to explain personally to the complainant, in more detail, what was involved and to warn her that the procedure would not necessarily improve her husband's condition. He had advised her to consult her family practitioner, which she did and as a result decided that the procedure should not be carried out. The complainant's husband was therefore returned to hospital B. The DSA said that the ward sister could not recall any problems with the complainant's husband's personal property; the DSA thought that, as it was originally not envisaged that he would be at hospital A for more than a few days, it would not have been necessary for him to have all his belongings with him, but the further consideration given to the need for carotid arteriography had delayed his return to hospital B. During his 10 days at hospital A he was in a single room and was kept under careful observation. He was able to summon help by the use of a bell.

36. On receiving this reply, the complainant informed my officer that two days after being asked she told the sister of her decision not to allow the scanning procedure. She therefore did not know why her husband had been kept at hospital A for 10 days.

37. When my officer spoke to the consultant neurologist, he explained that a 'brain scan' was an x-ray procedure which did not involve the giving of an anaesthetic whereas a carotid arteriogram was a different procedure carried out under anaesthetic. He had explained to the complainant at some length on 9 December the difficulties involved, and thought he probably told her the procedure was unlikely to help him. The ward sister told my officer that she also had discussed the proposal with the complainant; and she confirmed that she could not recall any reference to difficulties about his personal possessions. I have seen the record kept by the x-ray department which indicates that the complainant's husband was booked for a carotid arteriogram on 7 December 1976 which was cancelled that day. A further arteriogram was booked for 14 December but this was cancelled on 13 December. I have also seen a copy of the ward property book for ward x which indicates that the complainant's personal effects were listed for transfer on 8 December 1976 and an enclosure slip from the administrator at hospital B suggests they were sent to hospital A on 9 December. Subsequent records indicate that his possessions arrived back on ward x at hospital B on 16 December. My officer was informed that no comparable records of personal property are kept by hospital A.

Findings

38. The complainant's husband was transferred to hospital A, as a result of a decision by the consultant neurologist that he should undergo a carotid arteriogram, but the consultant then decided he would see the complainant to explain what this procedure involved. The decision to arrange for an arteriogram (as distinct from a brain scan) was taken in the exercise of the consultant's

clinical judgment, as was his decision to cancel it until he had seen the complainant himself to explain what was involved. I do not question his decisions. The booking for the arteriogram on 14 December was made so that if the complainant had decided, after consulting her FP, that her husband should undergo this procedure there would have been no further delay. The complainant does not consider the explanation given to her was adequate. I believe the consultant explained to the best of his ability what would be involved but the fact that the complainant referred to the procedure as a brain scan when she wrote to the Authority suggests that she may not have fully understood the distinction between a brain scan (which her husband had previously undergone) and an arteriogram investigation. Nevertheless, it seems she understood its nature sufficiently to decide that it should not be carried out.

39. The consultant's decision to talk to the complainant about the arteriogram led to her husband staying longer at hospital A than originally envisaged. The complainant saw the neurologist on 9 December, a Thursday, and said she told the sister of her decision two days later. I think it likely that the consultant was not aware of the decision until after the weekend and that, allowing for the 48 hours' notice which is required by the ambulance service for a scheduled journey, this accounts for the fact that the complainant did not return to hospital B until 15 December.

40. I am satisfied that the complainant's husband's personal effects were not at first sent to hospital A for the reason suggested by the DSA, and I do not criticise the Authority for this. But I think the Authority should consider introducing a record of transfers of personal effects at hospital A as used at hospital B.

41. I do not regard the accommodation of the complainant's husband in a single room as cause for complaint, having noted that adequate nursing supervision was provided and that he was capable of summoning assistance by means of a bell.

(*i*) *The complaint that the complainant's husband was transferred to a different ward in hospital B without his wife's knowledge*

42. The complainant told the Authority that she had been informed on 15 December that her husband had been returned to ward x, hospital B, on transfer from hospital A but when she visited there that day she was told that he was still at hospital A and it was only after she had insisted on enquiries being made that she discovered he was in ward y, hospital B. On 16 December he was moved back to ward x and on 20 December to ward z. On 28 December he was transferred to ward 1 at hospital C.

43. In her reply the DSA said she did not know why the complainant was given the wrong information about her husband's transfer. She could not find the transfer form normally sent with the patient and apologised for the error. Special arrangements were made at Christmas which necessitated some inter-ward transfers and the complainant subsequently agreed to her husband's transfer to ward 1 at hospital C on 28 December. I have seen a copy of the transfer form completed by the staff nurse in charge of ward b at hospital A on 15 December, indicating that the complainant's husband was to be transferred to ward x, hospital B. I have also seen a statement by the sector administrator at hospital B confirming that the complainant's husband should have

been admitted to ward x on 15 December but that no bed had been available. He was therefore temporarily put into ward y and transferred to ward x the following day when a bed became vacant. The admissions clerk at hospital B confirmed however that the diary entry showed the complainant's husband as allocated to ward y. I have been informed that a new procedure has now been instituted whereby all information about patients' whereabouts is given to the gate porter, whose responsibility it is to direct enquirers to the appropriate ward. The medical and nursing notes indicate that the transfer to hospital C took place on 29 December and not on 28 December as stated by the complainant and the DSA.

44. The sector administrator told my officer that, as a result of a decision by the District Management team, taken after consultation with medical staff, ward x had been closed from 22 December 1976 to 5 January 1977. It was accepted practice to close some wards over the Christmas period.

Findings

45. It is clear that the original intention was for the complainant's husband to be returned to ward x, and that the complainant was told of this by hospital A in good faith. It is regrettable that she was not informed about the changed arrangement, and I understand her annoyance at failing to find her husband where she expected. The Authority have apologised to her, and I am glad to learn that steps have been taken to avoid similar incidents. The frequent changes of ward experienced by the complainant's husband were due to organisational problems and the need to make effective use of resources over the holiday period.

(*j*) *The complaint that speech therapy was inadequate*

46. The complainant told the DSA when she met her that her husband had not been referred for speech therapy until, on her insistence, a therapist gave him a test in July 1976, and agreed to take him for treatment. She told my officer that she believed speech therapy would be beneficial for her husband, and protested at the speech therapist's subsequent decision to discontinue treatment. In her reply, the DSA said she understood that the complainant's husband had first been seen on 15 June 1976 for assessment of speech and language problems and was seen twice more before his discharge home. The speech therapist had been instrumental in arranging for another speech therapist who lived near the complainant to attend her husband at home on several occasions before his re-admission to hospital B on 2 August. Attempts were made by the hospital speech therapist to help the complainant's husband to achieve understanding of written and spoken words, but with very little success. Since his transfer to hospital C he had been seen on a number of occasions but the speech therapist did not consider that she could recommend the resumption of treatment.

47. The speech therapist told my officer that the complainant's husband had suffered damage in the language area of the brain causing a loss of vocabulary. He had been aggressive and uncooperative and treatment was therefore unproductive; she was not sure whether his behaviour was because of his frustration at not being able to communicate. She said that, whilst the complainant's husband was capable of carrying out simple tasks such as matching

objects of similar colours and shapes, he was unable to perform more complicated tasks. He was unable to speak, write or read. She believed the damage was so severe that therapy was unlikely to have any effect at present and recommencement of treatment was not therefore considered practicable after he had gone to hospital C. She had continued to visit him occasionally at hospital B and hospital C, and had carried out an assessment as recently as 22 July 1977, but there had been little change in his performance.

48. I have seen a record of the speech therapy appointments which indicates that the complainant's husband was referred by the physio-therapy department for speech therapy on 10 June and was subsequently seen on 15, 18, 21 and 30 June, 7, 14 and 21 July and that he had been unable to attend on 23 and 25 June and 28 July. He was visited on the ward at hospital B on nine occasions between 3 August and 5 October but regular visits ceased after this because of his uncooperative attitude and the therapists' heavy workload. After his transfer to hospital C the complainant's husband was seen on the ward on 7 and 28 January, 18 March, 6 May, 17 June and 8, 15 and 22 July 1977. The consultant neurologist told my officer that the complainant's husband had a gross defect in his speech and in such cases it was unlikely that speech therapy would result in a greater improvement than would occur spontaneously. Nevertheless the advice of the speech therapist would continue to be available.

Findings

49. The decision as to whether a patient should receive speech therapy arises from the exercise of clinical judgment by the doctors and their professional advisers. The evidence indicates that genuine efforts were made to help the complainant's husband with his communication problems but owing to the severity of his handicap and his inability or unwillingness to cooperate the therapy has not been successful. His condition is being kept under review in case there should be a possibility of his benefiting from therapy in the future and I hope this will be reassuring to the complainant. I do not uphold her complaint that the speech therapy provided was inadequate.

(*k*) *The complaint that glasses were returned unrepaired from hospital A*

50. The complainant told the authority that when her husband broke his glasses on 30 December they were sent to hospital A for repair but were returned unrepaired on 29 January because the frames had not been supplied under the NHS. In her reply the DSA apologised for this, saying that the staff at hospital C would normally have sent them for repair to hospital A but there was no record of them having been sent there. She understood that new glasses had subsequently been supplied through hospital D, and apologised for the delay.

51. The charge nurse in charge of ward 1 at hospital C remembered that the glasses were already broken when the complainant's husband was transferred at the end of December. His normal practice would have been to instruct the medical records clerk to arrange for repair, and as the complainant's husband had a spare pair of glasses he would not have asked for urgent action. After discussion with the complainant, arrangements had been made for her husband to be examined at hospital D, where optical treatment was normally carried out. I have seen records indicating that the eye test took place on 27 January. The medical records clerk told my officer there was no record of the complainant's husband's glasses having been sent for repair until 27 January, when

they were sent to hospital D; it would have been unusual to send glasses to hospital A for repair.

Findings

52. I cannot say with certainty why there was a delay before the glasses were repaired but I think the DSA was probably mistaken when she said glasses were normally sent for repair from hospital C to hospital A since this would apparently have been an unusual arrangement. I have been assured that the procedures have been revised to obviate similar errors in the future, and I note that the complainant has received an apology.

(*l*) *The complaint about the way in which the Authority dealt with her complaint*

53. The complainant told me that she complained verbally to the patients' services administrator of the health district in August 1976 but that no further action was taken to look into her complaints. After her approach to me she sent a detailed statement to the Authority on 12 February 1977 and, after an acknowledgement dated 16 February, she received no reply until a letter from the DSA dated 23 March suggested a meeting to discuss her complaints more fully. The DSA wrote to the complainant on 12 May describing the progress of the investigation and sent a comprehensive reply on 1 July.

54. The patients' services administrator recalled that when he met the complainant her main concern appeared to be about the possibility of her husband being transferred to hospital C. He said he thought she was seeking help and advice rather than answers to specific complaints, and therefore arranged a meeting with one of the doctors responsible for the complainant's husband's care. He was not aware of the outcome of this meeting but on 3 September he wrote to the complainant asking her if she had all the information she required. There was no response and he heard no more until he received a copy of the complainant's letter on 21 February to the Authority. He had then asked the sector administrator to investigate. I have seen the rough notes made by the patients' services administrator at his meeting with the complainant in August 1976. These contained references to many of the points which had caused her concern up to that date and which she subsequently included in her formal complaint. I have also seen a copy of the letter of 3 September which was correctly addressed and was apparently not returned by the post office, but the complainant told my officer she had not received it.

55. The DSA told my officer that she had been instructed to commence an investigation on 28 February. She had not been able to deal immediately with the complaints owing to difficulties in obtaining the medical records which the consultant who was then in charge of the complainant's husband's care at hospital C had been reluctant to release. Her office had also been short-staffed during that period and this had increased her own workload. After talking to the complainant on 30 March she had written to the members of staff involved in the complaints, most of whom replied in the following few weeks. There were, however, some delays partly due to the need for several witnesses to refer to the same set of documents. One reply containing important information had not been received until 13 June. It had been necessary after receiving written statements to clear outstanding points by discussion, in some cases with staff who had left the hospital.

Findings

56. I cannot be sure what happened during the discussion between the patients' services administrator and the complainant in August 1976 because a full record was not made of it, but the administrator's rough notes show that she referred in some detail to incidents which had occurred in hospital A and hospital B. I therefore find it surprising that it should have been assumed that her concern was only with the proposal to transfer her husband to hospital C. The complainant herself thought she had made it clear that she wished her specific complaints to be investigated. The crucial factor is the apparent non-delivery of the letter of 3 September inviting the complainant to say whether she was satisfied. Had she received it she would have had an opportunity to pursue her grievances further. In the absence of a reply, the patients' services administrator assumed that she was no longer aggrieved. As the complainant's husband was still a patient at hosital B I think it would have been prudent for him to have made such internal enquiries as would have satisfied him that there was no continuing cause for dissatisfaction on the complainant's part, and to have ascertained from the doctor who saw the complainant whether he thought she was satisfied.

57. A period of more than four months elapsed between the receipt of the complainant's formal complaint by the Authority and the despatch of their final reply. Part of this delay was accounted for by the lack of urgency with which some of the witnesses treated the DSA's request for information. There was an interval of some five weeks between the date the complainant's letter was acknowledged and the offer of an interview to discuss her complaints. I think the Authority, knowing that the complainant had already complained of delay in dealing with her verbal complaints, should have given a greater degree of priority to dealing with their enquiries. The eventual reply was, in my view, both comprehensive and sympathetic and I do not criticise the thoroughness of the Authority's investigation nor the content of the reply.

Conclusion

58. I have been impressed by the number of references made by hospital staff to the loyal and devoted care and support the complainant has given her husband since his disablement. Apart from her natural concern for his welfare and comfort, the incidents at the start of his treatment in hospital, in particular the regrettable failure to prepare her for the shock of seeing his condition after his stroke, no doubt undermined her confidence in the hospital staff.

59. I find several of the complaints to be justified. Some were more serious than others and their cumulative effect was undoubtedly distressing for the complainant and her husband. As a result of their own investigation the Authority have already apologised for most of their failures and, where appropriate, have undertaken to review, or have altered, any procedure which was found to be at fault. I consider that, in the main, the complaints represented isolated failures rather than any major identifiable weakness in the organisation of the hospitals concerned.

60. In my view, complaints of this kind are best dealt with if they are brought to the attention of the people immediately responsible at the time the incident occurs. I understand that the complainant's husband is still in hospital and I have recently received further complaints from the complainant. I hope that a mutually

acceptable arrangement can be made between the complainant and those concerned with her husband's continuing treatment and care so that she can raise with them any matters which continue to worry her. Thus her confidence might be restored and the risk of misunderstandings reduced.

Case No W334/76–77—Planning delay

Complaint

1. The complaint is of unnecessary and unreasonable delay on the part of a Regional Health Authority (the Regional Authority) and an Area Health Authority (the Area Authority) in arriving at a decision on the conversion of a children's hospital (hospital A), which closed in October 1974 after the transfer of the last patients to the new paediatric department of a general hospital (hospital B).

2. Since 1973 representations had been made to the health authorities that hospital A, when it became surplus to requirements, should be used as short stay accommodation for mentally handicapped children. In December 1975 the local Member of Parliament was advised by the Minister of State (Health) that the Area Authority had agreed in principle to the conversion of the hospital for that purpose, and that plans were being prepared. He was told in March 1976 that a project team was shortly to be set up. However, when he learned in November 1976 that no action had been taken he wrote to me and asked me to look into the matter.

Investigation

3. The files of the Regional Authority show that the future of hospital A was first considered by officers of the then Regional Hospital Board (the Board) in the summer of 1972. Conversion proposals were made, and a board officer meeting on 15 November agreed that consideration should be given to adapting hospital A for use by mentally handicapped patients when it was vacated. The planning officer dealing with this project told my officer that exploration of the site and its possibilities and the preparation of a draft schedule of operational policies took them into the spring of 1973, and this was followed by the preparation of a series of sketch plans of adaptations to various buildings. The scheme was costed in August 1973 and the regional quantity surveyor reported that it would cost between £275,000 and £300,000, excluding furniture and fees and work on certain of the existing buildings.

4. The scheme to adapt the hospital was considered by the Board's central planning group at a meeting on 13 September 1973 when reservations were expressed on the grounds that it would provide only 82 beds against a more desirable provision of 100 beds for the area; that the cost was higher than expected; and that the unit would be somewhat sub-standard compared with purpose-built accommodation. The planning group suggested it might be better to sell the hospital and build a purpose-designed unit on the hospital B site. The Board's secretary then wrote to the Department of Health and Social Security (the Department) outlining the proposals and seeking their informal views on the suggestion that a purpose-designed unit should be built. The Department replied that provided such a unit could be sited so that it would not be seen as part of the general hospital, and provided it was separated functionally

and physically from the clinical facilities of hospital B, they thought that the proposal would be acceptable. At a meeting of the Board's hospital services development committee on 1 October 1973 it was agreed to recommend that hospital A should be disposed of and that provision for the mentally handicapped should be made in a purpose-built unit on the site of hospital B.

5. This alternative scheme was under consideration when, on 25 January 1974, the Department suggested to the Board that in the current, changed, economic climate the building of a new unit could be many years away. They asked the Board to consider whether in the meantime hospital A could provide temporary accommodation for the mentally handicapped, perhaps by means of a less ambitious scheme than that previously envisaged. I was informed that this possibility was referred to the newly constituted Area Authority.

6. During 1974–75 discussions took place within the health area about the future use of the hospital A site in the general context of the need to develop hospital facilities for the mentally handicapped within the area. The Area Authority's general administrator told my officer, however, that, after their establishment in April 1974, they had been too busy to give particular attention to hospital A. As with most of the new authorities things were in such a state of flux that they had just been 'keeping things afloat'. No substantive appointments other than the area team of officers, had been made until late in 1974 and the general administrator, who is responsible for planning, did not join the Area Authority until June 1974. I was informed that the specialist in community medicine (planning) did not join the Area Authority until much later in 1974. I was also told that the capital programme which had been handed over to the Area Authority had to be reviewed and that it took about a year before they were able to direct serious attention to the future of hospital A.

7. In October 1974 hospital A closed and the district administrator of the health district wrote to the Area Authority's area administrator referring to proposals which the district management team had sent him in September; he said he was not sure where they were with these but said he felt that a firm proposal for the use of the hospital ought soon to be made to the local Community Health Council, even if no date could yet be given to implement it.

8. The Member wrote to the area administrator in December 1974 to ask how matters now stood, saying that it was a pity if useful facilities were neglected. When this letter was referred to the district administrator, the latter wrote to the area administrator reminding him that the district management team's proposals had been submitted in September, since when he was not aware of the current position. He said that a health care planning team for mental handicap had been set up at the request of the area administrator but was pessimistic that this would lead to a quick decision on the hospital's future, and he urged an early resolution of the problem. (The task of this planning team was to study the need for health service provision for mental handicap in the district, to identify gaps in existing services, and to make recommendations for improvements.) The area administrator replied to the Member in January 1975, saying that the matter was being considered by the district health care planning team supplemented by an area working group for the mentally handicapped, which would review the level of need on an area basis. He said it was likely to be some

months before a decision was reached and a year or so before any local service for the mentally handicapped would be provided.

9. In March 1975 the regional administrator asked when he might expect the Area Authority's proposals for hospital A, to which the area administrator replied that a final answer had not yet been produced but that he had reminded the health care planning team and the area working group of the urgency of reaching a decision. In June, the Department wrote to the area administrator for a progress report. In reply, the area administrator said it was difficult to predict, but it was hoped that within the next few months clear advice (from the planning team and area working group) would be given on the facilities which were required, after which a quick decision could be taken on the future of hospital A. In September, the Department again asked whether a final decision had yet been reached.

10. The reports of the health care planning team and the area working group were considered in the autumn of 1975. Both recommended that initial provision for the mentally handicapped should be by means of a 48-bed unit on the hospital A site. On 6 October, the area administrator told the Department that the district had decided to use at least part of the site to develop mental handicap facilities and that a development programme would be drawn up. In November he wrote to the administrators of the three health districts in the area asking for the observations of their management teams on the proposals of the area working group, and these were given in December.

11. At a meeting of the area planning liaison team (comprising officers of the Regional and Area Authorities) on 27 January 1976 it was reported that the Area Authority proposed to set up a project team to investigate the possible provision of facilities at hospital A. It was agreed that information about another mental handicap capital development would be made available to the Area Authority to assist them in their study. On 22 March the area administrator wrote to the regional administrator informing him of the proposal to provide a 48-bed unit on the hospital A site, to be used mainly for mentally handicapped children from the whole of the area. He asked whether a design study could be commenced as a matter of urgency. At the next meeting of the planning liaison team on 27 April it was agreed that the regional officers should seek authority to prepare a feasibility study of the proposed scheme while area officers would produce an estimate of the likely annual cost of running the proposed unit.

12. A feasibility plan was produced in June 1976 and the planning liaison team heard in July that a report on the proposal had been sent to the regional team of officers seeking approval for planning to proceed. The regional team, who considered the report on 23 July, felt that before they were able to recommend that a project team be set up further information was necessary, particularly regarding the estimated annual running costs and the role of the social services in the development. The regional administrator asked the area administrator for the additional information in a letter dated 2 August. The acting area administrator replied on 13 August, explaining that it was not yet possible to give a final assessment of the running costs of the proposed 48-bed unit, but that funding would depend on three factors—the Area Authority's ability to re-allocate resources within the area, the Regional Authority's help in meeting

the costs, and any transfer of funds from a neighbouring Area Authority (which was providing a mental handicap service to the area). He hoped the scheme would soon be included in the Regional Authority's capital programme. After this reply had been considered the region felt it necessary to ask for further information on certain points, which they did on 2 October. The acting area administrator replied on 14 October. The regional team of officers considered this additional information at a meeting on 29 October and agreed that the planning of the project should go ahead but with no commitment in respect of either capital or revenue funds.

13. On 21 October, the acting area administrator (in a letter to the Community Health Council) said that a project team to consider plans and operational policies for the project had not yet been set up. He said the Area Authority had asked that the project be included in the Regional Authority's capital programme and 'would continue to press for its early inclusion', but that recent discussions with the Regional Authority had centred on the annual running costs of the scheme, an aspect which was being 'actively pursued'. About this time, the area team completed the Area Authority's 10 year strategic plan, as required by the Regional Authority and the Department, and the Area Authority approved it on 26 October. It included as one of its objectives the establishment of a mental handicap unit in the district as a first phase of providing the recommended number of beds for the area. In September, the district management team had produced their three-year operational plan for all health care services in the district. It included their recommendation for 24 places for mentally handicapped children on the hospital A site. The Area Authority formally approved the district plan in January 1977.

14. On 8 November 1976 the Department had written to the regional administrator, saying that the use of hospital A had been under discussion for some years and that the rate of progress looked like 'one step forward, two steps back'. The Department asked why the existing accommodation at hospital A was unsuitable for use by the mentally handicapped, and the likely cost and timing of providing new buildings. The regional officers had informal discussions about the proposals with officials of the Department and at a meeting of regional and area officers on 24 November 1976 they reported that the Department's officers shared their unease that the project was likely to be expensive both in terms of capital and running costs. In the light of the overall economic position this could well mean a very appreciable delay in implementing the scheme. Reference was made to correspondence between the Member and the Secretary of State in which the possibility of providing a 'quick and cheap' solution had been mentioned by the Member. The regional administrator asked the area team for advice on what alternatives might exist to bring about an earlier improvement. He asked for their thoughts on the possibility of adapting existing building to provide a smaller unit of perhaps 24 beds for children and supporting facilities.

15. In the meantime, so that consideration of the main scheme should not be held up, the regional administrator recommended on 25 November that a project team of regional, area and district representatives be set up to further its planning. He told the area administrator that from the feasibility work already done regional officers were preparing an outline operational policy and details of the functional content and this would form the basis on which the

project team could begin its discussions. He hoped this would be ready in two or three weeks and that a first meeting of the project team could take place early in January 1977.

16. A meeting of the Area Authority on 21 December resolved to seek the immediate establishment of a regional/area/district project team with a broad remit to include not only the original phased scheme and lower cost alternatives, but also the possibility of using the existing buildings for social services hostel accommodation as an interim measure. However, when the area administrator wrote to the regional administrator on those lines, the latter pointed out that the Area Authority was proposing a somewhat different kind of joint planning team from the project team proposed by region, the purpose of which was to continue a more detailed examination of the proposals for the building scheme at hospital A.

17. A meeting took place between area, district and regional officers on 11 February 1977 principally to 'clarify opinion as to the appropriate course for future events to take before the formal project team was established'. It was pointed out at this meeting that the regional strategic plan (approved in January 1977) had identified capital specifically available for mental handicap services which would be available from 1981. However, there were no substantial funds available in the short term except those which area health authorities could make available from within their own capital programmes. Nevertheless it was felt that it would not be reasonable to slow down the work of the project team because of uncertainty about the ultimate source of funds. The project team have met several times since March 1977 and are working towards submitting a claim in mid-1978 for a share of the capital which is expected to be available from 1981.

18. In the meantime the district management team, with the assistance of regional and area officers, also considered the possibilities of a 'cheaper short term solution' and on 26 April 1977 their proposal for the provision of 10 short-stay children's places and 20 day places for adults by adapting existing buildings was accepted by the Area Authority. The Area Authority have told me that this scheme backs up their emphasis on helping the mentally handicapped in their own homes. The Area Authority and Regional Authority subsequently agreed how this project would be financed and money for it was allocated in the financial year 1977–78. By late June the initial recruitment of staff and the adaptation of buildings was under way. The Area Authority's planning co-ordinator told my officer it was anticipated that the beds would be available for use about the end of January 1978 and that the day places would be available about the beginning of March. The Area Authority have achieved their first objective with the opening of the children's beds on 18 January and the adult day unit is also now completed.

Conclusions

19. Hospital A was closed in October 1974. In 1973 the Board had been considering what new provision should be made for the mentally handicapped and in the spring of 1973 proposed an adaptation of buildings at hospital A for this purpose. By the autumn of 1973 the Board had changed their view and were proposing new building at the hospital B site. But by the early months of

1974 the Department had suggested that because of financial stringency they should revert to a more modest plan. At this point a new Government took office and the new organisation of the health service entered into force.

20. Three levels of authority were now concerned with the planning of this facility—the Regional and Area Authorities and the health district. Each had its own team of officers and planning team. It is no part of my function to examine the planning processes as a whole, but I have found it necessary to take account of them in following the development of work relating to hospital A. It appears to have been the policy to start with a clean sheet and look afresh at the whole question of hospital needs and provision in the district, the area and the region. The district produced its operational plan. The Area Authority produced its strategic plan within which proposals from the district had to fit. All this then had to be submitted to the Regional Authority.

21. I have set out in paragraphs the various steps taken by the authorities and their planning advisers in considering provision for the mentally handicapped in the area and the use of hospital A. I cannot say that I can identify instances of maladministration in their actions, but they seem to have proceeded largely without guidelines, and in a somewhat aimless and desultory way. I observe that it was, in the main, influences external to the authorities which kept bringing them back to the need for progress and for realism; although I note that throughout 1974 some medical officers in the authorities were pressing for a limited and modest scheme utilising the facilities of hospital A. In the end, I believe it was the approach from the Department, spurred on by the Member, in November 1976, which spoke of 'one step forward, two steps back' which finally precipitated the solution now adopted, which was approved by the Area Authority in 1977.

22. My general conclusion is that while all individuals concerned with the planning were, I am sure, acting with all deliberation and care, the environment in which they were working seemed to lack realism, purpose and urgency. I recognise the uncertainties created by the introduction of a new planning system, by economic constraints, and by policy changes in methods of caring for the mentally handicapped. Nevertheless, the fact is that the hospital was left unused by patients for more than three years and it was external influences which were mainly responsible for its being now back in use. The scheme in force has involved the adaptation of buildings, an idea first considered by the Board in 1973, but its concept is said to be radically different, being strongly orientated towards community care.

Case No W419/76–77—Complaints about nursing care

Complaint and background

1. The complainant's mother, aged 83, was for many years cared for by her disabled daughter, with whom she lived, and her three married daughters, including the complainant, who provided help whenever they could. On 17 July 1976 the complainant's mother was admitted to hospital A to allow her single daughter to take a holiday. Unfortunately on the day of her admission she fractured her ankle and her stay was prolonged until 4 October 1976. She died at home on 31 October 1976.

2. The complainant made a number of complaints about nursing care and other matters which she put to the Area Health Authority (the Authority) on 19 October 1976, but she was not satisfied with their reply dated 10 January 1977.

Investigation

The complaint that there was a delay in x-raying the patient's ankle

3. In the correspondence she sent me and in an interview with my officer, the complainant said that she had telephoned the ward at 8.30 pm on Saturday 17 July, the day of her mother's admission, and a nurse had told her that her mother had left the ward unnoticed and appeared to have sprained her ankle, and that a doctor had been called. When the daughters visited their mother on 18 July, they had been told that her leg was probably only bruised but that she would be taken to hospital B the following day for x-rays. On Monday 19 July the family were told that, because of a mix-up, the ambulance had not arrived but that she would have an x-ray the next day. They learnt from a nurse on 20 July that x-rays had been taken that morning and a hairline fracture found. The complainant said she thought the delay was inordinate.

4. The ward sister told my officer that after the patient's accident on 17 July she had telephoned a doctor at hospital B who, after examining the patient, had arranged for an x-ray. This was done at about 9.15 pm that evening and the x-ray film brought back to the ward by the nurse. The next day the patient had been seen by a registrar from hospital B who thought there might be a fracture. He had arranged for her to go to the fracture clinic the next day (19 July). The nursing notes and the radiology department records confirm this sequence of events.

5. My enquiries of the ambulance control centre showed that transport had been ordered for Monday 19 July but that, by an oversight which they could not explain, the patient had not been taken to the fracture clinic until Tuesday 20 July. The clinic notes show that her leg was plastered then.

6. There is no doubt that the patient was x-rayed the same day as she had the accident and I cannot understand why her family should have been told otherwise. But I think it was unfortunate that because of an oversight by the ambulance centre she did not visit the fracture clinic on the day intended.

The complaints about nursing care

7. The complainant told my officer that the nurses had not noticed that her mother's stomach was swollen and her hand bruised, that her mother was not allowed to go to the lavatory when she wanted, and that the nurses had ignored a doctor's instruction to remove an elastic stocking from her mother's leg at night.

(*a*) *The failure to notice the patient's swollen stomach and bruised hand*

8. The complainant told my officer that when the family visited their mother on 20 July they noticed that her right hand was bruised and her stomach distended. The complainant said she had called a nurse who said the patient had a blockage and that an enema would be given.

9. None of the nursing staff interviewed could remember either the bruised hand or the distended stomach. The nursing notes contain no record of an

enema being given around this time nor any reference to bruising. The consultant geriatrician (the consultant) told my officer that he recalled that on admission the patient was impacted and an enema had been ordered, but the nursing staff believe that he was mistaken about this. Both the divisional nursing officer (DNO) and the senior nursing officer (SNO) responsible for the geriatric area said that a nurse would not give an enema on her own initiative and that, had one been administered, it would have been recorded. The SNO told my officer that geriatric patients do bruise easily.

10. I have obtained no evidence, either written or oral, to support the complainant's statement and, in these circumstances, I cannot resolve this part of her complaint.

(*b*) *The complaint about the visits to the lavatory*

11. The complainant said that, from the time she was admitted to hospital A, her mother had started to soil her clothing, and the family felt that this would not have happened if she had been allowed to use the lavatory more frequently. They said that, during visiting hours, nurses who were apparently free to deal with their mother were not interested and her requests were either dealt with slowly or ignored. The family had often found her wet or sitting in excrement, and one of the complainant's sisters said that several times she had found her mother sitting in faeces which had dried on her; sometimes she herself had cleaned up her mother and sometimes she had asked a nurse to do so.

12. In their written comments to me the Authority said that there were regular 'toilet periods' on the ward but that the staff should attend to patients' needs at any other time, although this would have to be fitted in with their other duties. But while the complainant's mother was there, there had been a serious shortage of nursing staff. This was confirmed to my officer by the nursing officer and the district administrator but this shortage had been remedied subsequently.

13. None of the nurses my officer interviewed could remember the patient having been doubly incontinent, but they said that she was incontinent of urine regularly at night and occasionally in the day. The ward sister told my officer that there were five regular daily toilet times on the ward, but patients who needed to use the lavatory at other times would be dealt with as soon as possible. She could not recall any difficulty with the patient; she had usually gone to the lavatory herself or had asked to be taken.

14. Although there is a conflict of evidence about the patient's incontinence, I have no reason to doubt that her relatives did occasionally find her wet and unclean. This is unpleasant both for the patient and the relatives and, ideally, it should not happen; but I have found no evidence to suggest that it was due to negligence. It is more likely to have been due to the shortage of nursing staff which, I am glad to note, has now been remedied.

(*c*) *The complaint about the elastic stocking*

15. One of the complainant's sisters told my officer that on 6 September she had been with her mother at hospital B when her plaster was removed. The doctor had said that in the letter they had written to hospital A they had forgotten to explain that the elastic stocking she had been given was for support during the day only and should be taken off at night. The complainant's sister

had straight away passed the message to a nurse at hospital A. But when she and a cousin had visited her mother on 12 September she had found that the stocking had been left on and that her leg was covered in sores.

16. The orthopaedic registrar who had written the letter told my officer that the purpose of the elastic stocking was to provide support and to reduce the swelling which often took place when plaster was removed. He said that, although he thought it best for a stocking to be taken off at night it was very unlikely to cause sores if left on. The consultant told my officer that, in his view, such stockings should be kept on 24 hours a day. He thought that the patient's sores had probably been caused by the plaster and not by the stocking.

17. The nurse to whom the complainant's sister had given the message about the stocking told my officer that she had received it and passed it on to the other nurses. The ward sister, who had been on leave from 29 August, recalled that when she had returned on 12 September the relatives had drawn her attention to a sore area on their mother's leg which they thought had arisen because the stocking had not been removed at night. The ward sister said that, after arranging for the sore area to be dressed, she had satisfied herself that the staff had been aware that the stocking was to be removed at night. The night nurses told my officer that they could not remember having seen the patient wearing an elastic stocking.

18. The nursing notes contain no mention of any soreness on the patient's leg until 12 September when an entry referring to a 'big sore area' was made by the ward sister. On the evidence, I have no reason to doubt that the stocking was removed at night. And the consultant thought it anyway unlikely that the soreness was caused by the stocking. But I think that there were probably signs of the sore area developing prior to 12 September and I consider it unfortunate that these were missed.

The complaint about the loss of nightdresses

19. In her letter to the hospital the complainant stated that five of her mother's nightdresses had been stolen. In their reply the Authority said—'from the reports . . . received it really does seem that the use of the word "stolen" is completely unjustified'. They had apologised for the loss and said it was likely that the nightdresses had been sent inadvertently to the hospital laundry.

20. The complainant told my officer that all her mother's clothes had been marked with her name and that she believed that someone had taken the missing nightdresses and removed the name tapes. But one of her sisters said she accepted that the nightdresses had been sent in error to the hospital B laundry. However, the family considered that the nurses did not make thorough enquiries and were content simply to give this excuse.

21. The ward sister told my officer that, when a patient's own clothing is removed, it is normally placed in a wax bag in the bedside locker to await collection and washing by the relatives. She said that, as a reminder to staff, she had put a notice on the patient's locker to the effect that her dirty clothes should be put in the wax bag. The complainant's relatives cannot recall being told this, but one of her sisters confirms that she saw the notice on the locker.

22. The Assistant Manager of the hospital B laundry told my officer that they often receive in error items of patients' personal clothing; but if they are properly marked they are returned and there is no difficulty. Items which cannot be identified are kept for a time so that they can be claimed but they are eventually put into the hospital stock. As a result of this complaint the DNO issued a reminder to staff that they should get in touch with the laundry as soon as a loss becomes known; and the District Administrator told my officer that in future relatives will be asked to allow any clothing they bring in for the patient to be sent straight to the hospital laundry for marking.

23. I think it likely that the nightdresses were sent to the hospital laundry in error and that this was how they came to be lost. I have seen no evidence to suggest that they were stolen.

The complaint that the ward sister was unsympathetic

24. The complainant and other members of the family told my officer that they had found the ward sister unapproachable and not prepared to listen to criticisms or complaints; they had been frightened of complaining about their mother's care because they feared the staff would take reprisals against her. One of the complainant's sisters cited her complaint that the elastic stocking had been left on at night; the ward sister, she said, had replied that if she thought she could do better she could take her mother home. A cousin of the complainant who was there at the time said in a separate interview with my officer that the ward sister's attitude had been unpleasant, and confirmed that she had made the remark.

25. The ward sister told my officer that she had not made the remark attributed to her. She said she believed that the daughter, who was very irate, had not heard correctly what she said at the time, which was probably something like 'the nurses are doing their best'. In a statement shortly after the complainant had complained, the ward sister said that the daughter who lived with the patient, and who visited her most often, had always seemed pleasant and had never complained. She did not remember seeing the other daughters regularly and, apart from the complaints about the stocking and the loss of nightdresses, no other complaints had been made to her. She believed that the patient had been happy on the ward.

26. A nurse who had been on duty at the time of the complaint about the stocking said that she did not think the ward sister had said anything unpleasant; but she remembered thinking that the relatives had over-reacted to the discovery of the sore area and the sister saying that it was just a break in the skin. Other nurses seen by my officer could offer no evidence about the incident.

27. An entry in the nursing notes made by the ward sister on 12 September 1976 says 'When patient's stocking was removed from leg, big sore area. Seen by relatives before Nurse had time to dress it. Not very nice people—complaining a lot. Nurses do their best to cope with shortage of staff'.

28. There is no doubt that a conversation took place on 12 September between the ward sister and two members of the complainant's family which both parties found unpleasant. Precisely what was said I cannot say. But I doubt if the complainant's sister and her cousin could both be mistaken in their recollections of what took place. I am inclined to think that the ward sister

showed some lack of tact in her conversation with the complainant's relatives. But I have no reason to believe that there was any basis for the family's fear that, had they complained, reprisals would have been taken against the patient.

The complaint about the patient's discharge and the consultant's failure to keep an appointment with her daughter

29. In her letter to me and in her interview with my officer, the complainant said that when her mother was discharged on 4 October she could not walk althought the ward sister had assured her sister that she could. The complainant said that her sister had been asked to see the consultant together with a social worker on 30 September in order to discuss discharge arrangements but the consultant had been unable to keep the appointment. He had sent a telephone message to confirm that the patient could be discharged. The complainant's sister could not recall who had asked her to see the consultant on that day, but it was the ward sister who had told her that he had been delayed and had been insistent that her mother could walk.

30. The ward sister told my officer that she, the complainant's sister and the consultant had seen the patient on the ward on 29 September. The consultant said that he believed that this was so and that the patient had walked on this occasion. He had felt it was a little too soon to discharge her because, although she was ambulant and had attained a reasonable degree of continence, she could not dress herself easily; but as her daughter had been anxious to have her mother home he had taken the decision to discharge her on 4 October. The consultant added that he had also seen the patient on 2 October and she had been able to walk then. He also said that he had once arrived late for an appointment with the complainant's sister and found that she had left, but he could not remember when this had happened. The social worker remembered speaking to the complainant's sister on the ward on one occasion but she was unaware that the consultant had arranged an appointment to see her.

31. Two members of the nursing staff who had been present when the complainant's mother had been discharged were quite sure that she had been ambulant at this time. Other nurses confirm that during the latter part of her stay at the hospital the patient had walked both with and without a walking aid; and the senior physiotherapist who had treated her said definitely that she could walk at the time of her discharge. He added that geriatric patients sometimes become so accustomed to hospital routine that any change disturbs them. It might have been that the journey from hospital to home could have upset the patient and impaired her ability to walk.

32. The district nurse who had visited the complainant's mother on the day of her discharge told my officer that she thought the patient had slowed down a lot. Before her admission to hospital A she had been able to move around on her own, but on her discharge she was able to walk only with an effort and with assistance.

33. I am satisfied from my enquiries that the complainant's mother was able to walk when she was discharged from hospital. But the family were naturally disappointed when, on her arrival home, their mother was not as active as they had hoped. It seems that on one occasion the consultant was unable to see the complainant's sister at the time agreed and that she was unable to wait for him,

but I have been unable to reconcile the evidence of the consultant and the ward sister with that of the complainant's sister about a discussion at the end of September.

The complaint that the complainant's mother was discharged with sores on her buttocks

34. The complainant said that the family were most concerned that, when her mother was discharged from hospital, she had two extensive bleeding sores on her buttocks. The district nurse had reported the sores to the family doctor who had visited the day after the discharge. (According to the doctor, it was three days after her discharge.)

35. The consultant told my officer that he had last seen the patient two days before discharge and he had not seen any pressure sores when he had examined her then. He said that it was probable that she was not seen by another doctor before she left hospital and that it was left to the nursing staff to observe and report her condition.

36. The nursing staff interviewed by my officer were quite sure that the patient had not had any pressure sores. The ward sister said she had last seen the patient on the day before her discharge and she was in good condition. On the day of discharge, a nurse showered and checked the patient. The statement she wrote some five weeks after the patient was discharged reads—'I gave her a shower and dressed her . . . there were no pressure sores. The sore she had had on her leg was completely healed'.

37. The district nurse and the family doctor told my officer that after her discharge, the complainant's mother had had one pressure sore on each buttock but they were not bleeding and they were not eroding. They believed that she had left the hospital with the sores.

38. I have no doubt that the complainant's mother did have two sore areas on her buttocks when she arrived home on 4 October. It seems that these sores must have been present when she left the hospital, and I think it is most unfortunate that they were not noticed before she was discharged.

The complaint that the patient had a stroke which was not reported to the family

39. In her letter to me and in her interview with my officer the complainant said that when the family doctor had visited her mother shortly after her discharge, she had thought that she had suffered a slight stroke. But, the complainant said, the hospital had not reported this either to the family or the family doctor.

40. The consultant told my officer that, in his view, it was highly unlikely that the patient had had a stroke before she left the hospital. But the family doctor said that, when she had seen the patient at home three days after her discharge, she had concluded that the patient had had a slight stroke; and a colleague who had seen the patient five days later had confirmed this. The family doctor said that she could not say whether the stroke had occurred before or after the patient's discharge from hospital.

41. The medical evidence suggests that the patient did suffer a slight stroke, but I have been unable to establish when this occurred.

The complaint that the Authority's reply was inaccurate

42. In the correspondence she sent me and in the interview with my officer the complainant said that she was totally dissatisfied with the Authority's reply which seemed to her to twist the facts and, moreover, made no mention of the remark made by the ward sister.

43. My enquiries show that, in their investigation, the Authority obtained written statements from the ward sister and other members of the nursing staff, from the senior physiotherapist, the nursing officer, the SNO, the DNO and the consultant. I find that a number of the Authority's conclusions are the same as my own, but I can understand the complainant's disbelief in these when in the same letter the Authority gave the impression that they did not accept the complaints about her mother's incontinence, that she did have pressure sores on her buttocks, and that she was unable to walk on arriving home after being discharged from the hospital. I consider that the Authority might have been more willing to place credibility on the evidence of the complainant on these aspects of her complaint. The District Administrator told my officer that he had been unable to satisfy himself about the attitude of the ward sister but he believed that she was prone to making remarks which were open to misinterpretation. In their reply to the complainant, the Authority apologised 'if any member of staff was in any way rude to you or to your mother'. But the complaint was specifically about the ward sister and I think that the Authority should have answered this directly.

Conclusions

44. The complainant's mother was very well cared for at home by the daughter who lived with her and the complainant's other sisters. The family doctor told my officer that she had never known a patient so well looked after by relatives and that no geriatric ward could possibly provide the same detailed personal care and attention. I think for this reason the family may have been over-critical of the treatment that the complainant's mother received in hospital.

45. Some of the complaints I have been unable to resolve; but I accept that on occasions the complainant's mother was found to be incontinent and unattended and, whilst this is regrettable, I have found no evidence to suggest that this was because of negligence by the nurses. I think, too, that the loss of the nightdresses was unfortunate. I have criticised the hospital for discharging the complainant's mother with pressure sores; and I believe that the ward sister showed a lack of tact in her dealings with the relatives. I also consider that the Authority could have displayed more sympathy with the complainant's points of view. The Authority have asked me to apologise on their behalf to the complainant and her sisters for the shortcomings shown by my investigation. The ambulance service have also asked me to apologise on their behalf for the oversight to which I refer in paragraph 6.

Case No W432/76–77—Failure to safeguard personal effects

Complaint and background

1. On 5 August 1976 the complainant's father fell outside his home and was taken to the accident and emergency department of a hospital. Later that day he was transferred to another hospital where he died on 20 September 1976.

2. The complainant states that, after her father's death, a watch, a walking stick and over £100 in cash were not returned to the family by the hospital and that she is not satisfied with the way her complaints were dealt with by the Area Health Authority ('the Authority').

Investigation

The complaint about the loss of the property

3. The complainant told my officer that on 9 August 1976, whilst she was visiting her father, she looked in his wallet, which was in his locker, to check the address of a friend. She said the wallet was very bulky and contained some 10 pound notes together with a few notes of lesser denomination. The complainant said she asked her father about the money and he said 'there's £168 there'; the complainant said she decided not to pursue the matter then because there were people in the room at the time. She put the wallet back in her father's locker thinking that her brother would see about it when he visited him the following day; but she herself did not mention the money to her brother. The complainant said that some time later, when she telephoned the hospital to enquire how her father was, a nurse told her that £46 had been taken into safe keeping. She did not query the amount then because she thought that, if she appeared to be causing trouble, it might rebound on her father.

4. The complainant also told my officer that her father was very interested in clocks and watches and often carried more than one watch with him. She said that when she visited him in hospital she saw a pocket watch, a wrist stop watch and a wrist watch. When he died only the pocket watch and the wrist stop watch were returned to the family. She also said a walking stick had been lost.

5. The complainant's brother told my officer that when he visited his father on 6 or 7 August his father told him that he had over £100 with him at the hospital. But he did not question the wisdom of this because his father was alert and capable of managing his own affairs, and he believed, anyway, that a patient's belongings would be safe at a hospital. He also said that he had seen his father wearing two wrist watches. When only one was returned, he thought he might have mentioned to the nurse that one of them was missing, but he would not have pressed the point since, for all he knew, his father might have given it away. He could not recall seeing his father's walking stick at the hospital. The complainant's brother summed up by saying that his main concern was that the hospital had failed to safeguard his father's property when he became incapable of doing so himself.

6. My officer discussed this part of the complaint with two of the complainant's father's long standing neighbours, who had been with him after he fell outside the flats until the ambulance came. They said that the complainant's father had been in the habit of keeping large amounts of cash in his flat, but, after it had been broken into, he had taken to carrying his valuables with him when he went out in case he was robbed again. They confirmed his interest in clocks and watches but could not remember seeing more than one wrist watch at the hospital. They also confirmed that he always used a walking stick but did not remember what had happened to it after his fall.

7. The ward sister at the hospital told my officer that she could not recollect the exact circumstances of the complainant's father's admission. But she said that, at the time, admission procedures were very lax and no proper check was made of patients' property. My officer interviewed staff who worked on the ward during the complainant's father's stay in hospital. Several of them remembered that he had three watches which he liked to keep with him. But it was not until the night of 23 August that the complainant's father talked about the amount of money he had in his locker. A charge nurse and an enrolled nurse told my officer that, on that night, the complainant's father had been talking about money left unguarded in his locker and had been 'fumbling' to reach it. They said they had looked and had found £46 in his wallet, and had counted it in front of him. It comprised seven five pound notes, one ten pound note and one pound note. All except the one pound note, which they left with him, were placed in the hospital safe, and the charge nurse made out a receipt for the £45 taken into safe keeping. After he died the ward sister and a pupil nurse checked and listed his possessions. Both of them, independently, told my officer that although they remembered seeing the complainant's father with three watches it did not occur to them when they were listing his possessions, that there were only two. None of the staff could remember seeing a walking stick.

8. I have seen a copy of the patient's property record made out by the charge nurse on 23 August 1976 which confirms that £45 was taken into safe keeping; a further entry was made on 20 September showing that a wallet, two watches and other personal effects were taken into safe custody and later handed to the complainant's brother. But although several nurses recall having seen the complainant's father with three watches there is no record of this. I have been unable to establish whether or not he had his walking stick with him in hospital.

9. In 1971 the Department of Health and Social Security issued guidance to hospital authorities saying that patients in all hospitals should be warned that the authority could not accept responsibility for cash and valuables not deposited for safe custody. It seems very unlikely that the complainant's father was so warned. The nursing staff apparently failed to establish what property he had with him in hospital and no record was made in the notes when it became known that he had valuables which he wished to keep. I have little doubt that there was a failure here and I uphold this part of the complaint.

The complaint about the way the Authority handled the representations

10. The complainant first wrote to the hospital on 22 September 1976. The senior nursing officer (SNO) made enquiries into the complaints and dictated a reply which was sent to the complainant, in his absence, on 1 November by the acting SNO. On 6 November the complainant wrote to the Authority saying that she was concerned that the police had not been informed by the hospital of the loss of her father's property and asked for the matter to be further investigated.

11. On 7 December 1976 the Authority wrote to the complainant giving her the results of their enquiries; and on 12 December the complainant replied pointing out that the letter contained inaccuracies, in that it said that her father had handed in £45 for safe keeping on 23 August 1976 at the time of his

admission to hospital when her father had, in fact, been admitted on 5 August; and it was not until 23 August that £45 was 'taken into ' safe keeping by the nursing staff as opposed to being 'handed in' voluntarily.

12. On 17 December 1976 the Chairman of the Authority wrote to the complainant saying that he had referred her complaint about the loss of her father's property to his officers. On 24 January 1977, the Authority wrote again to the complainant apologising for the incorrect information contained in the letter of 7 December and telling her that the police had been informed of the loss of her father's property.

13. My officer spoke to the area security officer who has now left the hospital service. He said he thought that the sector administrator had shown him a letter from the complainant in either December 1976 or January 1977, and he had then notified police officers who were dealing with cases of theft which had occurred at another hospital in the area. He also said that he had not kept any official records of cases he had dealt with during the time he was at the Authority and he had destroyed any informal notes he had kept when he had left. I made enquiries of the local police stations in the area and of the metropolitan police headquarters, who told me that there is no record of any official report of the case having been made to the police by the Authority.

14. In cases where there is a complaint about the loss of valuables belonging to a patient it is clearly essential for the police to be informed as soon as possible. This was not done by the hospital when the complainant first complained shortly after the death of her father. Nor, apparently, did the Authority do so when the complainant wrote on 6 November pointing this out. Despite the assurances given to her on 24 January 1977 by the area general administrator my enquiries of the police have shown that they have no record of any request having been made for them to look into the loss of the complainant's father's effects. The complainant also complained about the inaccuracies contained in the letter sent to her on 7 December 1976 by the Authority, which they have admitted and apologised for. I fully uphold the complaint that the original complaint was dealt with quite inadequately by the Authority.

Conclusions

15. The ward staff clearly should have asked the complainant's father what property and valuables he had with him at the time of his transfer to the hospital and I think it unlikely that this was done. I note that a procedure has now been introduced whereby patients or their relatives are asked to complete a form acknowledging that they have been advised to hand in valuables for safe keeping and I hope that this will prevent similar incidents occurring in the future. I criticise the Authority for their failure to safeguard the patient's property and for the unsatisfactory way they dealt with the complaints and, in particular, for apparently not informing the police of the loss. The Authority have told me that they will shortly be writing to the complainant to apologise for the shortcomings revealed by my investigation.

Case No W437/76–77—Inadequacies in obstetric care

Complaint and background

1. The complainant's wife was admitted to hospital A at 4.45 am on 4 July 1976 for the delivery of her second child and was transferred at 7.30 pm on the same day to hospital B. The complainant wrote to the Area Health Authority

(the Authority) on 17 August about the delay in transferring his wife during labour to hospital B, which he considered was the result of the inexperience of the midwifery staff who, in his opinion, were also inconsiderate to his wife. The complainant was dissatisfied with the reply he received from the health authority and considered that the delay of nearly six months which elapsed before he received a substantive reply was excessive.

Investigation

2. In his letter of 17 August to the Authority, the complainant explained that he had been present throughout his wife's labour and that in his opinion the midwifery staff at hospital A were unable to cope with the situation which developed. He said that his wife had been in labour 17 hours before it was decided to transfer her to hospital B and that she had informed him that the midwife had admitted when she accompanied her there in the ambulance that she should have been transferred earlier. The complainant told me that he considered that the lives of his wife and baby had been put at risk because of the delay, and his wife had been subjected to unnecessary suffering. He said he and his wife had looked forward to having three children but his wife's experience at the hospital had made her apprehensive about having another child. At one point, shortly before his wife's transfer to hospital B, he had become convinced that she and the baby would die, because the staff did not seem to know how to cope. The complainant said he had been told by the midwife that she had not delivered a baby for three years and that she had asked the student midwife, who was checking the foetal heart, whether the baby was still alive. The complainant had concluded from this that the midwife was inexperienced and he thought she had been insensitive in asking such a question in the presence of his wife and himself. He also told me that he and his mother-in-law had overheard two doctors at hospital B saying that the mismanagement of patients at hospital A led to unnecessary demands on the beds in their hospital.

3. In reply to the complainant's letter an assistant district administrator said in a letter dated 4 February 1977 that because hospital A was a separate hospital and because of the distribution of senior medical staff and the superior equipment at hospital B it was considered wise to transfer complicated maternity cases from hospital A to hospital B. Patients were transferred as soon as a complication arose but unfortunately transfers sometimes had to be made during labour. The letter said that this was regretted and that they were aware of the risks involved. The administrator said it was hoped that within the next few years the labour ward at hospital B would be extended and transfers would then be unnecessary. He went on to say that the complainant's wife's second labour must have seemed longer because her first labour had been so short but he stressed that the consultant obstetrician considered that her progress had been within normal limits. He also said that they had been unable to find any evidence to suggest incompetence on the part of the midwifery staff and that at 7.30 pm when the staff became concerned about the baby's condition it had been decided to transfer the complainant's wife to hospital B. The administrator stated that the consultant thought that the staff who supervised the complainant's wife's labour had followed the correct procedure except that the consultant had said that he would have ordered an alternative but equally acceptable form of analgeisa. The administrator added that it was not possible for him to comment on the conversation between two unidentified doctors.

4. One of my officers spoke to two members of the nursing and midwifery staff who, until midday on 4 July, had helped to care for the complainant's wife. They said that when they last saw her at around midday, she had been in a comfortable condition.

5. The nursing officer who cared for the complainant's wife from midday onwards told me that she was unable to understand why the complainant had thought she was inexperienced because at the time of his wife's confinement she had been a midwife for 21 years; she said she had not told the complainant that she had not delivered a baby in the last three years, since this would have been untrue. She was quite certain she had not asked the student midwife if the baby was still alive which, she said, would have been insensitive and inconsiderate. She said, however, that it was possible that she might have asked the student midwife whether the baby was alright. She thought it unlikely that she would have said to the complainant's wife that she should have arranged for her transfer earlier and she could not recall making such a remark. She pointed out that the decision to transfer the complainant's wife had been a medical one and that she and the student midwife, who had missed a meal in the hope of delivering the baby, had themselves expected to deliver the baby at hospital A. She explained that it had not been anticipated that the complainant's wife would present any problems during confinement since the birth of her first child had been very straightforward. The nursing officer said that if any problems had been foreseen during the ante-natal period the complainant's wife would have been admitted to hospital B, instead of hospital A. She recalled that on 4 July it had been very hot and the temperature in the delivery ward, in spite of fans operating, had probably been 85°–90°F and was not conducive to the comfort of a patient in labour. The nursing officer said that at 1.45 pm the obstetric registrar had looked in on the complainant's wife and was satisfied with her condition. At around 4.30 pm she had asked the house officer to get in touch with the obstetric registrar, who was at hospital B, because the baby had not yet been born. When the registrar arrived at 5.30 pm he examined the complainant's wife and gave her an anaesthetic. The nursing officer said that at approximately 7.30 pm because there was some slight indication that the baby was becoming distressed she had consulted the registrar again who decided that the complainant's wife should be transferred to hospital B. I was unable to interview the registrar and the house officer, each of whom is now working abroad; nor the student midwife who is also working abroad.

6. From my examination of the medical records, I am able to confirm that the nursing officer informed the registrar at 7.30 pm of the baby's distress and that it was then decided to transfer the complainant's wife to hospital B.

7. My officer spoke to a registrar at hospital B who was identified from the complainant's description of her and who had allegedly commented on the management of patients at hospital A. She told my officer that she would not have remarked on the management of patients at hospital A and she thought it unlikely that any member of the medical staff would have made such a remark but said she was unable to recall the circumstances surrounding the complainant's wife's confinement since she had been involved with many other patients since then.

8. The consultant obstetrician told my officer that he had spoken to the complainant shortly after the birth of the baby and had thought that he had

resolved the complainant's anxieties. He said that, in his view, although the labour was a little long, it was well within normal limits and the outcome was that both mother and baby were well. He considered that the delivery of the baby had been satisfactory and that there had been no indications prior to the onset of labour that delivery at hospital B was necessary. However, he also said that he was generally concerned about the transfer of patients from hospital A to hospital B, which involved some risk. Although patients were carefully screened and selected for admission to the respective hospitals, it was not always possible to anticipate the development of complications during labour which might require the expertise and facilities available at hospital B. He thought the senior medical and paediatric cover was inadequate at hospital A and said he was disturbed that maternity services were not improving. Plans for an extension to the maternity unit at hospital B had, he said, been delayed, which meant that the unit at hospital A had to continue in use.

9. The complainant's wife's labour was protracted but I have been unable to find any evidence of delay in transferring her to hospital B following the registrar's decision to do so. I cannot question the clinical opinion of doctors and midwives in judging what course of action is best for their patients so I cannot say whether transfer should have been considered earlier, but I have noted the consultant's professional opinion that the complainant's wife's labour was within normal limits, although lengthy; and I have noted that the midwife sought a medical opinion on three occasions during the period between midday and 7.30 pm. I can well understand the complainant's concern for his wife but I hope he will be reassured to learn that the nursing officer who supervised his wife's confinement at hospital A had had many years experience as a practising midwife. Because of a conflict of evidence, I am unable to say whether or not the nursing officer asked if the baby was alive. Whatever phrase was used, it is apparent to me from the distress caused by this incident that staff must be especially careful to think of the possible effect on an anxious patient of an unguarded word, and to act accordingly. I am unable to corroborate the complaint concerning the remarks by the doctors about the management of patients at hospital A but I have noted the registrar's belief that she would not have made such a remark. I am surprised at the Authority's apparent lack of concern at this aspect of the complaint, as demonstrated by the administrator's expressed inability to comment on it. I think the administrator should have made some attempt to identify the doctors who were on duty at the time the reported conversation took place and have asked them for their recollections. However, I am sure the complainant will be pleased to learn that the Authority have recently decided that all confinements should now take place at hospital B.

10. The complainant told my officer that he thought that a period of almost six months for the Authority to reply to his letter of 17 August was excessive and said that he had been concerned that a reply to his complaint had not been sent until 4 February, when on 3 December it had been promised within a few days. The complainant also pointed out that the five items of correspondence he received had been signed by three different people all purporting to be the assistant district administrator.

11. Examination of the correspondence shows the following sequence of events. The complainant sent his letter of complaint on 17 August which was

received and acknowledged on 23 August by an assistant district administrator. On 27 August the unit administrator at hospital A wrote to the consultant who provided a report on the complaint on 8 October and asked to see the draft reply to the complainant. On 20 September and 11 November interim replies were sent to the complainant apologising for the delay and explaining that a report would be sent to him as soon as all the information required was available. A further letter was sent to the complainant on 3 December stating that he would be sent a 'full report within a few days'. But it was not until 8 December that the unit administrator at hospital A sent the draft reply to the consultant for his comments. On 31 December the consultant wrote to the assistant district administrator advising him of suggested amendments to the draft. The consultant was sent a revised draft on 12 January which he approved on 31 January and on 4 February a substantive reply was sent to the complainant.

12. The consultant told my officer that part of the delay in replying to the correspondence from the administrative staff was accounted for by staff holidays; to a delay in receiving the case notes; and to the fact that he had a locum secretary from 17 December to 17 January who, he said, was only able to cope with the most routine matters.

13. The assistant district administrator told my officer that although the consultant had sent his comments to the unit administrator on 8 October he himself had not received them together with the nursing comments until 26 and 27 October because of the unit administrator's absence on annual leave. He also had been on annual leave for two weeks at the end of November. He said that in retrospect he thought it had been unwise to write to the complainant on 3 December saying that he would have a full report within a few days when the draft report was not sent to the consultant for his approval until 8 December. He also explained that, in the event of his absence from the office, it was not usual for his assistant to indicate that correspondence had been signed on his behalf; in dealing with replies to complaints, the senior administrative assistant normally dictated a reply which she then signed using his name. In the event of his assistant and himself being away from the office concurrently, correspondence about complaints was signed by another assistant district administrator.

14. My investigation has revealed that there was an unfortunate sequence of events which contributed to the delay in replying to the complaint. I can well understand the complainant's concern when he received letters signed by three different people all using the assistant district administrator's name. I think the Authority should review their procedure for dealing with complaints and their arrangements for signing correspondence; the present system cannot inspire confidence in the recipient of a series of letters signed as these were.

Conclusions

15. I have been unable to uphold the complaint that there was a delay, caused by the inexperience of the nursing officer, in transferring the complainant's wife to hospital B. But I have criticised the Authority for informing the complainant on 3 December that he would receive a reply within a few days which subsequently arrived two months later, nearly six months after he

had made his complaint. And I have asked them to examine their procedures for dealing with complaints and with the signing of correspondence generally. I am pleased to say that the Authority have asked me to extend their apologies to the complainant for the manner in which his complaint was handled.

Case No W444/76–77—Dental damage during electro-convulsive therapy

Complaint and background

1. The complainant claims that while undergoing electro-convulsive therapy (ECT) at a hospital on 20 August 1976 she suffered damage to one of her teeth, which later resulted in its total extraction and necessitated the remaking of her denture, for which it acted as an anchor. On 14 September 1976 she complained to the Area Health Authority (the Authority) which on 6 January 1977 denied liability, on the grounds that its staff had not been negligent, and refused to meet the estimate of costs for remedial work which had been submitted on 22 September by the complainant's own dentist. The Authority did not propose an alternative, such as treatment within the NHS dental service, and so the complainant was compelled to make her own arrangements and to meet the cost of these, for which she paid on 21 June 1977.

2. The complainant was dissatisfied with the Authority's decision, despite a second application which she made on 15 January 1977, and she asked me to intervene. I explained that, whilst I could not question the decision of the Authority, I could, nevertheless, investigate the handling of her claim for reimbursement to ascertain whether the decision had been reached without maladministration. The complainant agreed that an investigation carried out by me on this basis was acceptable to her.

Investigation

3. The complainant told my officer that the tooth which broke had supported a denture which was removed before each administration of ECT. On the day in question as she recovered from the anaesthetic she had felt that the tooth had broken. Her own dentist, who treated her as a private patient, had removed the broken stump and would be making a new denture for her. She said the sector administrator had asked for her dentist's quotation for the work and this had been sent to him. She told my officer that when she had last seen her dentist before she received ECT he had told her that that particular tooth would probably last her for the rest of her life. She did not however want an admission of negligence by the hospital, only a reimbursement of the cost of her dentist's account, which she paid during the course of my investigation.

4. The Authority told me that written statements by hospital staff who had been present at the time indicated that the correct dosage of anaesthetic and relaxant had been administered and that ECT was given only after a gag had been inserted in the complainant's mouth, in accordance with normal procedure. The clinical assistant who administered the shock had noted the state of her mouth before starting the treatment but when the electrical shock was applied her teeth clenched as was usual, and the tooth snapped off. The tooth was unsupported by teeth on either side and on examination proved to be quite carious and discoloured throughout. The nursing sister at the clinic had shown the tooth to the complainant and had explained what had happened. The

claim from the complainant was submitted by the Authority to the legal adviser at the Regional Health Authority who advised that the Authority should not pay the cost of the dental treatment as he was of the opinion that there had not been any negligence by the staff involved.

5. I have examined the relevant correspondence which shows that after the sector administrator received the complainant's first letter he replied to tell her that he was making enquiries and he requested her to submit a quotation from her dentist. On the same day he wrote to the medical staff involved, a medical assistant and an anaesthetist, to ask them for their observations, at the same time acknowledging receipt from them of a completed accident report dated 20 August. The observations from the medical staff formed the basis of the Authority's comments to me (paragraph 4).

6. The papers on the case including the quotation were passed to the district administrator who discussed them with the district finance officer. The latter thought that if the Authority was considered liable for the accident a dental repair should be carried out with National Health Service resources and suggested that the views of the legal adviser should be obtained and on 6 October 1976 all the papers were sent to him. He was asked if the hospital was liable to pay compensation. After consulting the medical assistant's medical defence society the legal adviser gave the assistant administrator a suggested reply to the complainant, which was sent to her on 6 January 1977.

7. The medical assistant told my officer that the accident report, although dated 20 August 1976, had not been completed at the time due to an oversight. It was not in fact sent to the sector administrator until after the complaint had been received. He also explained that a rubber gag was always used to protect patients' teeth during ECT. In spite of this precaution there was always a danger of teeth breaking, although it was a rare occurrence. Before giving ECT, therefore, he examined each patient's mouth and if he saw an obviously loose or weak tooth which he thought might be damaged during the treatment he would refer the patient to his or her dentist. The complainant's tooth which later broke would have been subjected to a fair amount of pressure during the ECT. It had looked reasonably sound when he had first looked at it but when it was examined after it had broken it was found to be decayed inside. He said it would not have broken if it had been in a healthy condition. Both the anaesthetist and the sister who had been present confirmed to my officer that the broken tooth was found to be in a very poor condition. The complainant's dentist when asked for his comments told my officer that when he had last seen the tooth in July 1976 it was in 'pretty fair condition'.

8. The district administrator was not available for interview but the assistant district administrator told my officer it was normal policy to obtain legal advice on claims where there was some doubt as to liability. And because there was found to be no liability he had not thought that an *ex-gratia* payment was appropriate. The legal adviser, when interviewed, said that the Authority was correct in sending the claim to him. Area health authorities in the region usually got in touch with him about claims and always did so when a doctor was involved. After the medical defence society had told him there had been no negligence on the part of the medical assistant and he had agreed with them the

form of the suggested reply to the complainant, he had sent it to the district administrator. He said he had not considered an *ex-gratia* payment because medical staff were involved.

Conclusion

9. From my examination of the handling of this complaint I am satisfied that the district administrator made a thorough examination of the available evidence, and that his reply to the complainant was written on the advice of the Regional Health Authority's legal adviser and was intended to make it clear that there had been no negligence by hospital staff. It appears that because of this advice and because medical staff were involved, an *ex-gratia* payment was not considered. There is no doubt that the complainant's tooth broke whilst she was undergoing hospital treatment. No negligence was involved but I think the Authority should at least have offered remedial treatment to be carried out within the National Health Service, without admission of liability.

10. I observe that the district finance officer wrote to the administrator in October questioning whether the necessary remedial dental work should be done by the National Health Service dental service. No such offer was made so the complainant made her own arrangements, thus incurring expense which she need not have done. I think that the question of negligence was something of a red herring. I think the Authority should now consider making some financial recompense to the complainant.

11. I also invite them to impress on staff at the hospital the need to ensure that accident report forms are completed promptly following each occurrence. There is, however, no evidence that the delay in completing one in this case influenced the way the Authority dealt with her claim.

Case No W448/76–77—Lack of information about a relative's illness and death
Complaint and background

1. The complainant's aunt, aged 74, was admitted to hospital A on 4 May 1976 with chronic rheumatoid arthritis. On 7 May a fracture of the right femur was diagnosed and on 10 May 1976 she was transferred to hospital B, where she died on 17 June 1976.

2. The complainant first wrote to the Area Health Authority (the Area Authority) about his aunt's treatment in hospital A and later about the circumstances surrounding her death in hospital B. He also complained to the Regional Health Authority (the Regional Authority) about the actions of the Area Authority.

3. Following a meeting with the consultant orthopaedic surgeon responsible for his aunt's care at the time of her death, the complainant remained dissatisfied and complains that:

(*a*) he was not informed, before his aunt's death, why her condition was deteriorating or told what treatment she was receiving;
(*b*) the consultant had after his aunt's death withheld information about her illness and death;
(*c*) the Area Authority and Regional Authority have failed to provide an adequate reply to his complaints.

Investigation

4. I cannot investigate actions arising wholly from the exercise of clinical judgment and have therefore excluded from my investigations complaints relating to the complainant's aunt's diagnosis and treatment. But I have obtained information about the medical background in order to understand the circumstances which gave rise to the complaint. I refer to this information in my report.

(*a*) *The complaint that the complainant was not told why his aunt's condition was deteriorating or what treatment she was receiving*

5. The complainant told my officer that until her admission to hospital in May 1976 his aunt, who suffered from chronic rheumatoid arthritis, had lived alone in a wardened old people's bungalow and had been entirely self-sufficient. She had been admitted to hospital A on the advice of her family practitioner for general rehabilitation treatment. A day or two after her admission she had complained of intense pain during a physiotherapy session, and physiotherapy had been stopped. A few days later she had been transferred to hospital B and he had been told that she had a suspected fracture of the right hip, for which a 'pin and plate' operation would be necessary. A nurse had asked him to sign a consent form, but the operation had then been cancelled but he had not been told why. His aunt's condition had then rapidly deteriorated but he was assured that there was nothing wrong with her apart from old age. On the night of 16/17 June he was telephoned and warned of her imminent death.

6. In his report to the Area Authority following the complaint, the consultant geriatrician said that he had visited the complainant's aunt on 4 May in response to a request made the day before by her family practitioner, who had noticed that she had become bedfast. She had told him her arthritis had been steadily getting worse and that she had been confined to bed for two days. There was no history of injury to her right hip nor any complaint of pain in that region. She had been admitted to hospital the same day, and was again examined on admission with similar results. Routine investigations were carried out but, as the arthritic condition was apparent, and there were no specific complaints about her hip, x-ray examination of the joints was not thought necessary. I have seen the medical case notes relating to this examination, which are detailed and comprehensive. The consultant told my officer that, as the complainant's aunt had been admitted to improve her mobility, arrangements had been made for her to be assessed by a physiotherapist and this was done the following day, 5 May. The physiotherapist told my officer that she assessed each patient before commencing treatment. She had found the complainant's aunt to be rational and co-operative and with her aid, and that of a colleague, she had walked about five steps. She had complained of pain, but this had not been unexpected in view of her arthritic condition, and was not related to any specific part of her body. The process had been repeated the following day and she had complained of generally increased pain. The session had been discontinued and she was put back to bed to rest.

7. The ward sister told my officer that she had not been present during the physiotherapy session, but on 6 May, when she had been informed by her staff of the complaint of pain, as a result of which the complainant's aunt had been put to bed, she informed a doctor. His examination had not revealed any of the normal external signs of a fracture. The following day, as pain still

persisted, an x-ray of the pelvis had been ordered, and this revealed a fracture of the femur. The consultant geriatrician told my officer that, in view of the patient's age and general condition, and the possibility that the fracture was of long standing, he had not considered immediate surgery appropriate, but he had arranged for her to be transferred to hospital B under the care of an orthopaedic surgeon. The transfer took place on 10 May. The ward sister told my officer that she had had a long talk with the complainant before his aunt was transferred, during which he expressed his dissatisfaction and concern. She did her best to reassure him, and offered to arrange an interview with the doctors concerned with his aunt's treatment, but he did not take this up.

8. The consultant orthopaedic surgeon at hospital B told my officer that on admission, the complainant's aunt was medically examined and her leg put in traction. Arrangements were put in hand for a 'pin and plate' operation to be performed, but when he saw her on 12 May he decided that a surgical repair on such an old fracture would not be appropriate, and the operation was not performed. He did, however, consider a hip replacement as a longer term possibility, but in the event her general condition did not improve sufficiently to permit this. He would have been willing to discuss her progress at any time with the complainant or other relatives, but had not been asked to do so.

9. I have seen the medical and nursing notes completed at hospital B, which indicate that the condition of the complainant's aunt fluctuated markedly during her stay, though there are clear signs of deterioration during the few days before her death on 17 June. A note of 14 June reads 'condition is deteriorating; relatives informed of poor condition'. A ward sister confirmed that relatives had made enquiries every day, sometimes more than once, and appeared to find difficulty in appreciating that her condition was not stable. The night sister on duty on the night of 16/17 June, who warned the relatives of the patient's impending death, told my officer that, having seen her two days previously, they found it difficult to believe that she was dying. She suggested that they should talk to a doctor but they chose not to do so.

10. I have seen the consent form which the complainant was asked to sign. It has two parts, the first to be signed by the patient or a relative once he or she is satisfied with the explanation, given by a doctor, about the nature and purpose of the operation to be performed. The second part is designed to be completed by the doctor who undertook the explanation and his confirmation that he has done so. The form I have seen has the first part signed by the complainant but the second part has not been completed. Though the part signed by the complainant bears the orthopaedic surgeon's name as having explained the nature and purpose of the operation, he told my officer that he had not done so and did not in fact know that the consent form had been completed. The senior nursing officer told my officer that it was common practice for ward sisters to obtain consent for operations in advance, in order to allow preparations such as blood matching to take place in good time, the remainder of the form being completed subsequently. In this case the operation had been cancelled and therefore the doctor had not completed his part of the form.

Findings

11. The extent to which nursing staff can give details of a patient's condition and treatment is necessarily limited, as they are not qualified to give opinions on clinical matters or speculate on the progress of the patient's illness. I am satisfied,

however, that the nurses responsible for the complainant's aunt's care gave the relatives as much information as they could, and no doubt in doing so felt the need to avoid causing them undue distress or alarm. I note that, in his correspondence and discussions with the Area Authority, the complainant has specifically exempted nursing staff from any criticism and conveyed to them his gratitude and thanks. I have been told that the doctors concerned were ready and willing to talk to the complainant or the other relatives about his aunt's progress while she was in hospital but that he did not take up the offers of interviews nor does it appear that he himself took the initiative by asking to see a doctor. I cannot therefore support the complaint in this respect.

12. I have no evidence of what the complainant was told about the cancellation of the operation or when, but I note that his letter of 15 May to the Area Authority mentions the possibility of a hip replacement, which suggested that he was aware at that time of the consultant's revised decision. Nevertheless, I would regard any delay, however slight, in letting him know of the cancellation and the reasons for it as undesirable. A relative, having been asked for his consent, would naturally be anxious for news of the outcome and such anxiety should not be unnecessarily prolonged. I am, however, more concerned at the manner in which the consent was obtained. On 2 February 1971, the Department of Health and Social Security wrote to secretaries of Regional Hospital Boards telling them that agreement had been reached with the medical defence societies on a model form of consent. The letter was accompanied by copies of the agreed model (on which that used in the present case was based). This provided for a certificate by a physician or surgeon that he had explained the nature and purpose of the operation to the patient or relative. The Department's letter referred to the duty to obtain a 'fully informed consent'. Guidance given to its members by at least one of the medical defence organisations emphasises that the explanation should be given by a medical practitioner, who should sign the consent form confirming that he has done so. This advice was not followed in the present case, though in my view it represents a proper and necessary safeguard of the interests of patients and those responsible for their treatment. As it happened, the operation was cancelled and consent was not needed. I understand that the Area Authority have, since my investigation was completed, instructed medical staff to ensure that they give the necessary explanation to the patient or relative.

(*b*) *The complaint that the consultant withheld information*

13. The complainant told my officer that his complaints to the Area Authority up to his aunt's death culminated in a meeting with the consultant orthopaedic surgeon, which took place on 12 February 1977. Though he had been told by the Area Authority that he would be allowed to examine his aunt's case notes, the meeting was conducted in such a way that he was not given an opportunity of doing so, and the consultant failed to give him satisfactory explanations of the points he had raised.

14. The Area Authority told my officer that, as the complainant had not been satisfied by their written replies, they had decided to offer him a meeting with the consultant orthopaedic surgeon. He had agreed to this but had asked to be allowed to see his aunt's case notes before the meeting. This had been an unprecedented request and although they were themselves prepared to agree to it they had decided they needed the consultant orthopaedic surgeon's consent

in consultation with his medical defence organisation. The complainant finally agreed to a meeting, subject to the condition that the notes would be available for him to study. At the meeting itself, the complainant had been allowed to examine the notes, and the consultant orthopaedic surgeon had described the sequence of events by reference to them. The complainant had not, however, been permitted to remove them for private study.

15. The consultant orthopaedic surgeon told my officer that he had not thought it necessary to consult his medical defence organisation and had agreed to the meeting on the understanding that he would talk through the notes with the complainant. He had seen no reason not to tell the complainant as much as he had wanted to know and he had gone through the case in some detail. He had paid particular attention to the post mortem report, as the complainant had complained that the certificate issued as a result had differed in some respects from the information given on the certificate issued at the time of his aunt's death. He had explained that there was no conflict between the two documents as regards the main cause of death, which in each case was recorded as pneumonia, and that secondary conditions revealed by post mortem examination had not had a significant effect. He had pointed out that the post mortem had shown the age of the fracture as at least two to three months at the time of death, but the complainant had not been able to accept this.

Findings

16. The complainant wished to examine his aunt's medical notes at leisure and in private and this was not granted. It is unfortunate that he should have been given the impression that it would be before the consultant had been asked for his view. But I am satisfied that he was allowed to consult them at the meeting and that no attempt was made to conceal any of the facts they contained. I am satisfied, also, that the consultant orthopaedic surgeon's explanations were given in a genuine attempt to ensure that the complainant was informed of all the relevant details. In fact, his willingness, and that of the Area Authority, to allow a layman access to a patient's case notes was highly unusual and very open. Although the complainant would no doubt have preferred to have himself determined the course of the discussion and to have dealt with some points in greater detail, I think he was given the basic facts.

(*c*) *The complaint that the Area and Regional Authorities have failed to provide adequate replies to the complaints*

17. The complainant first wrote to the Area Authority on 15 May 1976 complaining about his aunt's treatment during her stay in hospital A. He had already been in telephone contact with them and steps had been taken to arrange a meeting with the consultant geriatrician. This had not been possible due to the complainant's own admission to hospital and the consultant's absence on holiday. Instead, a full reply was sent to the complainant on 17 June. This explained in detail the examinations carried out on admission and the treatment subsequently given. The complainant was not satisfied with this and continued in telephone contact with the Area Authority, who arranged a meeting with the senior nursing officer at hospital B on 13 August. The complainant was still dissatisfied, and after further informal discussions the Area Authority told him that he could ask the Regional Authority to conduct an independent enquiry into the circumstances of his aunt's death. This he did on 26 October.

He received from the Regional Authority an acknowledgement dated 3 November and a reply dated 29 November which expressed the view that the Area Authority's investigation had been satisfactory, and drew attention to the fact that the coroner had upheld the Area Authority's view that an independent enquiry was unwarranted. The Regional Authority also commented that the complainant had on several occasions been invited to meet the consultant geriatrician and the administrative officer, but had been unable to take up the offer; they suggested that further arrangements be made for a meeting. The complainant replied on 6 December pointing out that only two tentative appointments had been made for him to meet the consultant geriatrician, both of which had had to be cancelled for reasons outside his control. In any case the consultant geriatrician had been responsible only for his aunt's treatment at hospital A, and would not have been able to answer questions about her treatment at hospital B and about the circumstances of her death. The complainant made the further point that he had seen the senior nursing officer but that she was inadequately informed and could not answer his questions. He had spoken at great length to the assistant administrative officer, but had not been offered an appointment with the administrative officer himself. He again detailed the points on which he sought further information, and asked for an assurance that his aunt had received the best possible care and treatment whilst in hospital. In reply, the Regional Authority told the complainant that arrangements were being made for a meeting with the consultant orthopaedic surgeon at hospital B, and expressed their confidence that a personal talk would resolve his worries. In response to the telephone call from the complainant, the Area Authority wrote on 16 December giving further details of the results of the post mortem examination and asking the complainant when he would like the proposed meeting to take place. The complainant wrote again to the Regional Authority on 2 January 1977, asking for specific replies to his questions. The Regional Authority's reply on 6 January reiterated their view that the points should be cleared in discussion with the consultant responsible. Arrangements for a meeting on 14 January between the complainant and the Area Authority were made by telephone, but the complainant's request to see the case notes, and the consequent necessity to obtain the consultant's approval, caused a postponement. A meeting eventually took place on 12 February. The complainant remained dissatisfied and referred the matter to his MP who asked me if I could investigate.

Findings

18. The original complaint concerned the complainant's aunt's treatment in hospital A, and the Area Authority's reaction in attempting to arrange a meeting with the consultant geriatrician was in my view a proper response. When difficulties arose in arranging the meeting, the Area Authority gave the complainant a comprehensive written explanation of the course of events. Thereafter, apart from an interview with the senior nursing officer, contacts continued on an informal basis until the complainant wrote to the Regional Authority. I am unable to say precisely what took place during this period but I think it unfortunate that in view of the complainant's continuing dissatisfaction, which up to that point appears to have been exclusively concerned with medical treatment and diagnosis, further attempts were not made to arrange a meeting with a senior member of the medical staff. Apart from this the evidence

suggests that the Area Authority made genuine efforts to give the complainant the reassurance he sought. I can, however, understand his dissatisfaction with the response he received from the Regional Authority. The initial reply contained an unjustified implication that he had refused several invitations to meet the consultant and he should have received an apology for this. He was probably not aware that the Regional Authority have no direct responsibility for the actions of the Area Authority in dealing with complaints, and an explanation of the limitations of their powers would perhaps have modified his sense of grievance at having his questions referred back to the Area Authority, whose answers he had already deemed unsatisfactory. The subsequent delays in arranging the meeting, do not, in my view, reflect on either Authority in so far as they arose from attempts to meet the conditions the complainant had sought to impose.

Conclusions

19. I have given my findings in relation to the specific complaints. In general I have not been able to uphold them, though I have commented on the manner in which consent is obtained for operations, which I consider to be unsatisfactory. I am glad to learn that instructions have been given to ensure that explanations are given only by medical staff. I think that the meeting with the consultant could have taken place earlier, and that the Regional Authority could have been more forthcoming, but that on the whole the Area Authority made reasonable efforts to answer the complainant's questions. I hope that he will now be able to accept the assurances he has been given.

Case No W456/76–77—Loss of patient's property

Complaint and background

1. The complainant's husband suffers from a mental illness and has been an informal patient at a hospital on a number of occasions. On 19 February 1976 he was admitted to ward a of the hospital and on 6 April he was transferred to ward b. On 20 May, whilst he was at home on leave, he was informed of his discharge. The following day, when he returned to the hospital to collect his belongings, he found that a suitcase was missing and, on his return home, he found that other belongings had not been returned to him.

2. The complainant claims that the hospital did not take proper precautions to safeguard her husband's belongings and that when the losses were brought to their notice they did not take adequate steps to recover them.

Investigation

3. In her letter to me, and in discussion with my officer, the complainant said that when her husband went to the hospital on 21 May 1976 to collect his property he found that a suitcase which was marked with his name and which was kept in a locked store on the ward was missing, and the personal belongings which he had left locked in his bedside locker while he was at home on leave had been removed and put in a plastic bag. She said that when he returned home he found that several items were missing.

4. The complainant's husband told my officer that he had drawn the attention of a nurse to the missing suitcase when he collected his belongings and, on his return home, he had written to the unit administrator at the hospital listing

all the missing items. The complainant said that, in response to her husband's letter, the unit administrator had sent him a pair of trousers, two face flannels and a pair of slippers but, apart from the slippers, the items had not belonged to him. She said that she had destroyed the face flannels because of their condition and she had returned the trousers to the hospital. On 16 June she wrote to the unit administrator telling him about the trousers and asking him if he would make a further search for the missing belongings, including the suitcase, and suggested that if they could not be found he should arrange for a payment to be made to enable her to replace them.

5. In a statement she made about the incident, the sister in charge of ward b said that she had been on duty when the patient was transferred from ward a and that at that time he had his possessions in a suitcase; no list of property had been received from his former ward. She said that the patient had not handed in any property for safe-keeping, and that he was capable of looking after his own belongings. The state enrolled nurse who was on duty when the patient came to collect his belongings on 21 May 1976 said in her statement that the contents of his locker had been put into a plastic bag and, when she handed this to him, he had asked for his suitcase. She said she immediately checked the store room and the bedside locker but could not find it. The next day she asked other staff if they knew of any of the patient's property which was still on the ward, and a further search was carried out without success.

6. The unit administrator told my officer that when he had received the letter of 21 May from the patient he had made arrangements for a search to be made, and as a result a pair of trousers, a pair of slippers and two face flannels were discovered, which were thought to be the patient's property, and these had been sent to him. He said that when the complainant returned the trousers a further search had been made, but to no avail. The unit administrator said that there was no procedure in force at the hospital under which the belongings of a patient who was absent on leave would be listed and taken into safe keeping. Patients were expected to look after their own clothing and personal effects, with the exception of valuables for which a procedure was laid down. But he agreed that, as the suitcase had been stored in a locked room on the ward it was effectively in the care of the hospital, even though no record had been made of it.

7. The consultant responsible for the patient's care told my officer that the decision to discharge him whilst he was on leave from the hospital was taken because the social worker who had called on him reported that he had settled down at home, and there was no point in bringing him back to the hospital unnecessarily. The consultant also said that the patient would be aware of his possessions and know whether any of them were missing. My officer interviewed the nurses on ward b but none of them could remember who had emptied the bedside locker while he was on leave.

8. I accept the statement of the complainant's husband that when he went on leave he left some of his belongings locked up in his bedside locker. I also accept that when the ward staff were informed of his discharge it was probably necessary to empty the locker in readiness for the next patient. But I think that this should have been done by two members of the staff; that a list should have been prepared of the items which were packed for the patient to collect and signed by the staff concerned; and that a receipt should have been obtained from him at the time they were handed over. As to the suitcase, I find it difficult to

see how this could simply disappear when it was stored in a locked room to which only the hospital staff had access. I therefore uphold the complaint that inadequate precautions were taken to safeguard her husband's effects; but I am satisfied that when the patient's husband reported that some of his belongings were missing the hospital staff took proper steps to try to trace them.

Conclusions

9. I see no reason to doubt that the items listed by the complainant's husband were lost at the hospital whilst he was on leave, and I invite the Area Health Authority to consider making an *ex gratia* payment to the complainant which will go some way toward helping her to replace them.

Case No W468/76–77—The way in which a complaint was handled by two family practitioner committees

Complaint and background

1. The complainant's wife became ill on 14 September 1976 while they were on holiday. He approached several family practitioners but was unable to obtain National Health Service treatment. He eventually obtained private treatment from another family practitioner. On returning home the complainant wrote on 26 September to his local Family Practitioner Committee (FPC 1) and suggested that he should be able to recover the cost of private treatment from the Health Service. In his reply of 29 September the administrator of FPC 1 told the complainant that no refund could be made, but suggested that he contact the Family Practitioner Committee for the holiday area (FPC 2) if he wished to pursue the matter.

2. The complainant's Member of Parliament wrote, on his behalf, to the Secretary of State for Social Services on 13 October. In his reply of 13 November the Minister of State said that if a person urgently required medical attention and could not for any reason get in touch with his family doctor he might approach any other doctor practising under the National Health Service and ask for emergency treatment as a temporary resident. The Minister further said that a doctor was not obliged to agree but must nevertheless, if so requested, give the patient any treatment which is immediately necessary for up to 14 days or until the patient is accepted elsewhere as a temporary resident, whichever is the sooner. If a holiday visitor considered that he had been unfairly denied immediately necessary medical treatment, after having given full details of his symptoms to the doctor concerned, it was open to him to make a formal complaint to the local family practitioner committee concerned. The Minister also said that if the complainant wished to pursue the matter with FPC 2 he should mention in his letter that he had first written to FPC 1 on 26 September.

3. The complainant wrote to FPC 2 on 18 November, and again on 28 December as he had not received a reply. On 7 January 1977 the FPC 2 administrator replied; he apologised for the delay, set out the difficulties involved in resolving the complaint, and asked what further action the complainant wished him to take. He also said he felt sure the FPC 1 administrator would help the complainant if he wished to discuss the matter further. When he received this

reply the complainant thought the matter so complex and that he had so little hope of succeeding with his claim that he again approached his Member of Parliament, who wrote to me on 21 March.

4. I was unable to investigate that part of the complaint concerning the refusal of family practitioners to treat the complainant's wife as a National Health Service patient, since the actions of doctors taken in connection with the services they provide under contract with family practitioner committees is outside my jurisdiction. Those aspects of the complaint which I was able to investigate were that:

(*a*) the reply from FPC 1 was inadequate and did not explain the need to complain within the statutory period of eight weeks laid down in the National Health Service (Service Committees and Tribunal) Regulations 1974;

(*b*) the delay by FPC 2 in replying to his letter was excessive and the reply received was inadequate.

Investigation

(*a*) *The complaint that the reply from FPC 1 was inadequate*

5. In his reply to the complainant the administrator said he was sorry the complainant had been unable to obtain the services of a doctor under National Health Service arrangements, but regretted that the Service was unable to refund any charges incurred as part of private treatment. He said he understood from the administrator of FPC 2 that doctors in the holiday town were most reluctant to accept holiday visitors for National Health Service treatment, but pointed out that doctors were free to refuse to accept patients as temporary residents if they so wished. He said he would be happy to explain any point which seemed unclear but suggested that, if the complainant wished to go into the matter in depth, he should contact the administrator of the FPC 2.

6. The administrator of FPC 1 told my officer that the complainant's letter was unusually brief and contained very little information about the nature of the complaint. He agreed that he might have dealt with it by sending the letter to FPC 2, telling the complainant that he had done so, but he felt there was insufficient information in it to justify such action. He also felt it would be more helpful to show an interest and offer some advice, but agreed that, in retrospect, it might have been better to adopt the first alternative. He had not referred to the eight week rule governing the submission of complaints to FPC's as he had taken the letter as an application for reimbursement of fees rather than as a complaint. In any case, he had assumed that the complainant would take his advice and contact FPC 2 without delay. He said that the sentence in his reply that 'doctors in [the holiday town] are most reluctant to accept holiday visitors for NHS treatment' had been made in error. He had made such a comment when discussing the case with his administration officer, whom he had asked to deal with the reply and who had sent the letter, but he had not intended that it should be included. Had he seen the letter before it was sent he would have deleted the sentence; nevertheless, he took full responsibility for his officer's action. He confirmed that the comment had not been prompted by information from FPC 2, but arose from impressions of discontent he had himself gained from fellow holidaymakers who had required emergency attention when he had been on holiday.

7. The administrator said he had visited the complainant at the request of his FPC 2 colleague who had, after replying to the complainant, asked him to explain to the complainant the difficulties involved in pursuing the complaint. He had told the complainant about the obligation of doctors and explained the complaints procedure but told my officer he felt he was wasting his time because the complainant seemed to have formed the mistaken view that the object of the visit was to discourage him from pursuing the complaint, which it was not.

Findings

8. Although the complainant's first letter to FPC 1 did not explicitly say he wished to complain, it was, I think, evident that he was dissatisfied, since it stated that he had tried without success to get help for his wife from three doctors. The administrator's reply of 29 September acknowledged that a grievance existed by expressing regret at the complainant's failure to obtain the services of a doctor under NHS arrangements. The reply stated that no refund of charges for private treatment could be considered and that family doctors were free to refuse to accept patients as temporary residents, but it made no mention of their obligation to provide emergency treatment. It therefore appeared to discourage the complainant from pursuing the matter. The complainant was advised to contact the FPC 2 if he wished to 'go into the matter in depth' but was given no advice about the complaints procedure, nor was he told of the time limit. The administrator has made the point that the information in the letter of complaint was insufficient to justify sending it on to FPC 2. In that case, it was surely inadvisable for him to have attempted a substantive reply. I think he should have sent on the letter and told the complainant he was doing so. The observation about the attitude of doctors in the holiday town was unfortunate and may have led the complainant to believe that a general problem existed in that area and to pursue the matter more forcefully. I note that the letter was written in the first person, and signed in the administrator's name. It therefore purported to represent his personal view, and to have been written or at least approved by him. FPC 1 might usefully consider adopting the practice commonly accepted in the public service of having appropriate letters signed by their author.

9. On all these grounds, therefore, I find the administrator's reply to the complainant's letter to have been inadequate, and I support this aspect of the complaint. I accept that the administrator's visit to see the complainant at his home was intended to reassure him and to give him the information he needed. It is unfortunate that the complainant got the impression from this visit that he was being dissuaded from pursuing the complaint, possibly because the administrator's stated remit from the FPC 2 administrator was to explain the difficulties of solving the complainant's problem.

(*b*) *The complaint that the reply by FPC 2 was unduly delayed and inadequate*

10. When the complainant wrote to the administrator of FPC 2 on 18 November he explained that he had telephoned six surgeries without success despite stating in each case his wife's symptoms and his own concern. He could not remember all the doctor's names or the individual reason given but he gave the names of three doctors. He expressed concern about the administration of the health service in the holiday town and asked to be reimbursed the medical and prescription charges he had incurred.

11. When the administrator wrote on 7 January 1977 he apologised for not having replied sooner and for appearing discourteous. He said this was because the letter arrived while he was absent on sick leave and pre-Christmas pressures had prevented him from dealing with it. He said he was surprised to read that the complainant had been told by his colleague in FPC 1 that local doctors were 'most reluctant' to treat holiday visitors under the National Health Service and said this was not borne out by the statistical evidence of such treatments, which he quoted. He detailed the ways in which a complaint against a practitioner was normally dealt with by a FPC; these were amplified in an explanatory memorandum which he enclosed. The administrator said that any repayment of fees would be possible only if, after a full formal investigation, it was established that the doctor concerned had been in breach of his terms of service and that as a result of this breach the complainant was involved in expense. He drew attention to a number of difficulties in resolving the complaint in this way. He referred to the lack of detail about the specific circumstances of the complaint, saying that it would be difficult to take action against several doctors and asking in what specific respect the doctor concerned was in breach of his terms of service. While acknowledging that the complainant's approaches to FPC 1 and to his MP justified the delay, the administrator pointed out that the fact that the complaint was received after the eight weeks' limit would introduce another hurdle which had to be cleared before further action could be taken. He concluded by asking the complainant what further action he wished him to take and suggested the possibility of informal discussion with the FPC 2 administrator.

12. The administrator told me that an earlier reply was not sent for several reasons. He said the basis of the complaint was unclear and unspecific and the terms of the reply required time for consideration. The complaint was outside the time limits laid down by regulation and this point required careful explanation. The approaches to FPC 1, to the MP, and to the Department of Health and Social Security did not in any way alter the position, although they might well have been considered by the medical service committee to have provided reasonable cause for the delay in the event of a request for formal investigation. A request for a refund of the cost of private treatment could only be dealt with after a full investigation under the Service Committees and Tribunal Regulations. The administrator told me he had felt that the complainant was not clear about which of the doctors he may have tried to contact over the telephone and it was therefore unlikely that he could be specific about the precise nature of the message he gave to each of their receptionists and the response he received. He said that the suggestion that doctors in the holiday town were reluctant to treat patients under the National Health Service was unfounded and needed special consideration. The administrator said that important and complex complaints of this kind could only be dealt with by an administration officer, and one of the four such posts on FPC 2's establishment had been vacant from August 1976 to January 1977. The administrator himself had been on sick leave in October and November and the consequent backlog of work had caused delay in some less urgent matters. An interview would have been advisable but was impracticable as the complainant lived far away. This fact also prevented him from dealing with the case under FPC 2's informal procedure for complaints. The administrator stated that he felt his letter to the complainant had given the basic information necessary to enable

him to decide what action he wished him to take. As a result of the help provided by his colleague in FPC 1, a full oral explanation had been given to the complainant of the problems of meeting his request and of dealing with his complaint under the informal and statutory procedures. He pointed out that the final paragraph of his letter to the complainant said 'please let me know what further action you wish me to take', but no acknowledgement or further communication had been received.

Findings

13. I accept that the reasons given by the administrator for not replying earlier to the complainant's letter of 18 November justified some delay in sending a full and considered answer to all his points and I note that a suitable apology was made, but they do not excuse the absence of an acknowledgement or interim reply. The reply itself was, in my opinion, framed in a manner likely to discourage further action by the complainant and consisted mainly of a list of reasons why the complaint might fail. In particular I regard as unfortunate the wording of the paragraph related to the 'eight weeks rule'. This referred to justification for the delay but went on to say that this did not alter the fact that the complaint was late. I think this in itself must have acted as a deterrent to the complainant from pursuing the matter with the Committee. Again, the offer of an informal interview by the FPC 1 administrator was accompanied by the reservation that its purpose would be to 'explain the statutory complications which might appear from this letter to be unreasonably obstructive'. I think it not surprising that the complainant did not see much point in taking up the invitation to let the administrator know what action he wished him to take.

14. I consider the complaint that FPC 2 failed to deal adequately with the complaint to be justified. There was in my opinion a clear allegation of failure on the part of one or more doctors to provide emergency treatment in accordance with the terms of contract. It was appropriate for the administrator to seek further information and quite proper to include a reference to the conditions which needed to be satisfied, but I think that undue emphasis was given to obstacles and difficulties, which certainly gave the complainant the impression of seeking to discourage him from pursuing his complaint.

Conclusion

15. The administrators of both FPCs appear to have concluded that the complaint or application for refund of fees would have little chance of success. I believe this affected the way in which they dealt with his complaint. The FPC 2 administrator has already apologised for the delay in replying to the complainant's letter of 18 November. I conclude that the overall effect of the administrators' actions was to deter the complainant from pursuing his complaint. I understand that the complainant, having been informed that it would be necessary for him to travel to the FPC2 area to attend a hearing, does not wish to pursue his request for a refund. Should he wish to do so, however, I hope that FPC 2 would be prepared to consider his complaint under the normal procedure even at this late stage.

Case No W473/76–77—Delay in admission to hospital

Complaint and background

1. On 3 February 1977 the complainant visited his brother at his home and found him in a collapsed condition. The family practitioner visited on 7 February, and on 11 February he made a written request to hospital A to admit the complainant's brother as an in-patient. A doctor from the hospital saw him at home on 14 February and it was then decided to place him on the priority waiting list for admission either to hospital A or hospital B. He was visited by a family practitioner on 21 February and again on 24 February after the complainant had again found him in a state of collapse. That evening he was seen in a very distressed condition by a neighbour. A local councillor was asked to help and arranged for his immediate admission to an old people's home. He was transferred to hospital C on 26 February and died there on 27 February. The councillor complains that there was unjustified delay in admitting the complainant's brother to hospital, and that his death might have been averted had he been admitted earlier.

Investigation

2. On 27 February the councillor wrote to the Area Medical Officer of the Area Health Authority responsible for hospitals A and B (Authority 1) and said that he had been called after midnight on 25 February to see the complainant's brother, who was in extreme distress caused by frequent vomiting and nausea. The complainant's brother had informed him that he should have gone into hospital three weeks previously but his family practitioner had been refused a bed. The councillor had not been prepared to leave him in this condition and arranged through the Area Director of Social Services for him to be admitted to an old people's home. The councillor said that he was very critical of medical aid and subsequent back-up and suggested that the Area Medical Officer's department had not taken sufficient grasp of the situation.

3. In his reply of 18 March, the Area Medical Officer said that the request from the family practitioner for the complainant's brother's admission to hospital had been received by hospital A on Saturday 12 February. As there were no beds available for his admission to the geriatric unit, he was placed on the waiting list. The locum family practitioner (the duty doctor) was advised on 12 February that if his condition caused further concern the bed bureau should be contacted in order to arrange admission under the care of a general physician. A senior assistant geriatrician had visited the complainant's brother at his home on 14 February and confirmed his place on the geriatric waiting list. When further representations were made during the subsequent ten days, it was still not possible to admit him to a geriatric bed, but his family practitioner was repeatedly advised to request his admission through the bed bureau to another hospital or unit. The geriatric department had been told by the social services department on 25 February that the complainant's brother was in an old people's home and he was transferred to hospital C when a bed became vacant there next day. The Area Medical Officer concluded by saying that resources for dealing with geriatric patients were limited and the accepted pattern of dealing with such a situation when geriatric beds were not available was to refer the matter back to the family practitioner so that he could invoke

the help of general physicians if he felt such action was required. Neither the councillor nor the complainant were satisfied with this reply and the councillor wrote to me on 23 March.

4. The complainant told my officer that the hospital doctor who visited his brother on 14 February had said that there were no beds available, but it was possible that he could be taken daily by ambulance to hospital or that he could be admitted for three days. His cousin visited hospital A on Friday, 18 February and Monday, 21 February and was told that the complainant's brother was 'priority list No. 1'. The councillor told my officer that on 24 February a neighbour of the complainant's brother had telephoned him at about 10.00 pm and told him a man was dying. He visited the complainant's brother just past midnight and found him in extreme distress. He contacted the area director of social services, who told him there were no local authority beds available but later called back to say that he would arrange to admit the complainant's brother to an old people's home. The councillor did not know whether neighbours had called the family practitioner or the hospital or if they had requested an ambulance. Had the complainant's brother not been offered a bed by the social services department, he would have himself called an ambulance or taken him by car to a hospital casualty department.

5. The sector administrator who has responsibility for day to day management of hospital A told my officer that the geriatric department was responsible for geriatric beds at hospitals A, B, X and Z. Hospital C admitted patients from both Authority 1 and the second Area Health Authority (Authority 2), although it was essentially for Authority 2 patients. The administrator explained that requests for domiciliary assessment visits received from family practitioners would be registered, and a consultant would then indicate which doctor should visit the patient. On return from the visit, the doctor would tell the medical secretaries what to do (*ie* whether to put the patient's name on the waiting list, admit immediately or arrange for day hospital or out-patient attendance). The patient's family practitioner would then be informed. For those placed on the waiting list the forms would be filed and an index card completed indicating the priority in admission. The medical secretaries responsible for keeping these records told my officer that the doctors reviewed the waiting list each morning and examined the domiciliary visit sheets, index cards (which form the waiting list) and bed state returns which were obtained by telephone from the medical records department each morning. The patients' names listed on the cards were marked 'priority', 'very urgent', 'urgent', or left blank. One of the secretaries remembered that a relative of the complainant's brother had called at the office but said she would not have specified a date for his admission; she would not in any case be in a position to do this as the decision was made by the doctors.

6. The sector administrator told my officer that the bed bureau operated as a means of informing family practitioners of the whereabouts of vacant beds. It did not arrange admission—this was the responsibility of the practitioners—and it was not part of its function to seek to persuade a hospital to admit a patient. The services of the bed bureau were not needed for admissions to geriatric hospitals as a geriatric doctor was available 24 hours a day and the number of beds available would be readily ascertainable. A family practitioner enquiring on behalf of an elderly patient needing urgent treatment,

and for whom no geriatric bed was available, would be advised to apply to the bed bureau. The administrator said that, had the councillor or neighbours or relatives called an ambulance, one would have attended even if the family practitioner had not been consulted. On attendance at the hospital accident and emergency department, the patient would have been examined and, if considered in immediate need, would have been admitted to one of the hospitals in the district. Social circumstances would have been taken into account in deciding whether or not to admit.

7. The doctor from hospital A who made the visit to the complainant's brother on 14 February confirmed to my officer that she had promised that he would be placed on the waiting list and that he would be admitted as soon as possible, but she had been careful not to say that he would be taken into the next available bed. The complainant had clearly been disappointed that she could not promise immediate admission. The complainant's brother was not in pain or distressed, and looked quite well, but she observed certain symptoms which suggested it would be advisable to admit him to hospital for observation. There were usually about five or six patients requiring priority admission at any time. Patients with the same medical priority would be taken in order according to the date they were placed on the waiting list, though the order could be changed if circumstances justified it. She acknowledged that she had mentioned the possibility of using a day hospital, and had explained how patients were taken daily, but had only done this in the context of a description of the alternative facilities available. She would not, however, have considered daily visits by ambulance as appropriate in this case. She had spent some 20 minutes talking to the complainant and examining his brother who she thought at the time had understood her explanations. She had not seen the complainant's brother after his admission to hospital C.

8. The consultant geriatrician at hospital A (the consultant) told my officer that, on receiving the request for a domiciliary visit to the complainant's brother on Saturday, 12 February, he had sought further information from the family practitioner, but he was not available. He spoke to the duty doctor from the family practitioner deputising service, but found him unfamiliar with the details of the patient's condition. The consultant had advised the duty doctor to try to find a bed in another hospital, and promised to review the situation on the following Monday. He told my officer that the decision whether or not to admit the complainant's brother would have been made in the course of a daily consultation between himself and three colleagues. Account was taken of physical, social and mental conditions, and he thought that the complainant's brother probably would have been admitted had there been a vacant bed. He confirmed that he had been placed on the priority waiting list, and that this was the most urgent category. He also confirmed that the day hospital was used in some cases for monitoring and rehabilitation in order to prevent further deterioration but said that this was not suitable for all patients and that account had to be taken of the adverse effects of travelling. The consultant said that if a geriatric patient were brought to hospital by ambulance as an emergency and no bed was available he would be sent to any hospital in the area which could accommodate him, and there await transfer to hospital A or B when a bed became available.

9. I have examined hospital records and note that there appeared to have been two vacant beds in a ward at hospital B from 21 February till 26 February when the complainant's brother was admitted to hospital C. The consultant told my officer that at this time bed occupancy had been reduced and admissions stopped because of the shortage of nursing staff, and I have seen a copy of a letter which he wrote to senior nursing staff containing instructions to that effect. He thought that it was unlikely that the complainant's brother could have been admitted earlier to hospital C. As this was the only geriatric hospital serving Authority 2 he gave preference to patients on the priority waiting list in that area. He saw no merit in a common waiting list for the three geriatric hospitals (A, B and C) as he and his colleagues were in day to day touch with the situation. When no geriatric bed was available, it was the family practitioner's responsibility to find a bed elsewhere.

10. The medical assistant who arranged the admission on 26 February told my officer that he had been informed on 25 February of the need to admit the complainant's brother to the first available bed. He had telephoned all the wards in hospitals A and B, including those catering for long stay patients, and also spoke to the secretary of hospital C, where it was possible to place the complainant's brother the following day.

11. I have seen the medical case notes and nursing records relating to an examination of the complainant's brother on admission on 26 February and his treatment until his death the following day. These indicate that he had suffered a heart attack, though they also bear the comment that he was ambulant and that his condition was fair on admission. At 7.00 pm his relatives were informed that his condition was causing concern. He appeared to have improved by the next morning, but his condition suddenly deteriorated during the afternoon and he died at 3.30 pm. The post-mortem report, which I have seen, shows the main cause of death as congestive heart failure. The medical assistant who arranged the complainant's brother's admission on 26 February, and who examined him on that day, told my officer that the condition which caused his death could have arisen at any time. He was bound, in view of the diagnosis, to consider the possibility that death would ensue, but he was surprised that it had happened so suddenly.

12. The family practitioner told my officer that he had telephoned the hospital A geriatric department after the domiciliary visit by the hospital doctor asking for the complainant's brother's admission to be expedited. He had telephoned again later when the complainant attended his surgery and had also spoken to them at the request of the matron at the old people's home after the complainant's brother's admission there. He had from the first concluded that the only hospital likely to admit him was hospital A and it was with this in mind that he had made the initial application. From his experience, particularly with elderly patients, the bed bureau would be unable to find a bed except in an emergency, and he did not therefore think it worthwhile to enlist their aid. He had not arranged for the complainant's brother to be taken to hospital by ambulance, as he knew he would not be admitted if there were no vacant beds and the admitting doctor was not satisfied that he was in need of treatment as an acute case. While he thought that the complainant's brother should have been admitted earlier, he did not think that the delay had any material effect on the course of his illness. He confirmed that no one had asked him to visit the complainant's brother on the night of 24/25 February.

13. The other partner in the group practice recalled that there were delays of three to four weeks in arranging hospital beds for elderly people at the material time. He had spoken to the geriatric department and to the receptionist at hospital A in an effort to get a bed for the complainant's brother. On one occasion he had done this in the complainant's presence and was told that the complainant's brother was on the priority waiting list but that there were no beds. He recalled being told that a ward had been closed at the time. He agreed with his partner's view that there was general difficulty in getting patients admitted into hospital in the Authority 1 area and that this was not confined to geriatric cases. The situation was not so bad in the summer, when demand was lower and it was possible to admit elderly patients into ordinary beds, but in winter there were not enough geriatric and general medical beds to meet the demand. He saw no reason to believe that the delay in admission had affected the eventual outcome.

Findings and conclusion

14. The complainant's brother was an elderly man, living alone and in failing health. His family practitioner decided that he needed to be looked after in hospital, and formed the view that a geriatric hospital was most appropriate. This was endorsed by the doctor from hospital A who visited him on 14 February. Though he was treated as a priority case for admission, none of the doctors who saw him between 3 February and 26 February when he was finally admitted appeared to regard his condition at that time as justifying immediate treatment as an emergency. The decision of the visiting hospital doctor as to the degree of priority that should be given to his admission was taken in the exercise of clinical judgment, as were those of the family practitioners concerned not to seek an acute bed in a medical ward, and I do not question them. When the need for immediate admission was finally established, the complainant's brother was given a bed without undue delay. There seems little doubt that there are problems in the Authority 1 area in accommodating all those considered to need in-patient treatment, and that these problems were aggravated at the relevant time by the decision to reduce the geriatric bed occupancy at hospital B to maintain the quality of nursing care in a period of staff shortage. I have been told that, had there been a bed available, the complainant's brother would probably have been admitted earlier, and I have not found the delay to have been attributable to any administrative failure on the part of Authority 1.

15. I have been unable to establish precisely what the complainant was told about his brother's likely admission date, but accept that a misunderstanding did occur, possibly owing to the doctor's use of the word 'priority' which might have been taken to mean 'immediate'. Authority 1 may wish to consider how they might reduce the possibility of confusion, on the part of patients awaiting admission, as to the degree of priority they have been given. I am glad to learn that efforts are being made to establish a crisis intervention team in the locality, including representatives of the whole range of medical and social services, to cope with acute physical or mental disorder in the frail elderly. Had this existed at the time, it might have helped the complainant's brother.

16. The opinion of the two family practitioners, both familiar with the complainant's brother's condition while he was waiting to be admitted, confirmed by that of the hospital doctor who examined him after admission, was

that the delay had no significant effect on the condition from which he died. I understand that the councillor and the complainant now accept this and that their main concern is the fact that the complainant's brother's last days were spent in solitude and without the care and attention which hospital would have afforded. I sympathise with and understand their concern, but can only conclude that the circumstances which caused the delay arose from the pressure on available facilities rather than from any specific failure on the part of Authority 1.

Case No W6/77–78—Delay in arrival of ambulance at day clinic

Complaint and background

1. On 5 January 1977 the complainant accompanied her sister by ambulance to a hospital in town A for an examination which was completed by 11.15 am.

2. She complains that:—

(*a*) the ambulance to take them home was delayed and they were not offered any food whilst they were waiting;

(*b*) she was told that she would not be allowed to bring in food from outside the hospital and eat it on the premises, and as a result she had to hire taxis to take her and her sister to a restaurant and then home; and

(*c*) the replies she received to her complaint from the Area Health Authority (the Authority) through the Department of Health and Social Security (the Department) were inadequate.

Investigation

(*a*) *The complaint that the ambulance was delayed and they were not offered any food*

3. The complainant told my officer that on 5 January, when the ambulance to take her and her sister home to town B had not arrived by 12.30 pm, she asked members of the nursing staff about the delay, but none of them would say anything more specific than that it would arrive 'eventually'. On subsequent visits to the hospital with her sister the ambulance had returned them home to town B at about midday.

4. In her letter of 19 January 1977 to the Department, the complainant said that in order to be ready for the ambulance, which collected her sister and herself at about 8.30 am, it was necessary to have an early breakfast, so that by 12.30 pm they were getting very hungry. She told my officer that coffee and biscuits had been provided by the hospital, but when the ambulance was delayed they were not offered anything more substantial.

5. The sister in charge at the hospital told my officer that there was always an element of uncertainty about the time of arrival of the ambulance because it was also an emergency service which could easily be diverted to a road traffic accident or some other incident. When the complainant had asked when the ambulance was going to arrive she had explained this to her and said that it would arrive as soon as possible. In a statement the sister made about the incident, when the Authority were investigating the complaint, she said that at 12.45 pm tea and biscuits were served to the patients who were waiting for transport.

6. When interviewed by my officer, the area chief ambulance officer (CAO) explained that the hospital is mainly used for day patients who are taken to the hospital in the morning and return home in the afternoon. He said that although there is no outpatient department, as such, some patients do attend the hospital for assessment. These patients will not be ready to go home at set times and special transport arrangements need to be made. He said that rules had been issued for the guidance of staff about the use of ambulance transport and these require that ambulance control should be advised as soon as patients are ready to return home. All requests for transport are logged by the officer who takes the call and passed to a controller who allocates the work to a vehicle. The CAO said that there is no record on 5 January of any request having been made for transport to take the complainant and her sister home. The first record of any request for transport from the hospital to town B on that day is timed at 2.03 pm for another patient; but by this time an ambulance was, in fact, already at the hospital picking up one patient for town A and two for town B.

7. The CAO said that on 5 January 1977 the ambulance normally used for patients, such as the complainant's sister, had broken down and, if ambulance control had been informed at the time she was ready to go home, an ambulance car could probably have been used, in order to prevent a backlog of work building up which could have disrupted the afternoon outpatient journeys. The CAO also told my officer that, whilst controllers would often not be in a position to be precise about the time an ambulance would arrive, they would always give as much information as possible; and where difficulties arose because of a breakdown, the controller would tell the enquirer of this and apologise for the delay.

8. I have not been able to establish the precise sequence of events in this case. But a copy of the record of patients carried by the vehicle which eventually took the patients home to town B shows that the vehicle took a patient from the hospital, which it left at 12.51 pm, to town C and returned to the hospital where it arrived at 1.55 pm and collected one patient for town A and two patients for town B. The vehicle left the hospital at 2.05 pm and after putting down the patient in town A, collected another patient from another hospital before going on to town B where the last patient was delivered home at 3.09 pm.

9. I cannot say with certainty that no call was made from the hospital to ambulance control about the patients for town B before the one timed at 2.03 pm, but I think it unlikely that such a call was made. Nor have I been able to establish who directed the vehicle to return from town C to the hospital.

(*b*) *The complaint that the complainant was not allowed to bring food into the hospital*

10. The complainant told my officer that as no food was offered to them at the hospital, she and one of the other people from town B decided to go into town A to obtain food for themselves and others who were waiting. But, she said, she was told that it would not be possible for them to bring food into the hospital and eat it on the premises. She said that at 1.45 pm she felt that her sister and herself could wait no longer and she went to call a taxi to take them to a restaurant and then home. Although a nursing officer had told her the ambulance would not be long she had told him that she was not prepared to wait.

11. The hospital sister told my officer that, when the complainant had asked her whether she could go into town A to obtain food, she had advised her against it because the town centre was some distance away and the ambulance would probably arrive before she returned. The sister said that there was no rule at the hospital which prevented patients or their relatives from bringing food into the hospital to eat on the premises. The sister also said that the taxi ordered by the complainant arrived at the hospital at about the same time as the ambulance and she had tried to persuade her and her sister to go home in the ambulance but they would not do this.

12. I am sure that, in suggesting that the complainant should not go into town A to buy food, the sister was only trying to ensure that she did not miss the ambulance, and I think the complainant must have misunderstood the message the sister was trying to convey and believed she was being told that food could not be brought into the hospital and eaten. I find that the complainant's decision to use the taxi instead of the ambulance was a matter for her to decide and was in no way forced on her by the staff at the hospital.

(*c*) *The complaint that the replies received from the Authority were inadequate*

13. On 19 January 1977 the complainant wrote to the Department, who obtained the comments of the Authority and replied to her on 8 March. The complainant was not satisfied with the explanation offered to her and she wrote to the Department again on 15 March and they replied on 23 March. But she remained dissatisfied and wrote to me.

14. The acting area administrator told my officers that on receipt of the complaint from the Department he had obtained the comments of the health district and his reply to the Department has been based on these. He said he had also enquired of the ambulance headquarters staff to confirm that the timings given by the sister at the hospital were correct. He said he did not consider that the complaint was about the delay of the ambulance as much as the failure of the hospital either to provide the complainant and her sister with a meal or alternatively to allow them to bring their own food into the hospital.

15. I have seen the letter the complainant sent to the Department in which she says: '. . . (my sister's) examination was over by about 11.15 and we were told that an ambulance would arrive shortly to convey us and other patients home. An hour passed, no ambulance; another hour and still no ambulance . . .'. The wording of this letter leaves me in no doubt whatsoever that the basic complaint was about the delay of the ambulance and her other complaints arose from that. My examination of the shift return of patients carried made out by the ambulance crew revealed that it contains errors regarding the hospitals from which other patients who were returning to town B from town A that day were collected. Any detailed examination of these records by the Authority for the purpose of dealing with the complaint to the Department would have brought these errors to light, and I conclude that the enquiries made by the Authority at the time must have been very superficial.

Conclusion

16. I criticise the Authority for not investigating in detail the reasons for the delay in obtaining an ambulance to take the complainant and her sister home. Had they done so, I think it probable that they would have found that

no request had been made. But I do not consider on the evidence, that the hospital staff were unsympathetic to the needs of the patients and their escorts for food and, although they were not provided with a meal at lunch-time, they were given a hot drink and biscuits. I think the Authority owe the complainant an apology for the shortcomings revealed by my investigation.

Case No W23/77–78—Adequacy of nursing care and the attitude of a consultant towards relatives

Complaint and background

1. The complainant's husband, who was a diabetic, was taken to the Accident and Emergency Department (A and E Department) of hospital A on the evening of 23 July 1976 after suffering a hypoglycaemic attack. Later that night he was transferred to ward A where he remained until his death on 31 July 1976. The complainant was dissatisfied with aspects of the medical and nursing care her husband received and with the attitude of the consultant physician (the first consultant) when he met her and her son to discuss the complaints.

Investigation

I. The complaints about the medical care

2. The complainant told me that she believed that there was a failure to provide her husband with a reasonable and adequate standard of care after he received emergency treatment on 23 July until he was seen by a specialist in diabetes (the second consultant) on 29 July. She said she felt that there was a delay, even laxity, in obtaining the essential clinical opinion on which her husband's treatment should have been based. She complained that her husband's previous clinical notes were not obtained, that he was not seen by the second consultant until six days after his admission and that a chest infection was not treated early enough.

3. Under the Act which defines my powers I cannot investigate action taken in connection with the diagnosis of illness or in the care or treatment of a patient if, in my view, the action was taken solely in consequence of the exercise of clinical judgment. I cannot comment therefore on the medical treatment which the complainant's husband received, but where I think it may be helpful to the complainant I have set out the clinical information I have obtained.

(*a*) *The failure to obtain the previous clinical notes*

4. In her complaint to the Authority the complainant said she believed that many of the unhappy events which led up to her husband's death were attributable in part to the failure by the hospital to obtain information about his condition as a diabetic for many years. She told me that when she and her son met the first consultant, she understood that he had not called for or received the medical records from the diabetic clinic at hospital B, which her husband had been attending. She added that the divisional nursing officer (DNO) had said that it was routine to call for the previous records.

5. In his written comments and in the interview with my officer, the first consultant said that it was not necessary to obtain the medical records from the diabetic clinic at hospital B because the complainant's husband's treatment there

before his admission was not relevant. When the complainant's husband had been admitted, it was established that his insulin regime had been altered by his family practitioner two days earlier. She and her husband had given conflicting statements about the insulin dose and it had been decided to accept what the complainant said and to make any necessary adjustments that might be indicated by blood and urine tests. The registrar had later got in touch with the family doctor to obtain details of the previous insulin dosage.

6. The house officer who had examined the complainant's husband on 23 July and who had attended him on subsequent days told my officer that it was her responsibility to obtain the previous medical records if necessary, but in this case it had not occurred to her to do so. She explained that all that was needed was information about current treatment and this had been obtained from the complainant, her husband and the family doctor.

7. There is no doubt that the previous medical records were not obtained. The doctors have said that treatment before admission was not relevant to the treatment given to the complainant's husband in hospital A, and this is a matter for their clinical judgment. I have seen from the hospital's medical notes that the staff carried out tests to establish what treatment the complainant's husband needed after he came into their care.

(*b*) *The delay in obtaining an opinion from the second consultant*

8. The complainant said that the house officer had told her on 26 July that the second consultant would be seeing her husband in due course. On about 28 July she found that her husband's condition had seriously deteriorated and when she enquired she had been told that the second consultant had not seen him. The complainant said she had suggested that he or another doctor should see her husband as soon as possible, but the second consultant had not seen him until 29 July.

9. In his written comments, the first consultant said that the complainant's husband was admitted under his care and, as a general physician, he was fully trained and experienced in the management of diabetes, although it was not a special interest of his. He explained that control of the diabetes throughout 24 and 25 July was good, but the husband was rather confused and unwell, and his diabetes began to require increasing dosages of insulin for control. Although he had no obligation to do so, he did ask his colleague, the second consultant, to confirm his management of the treatment and the second consultant had visited the complainant's husband on 29 July and had confirmed that the appropriate treatment was being given.

10. The complainant's husband was admitted under the care of the first consultant. It was for him to decide, in the exercise of his clinical judgment, if and when to call in the second consultant, and having decided to seek his opinion, whether or not it was urgent for him to see the complainant's husband. These are matters which are not for me to question.

(*c*) *The delay in treating the chest infection*

11. The complainant told me that she was particularly disturbed to discover that no steps were taken until 26 July at the earliest, and possibly not until 29 July, to deal with the chest infection which had been noted in the house officer's initial diagnosis on 23 July.

12. The house officer told my officer that when she and the registrar examined the complainant's husband on 23 July they heard chest sounds, and the registrar ordered a chest x-ray and blood test to establish if there was any infection. The consultant, in his written comments, said that the x-ray suggested the presence of chronic bronchitis, but there was no local lesion suggestive of a recent infection, and a blood count did not support the suspicion that there was a hidden infection. The consultant said that, although the complainant's husband was apparently well, the registrar had decided to admit him to exclude the possibility of such infection and to stabilise his insulin dosage. The house officer told my officer that on 27 July the condition of the complainant's husband had deteriorated and at her request a senior house officer had examined him and diagnosed that he was suffering from pneumonia. She told my officer that he was then started on a course of strong antibiotics and physiotherapy. She said that on 28 July the results of blood culture tests were received which showed that the complainant's husband had septicaemia. The medical notes confirm this sequence of events. They show that the complainant's husband was seen at least once and sometimes several times each day from 23 to 27 July but it was only on 27 July that pneumonia was diagnosed.

13. Neither the evidence of the house officer nor that of the medical notes made at the time support the complainant's belief that there was a delay between the diagnosis of the chest infection and its treatment and I am satisfied that the complainant is mistaken.

II. Complaints against the nursing staff

(a) Events in the A and E Department

14. The complainant claimed that while her husband was in the A and E Department on 23 July he was not offered food or drink nor was he given a blanket although he had been shivering with cold; when she asked for a blanket one was provided but the nurses showed no concern that he was cold. He was also given some sandwiches which he could not eat because his dentures had been left at home. The complainant told my officer that she had explained to the staff that the food must be soft. They brought egg sandwiches, the crusts of which had been removed, but he was unable to eat them.

15. In their written comments to me the Authority said that the only reason for failing to provide food and drink was that neither the complainant nor her husband asked for them. Elaborating on this, the DNO told my officer that in-patient facilities were not provided in the A and E Department because patients were normally there for only a short time before being either admitted to the hospital or discharged home. He showed my officer automatic vending machines in the A and E Department from which drinks and snacks could be obtained. He pointed out that when the complainant had asked for food for her husband, egg sandwiches had been provided and he would have thought this food was reasonably soft.

16. On the question of failure to provide a blanket, the DNO said that 23 July had been hot (and I have confirmed that this was so) and the staff might not have realised that the complainant's husband was cold. The DNO said that it was possible that the staff did not check that patients who were in the A and E Department for longer than usual (as the complainant's husband had been) were comfortable, but if a patient seemed reasonably comfortable, had already

been seen by a doctor, and was not an emergency, he would not be visited as often as the other patients. The DNO told my officer that he had gone over all this with the complainant and her son when he met them and had apologised for any shortcomings.

17. Since automatic vending machines were available, I do not consider it unreasonable of the staff not to have provided food until they were asked to do so, and egg sandwiches with crusts removed seem to me to be suitably soft for a patient without dentures. Also, as it was a hot day, I do not think the staff can be criticised for not providing a blanket for the complainant's husband until they were asked to do so. But it may well be that the staff should have kept a closer eye on the complainant's husband than they did as he was in the A and E Department for rather longer than most patients.

(*b*) *The attitude of the nurses on the ward*

18. The complainant criticised remarks made by nurses and their attitude to her husband. She told me that she overheard two nurses saying that they did not want 'another hypo' (hypoglycaemic attack) on their hands, and she took this to be a reference to her husband.

19. The DNO told my officer that he had been unable to identify the nurses concerned, but he accepted that such a remark could have been made. The Authority told me that the complainant had been given an apology for this when she met the DNO and it had been explained that nurses in training sometimes might be a little thoughtless when they discussed a patient's condition.

20. The complainant claimed that a nurse adopted a bullying tone of voice when she asked her husband for a urine sample, and a ward sister treated him as if he were senile, saying, when she gave him an injection—'He'll let me do anything without making a fuss'.

21. Neither of the two ward sisters could remember these incidents, and the DNO had not been able to identify the nurse concerned with the urine sample. The ward sisters, in separate interviews with my officer, said that although they could not remember very much about the complainant's husband it was clear from the nursing notes that he had been confused; and in that case it would have been necessary to speak distinctly and firmly to him. One of the sisters said that the nurses would not have intended to bully such a patient, but it might have sounded as if they were doing so to a listening relative.

22. Both sisters told my officer that the remark quoted by the complainant (paragraph 20) did not sound like one they would make, but since neither of them could recall giving the patient an injection in the complainant's presence, they could not be sure.

23. It is clear from the medical and nursing notes that the complainant's husband did become confused in hospital. I accept that in such a situation nurses have to be firm when they speak to a patient, and I am sure that there was no intention to bully him. I have not been able to discover what happened when one of the ward sisters gave the complainant's husband an injection.

(*c*) *Failure to provide biscuits for the complainant's husband*

24. The complainant said that her husband was not given a biscuit with his mid-morning and afternoon drinks, although he had needed one to balance his blood sugar levels.

25. The ward sisters told my officer that they could not remember what the instructions had been in this case. One of them explained that the normal practice was that the dietician decided what the patient could eat and when he could have it. She said that if a biscuit was ordered with the mid-morning drink, instructions would have been given by the dietician to the ward orderlies who handed round the drinks; in the afternoon all patients were given a biscuit unless there were instructions to the contrary.

26. The medical notes for 24 July show that the prescribed carbohydrate intake allowed the complainant's husband a biscuit with the mid-morning and mid-afternoon drinks. One of the sisters pointed out to my officer that the nursing notes show that the complainant's husband had not been eating very well and had had to be given glucose instead of food: she thought it possible that he had not been able to eat the biscuits even had they been offered. I cannot now say whether or not the complainant's husband was denied biscuits when he was able to eat them; if this were so I would consider it regrettable.

(*d*) *The complainant's husband was left sitting in the middle of the ward*

27. The complainant told my officer that, when she visited her husband on 28 July, she was horrified to see that he had been left slumped in a chair in the middle of the four-bedded ward. She felt that this was another example of her husband being treated as if he were senile and with no respect for his dignity.

28. Neither of the two ward sisters could remember this incident. One of the sisters said she thought that a chair in the middle of the ward would have caused an obstruction and she expressed surprise that a nurse had deliberately placed it there. The DNO told my officer that he had not been able to establish with certainty why the chair was in the middle of the ward. Because the complainant's husband was confused, it may have been that he was in that position so that nurses could observe him. Whatever the reason—whether to give the complainant's husband a wider view of his surroundings or to make observation easier—I find it hard to believe that there was any deliberate attempt on the part of the nurses to humiliate him.

III. The complaint about the way the complainant's representations were handled

29. The complainant first complained to the district administrator on 13 January 1977, saying that, although it was almost six months since her husband had died, she wished to get 'to the bottom of the sequence of unhappy events' leading up to his death, and that she believed that many were attributable to delay in obtaining information about his condition and to inadequate medical and nursing attention during his stay in hospital.

30. The district administrator promised to investigate all her complaints but pointed out that the delay might make it difficult to establish the facts. The assistant district administrator arranged in February for the complainant to see the two consultants and the DNO on 2 March. Before this meeting took place, however, the two consultants met after the return of the first consultant from a trip abroad. The second consultant told the assistant district administrator that they both felt that since the complainant's husband had not been his patient, only the first consultant should meet the complainant.

31. When the complainant visited the hospital on 2 March, she was accompanied by her son, who took notes during the meetings. The complainant told me that the DNO went through the nursing aspects of her complaints 'carefully and in detail, conceding that there had been shortcomings in nursing care and stating what had been done to prevent their recurrence, or where he was investigating further'. The complainant said that he answered their questions 'sympathetically, and was evidently caring in his attitude'. The complainant and her son told my officer that when they left the DNO they were in the mood for an affable meeting with the consultants.

32. The complainant told me that, in contrast to the DNO's attitude, the first consultant's 'was cavalier and abrupt and he made us feel that our questions were, to say the least, unwelcome'. She told me that they left that meeting with a feeling 'of anger and dismay and great dissatisfaction'. The complainant's son told my officer that when they arrived for the meeting the consultant ignored them; he continued writing and did not invite them to sit down. He asked them what they wanted, whereas they were expecting him to have something to say to them. The complainant's son said that they then asked the consultant questions, some of which he refused to answer. When they asked him why the second consultant had not been called in sooner, his reply had been to tell them his own qualifications, and to say that the NHS did not provide specialists. But he later said that a specialist could be called in 'if we are not winning'. The complainant's son said that once, when he asked a question, the consultant had told him that he had granted an interview to his mother, not to him. Although they had told the consultant that the DNO had accepted that there had been shortcomings, he had replied that the complainant's husband had received the best medical and nursing care. They had expected to see the second consultant as well but the first consultant had told them that he had stopped him seeing them because he had been responsible. He then said they could see the second consultant if they wished to do so but he would not be happy if they did. The complainant's son said that they would have liked to have done this, but they were too shaken after this meeting to go to another one. The complainant's son said that they terminated the interview because the first consultant was getting 'wilder'.

33. When my officer spoke to the first consultant about this meeting he said that the complainant's son had adopted an aggressive attitude and had written down everything that he had said. The first consultant said that it was untrue to say that he had ignored the arrival of the complainant and her son; on the contrary, he had greeted them at the door. He agreed that he began by saying something like 'here we are, what's the problem', and that the complainant had said that she thought that he would have something to say. But he had genuinely not known what was expected of him, and so he had asked what questions she had. The consultant denied having refused to answer questions, and said that he had answered to the best of his ability. But he had felt that the complainant's son seemed to be trying to 'trip him up' by questioning everything that had happened, including matters of nursing care. The consultant said that the complainant's son had told him that the DNO had admitted negligence and therefore he might as well do so. The consultant said that he tried to say, as kindly as possible, that the natural history of diabetes was that there would be an event in the patient's life which would lead to his death, and that the complainant's husband, who

was elderly, had had an infection and septicaemia and nothing could be done to cure him. Although the complainant's son had told him that he had had diabetes himself, it did not follow that he understood everything about the condition. The first consultant said he had been annoyed that the complainant's son had written down everything he said and had even stopped him speaking while he finished writing. He acknowledged that at one time he had said that the interview had been granted to his mother. As far as seeing the second consultant was concerned, the first consultant said that he had been asked to see the complainant but thought it inappropriate to do so (see paragraph 30). This decision was not at his (the first consultant's) prompting. And he had made it clear that he was qualified to deal with diabetes, and that it had been a matter for his judgment if and when to call in the second consultant.

34. There is general agreement between the complainant and her son and the first consultant about the content of their meeting. But there are conflicting accounts of the attitudes adopted by the participants. The first consultant told my officer that he found the complainant's son aggressive and anxious to get an admission of negligence. He was particularly concerned that the complainant's son appeared to be recording everything he said. The complainant and her son, on the other hand, thought that the consultant had adopted an abrupt and unfriendly manner. The DNO told my officer that he had found the complainant's son willing to accept that there might have been some difficulties; he had not thought him abusive, but he had been a persistent questioner, and he had taken notes of what was said. He himself had been disconcerted about the taking of notes, although he had not said so to the complainant's son. It is difficult for me to judge what happened at the meeting with the consultant. I think there must have been some misunderstanding at the beginning and that the meeting got off on the wrong foot. I think the complainant and her son expected the consultant to say why her husband had died, and to admit to shortcomings, but the consultant expected them to tell him what they wanted to know. I can understand that the consultant was disconcerted when faced with a patient's relative who not only asked detailed and critical questions but also recorded all the answers, and it would not be surprising if he was cautious in his replies. I cannot say who was primarily responsible for the lack of rapport, but the fact that it occurred is very unfortunate.

Conclusions

35. Actions taken by doctors solely in the exercise of their clinical judgment are not within my jurisdiction, and I do not comment on the treatment the complainant's husband received. I can understand the distress that the complainant has felt since her husband's sudden death, and I hope that the information in my report will, at any rate, help to explain that treatment to her. The complaints against the nursing staff had already been investigated by the DNO, who had accepted that there might have been some shortcomings in the service provided to the complainant's husband, and I am unable to add very much to what he had already told the complainant and her son. As far as the meeting with the first consultant is concerned, it clearly broke down, but I cannot say where the fault lies.

Case No W24/77–78—The way in which an Area Health Authority implemented the reduction in pay beds provided for in the Health Services Act 1976

Complaint

1. A Medical Association (the Association) complain about the way an Area Health Authority (the Authority) implemented the reduction in pay beds provided for by Section 3 of the Health Services Act 1976. They complain specifically that:—

(*a*) although a consultation document proposing the apportionment of the pay bed reductions District by District was circulated by the Authority in October 1976, it was inadequate in that it was based on bed occupancy figures for 1975, and not for the two years ending on 31 December 1973 as specified in the Act, and that details of non-National Health Service (NHS) facilities for private patients were omitted;

(*b*) at a meeting of the Authority on 20 January 1977, when the proposed reductions were agreed, the views of the Association's members were not taken into account; and

(*c*) the Association members who wrote to the Authority to seek an explanation of the apportionments did not receive satisfactory replies.

Legislation

2. Section 3 of the Health Services Act 1976 provides, amongst other matters, that, in effecting the withdrawal of the numbers of private beds specified in Schedule 2 to the Act, Area Health Authorities should pay due regard to the extent to which the accommodation and services authorised to be used for private patients at each of the NHS hospitals in England and Wales were, in the period of two years which ended on 31 December 1973, used in connection with the treatment of resident private patients; and the extent to which in the case of each NHS hospital alternative accommodation and facilities for the private practice of medicine and dentistry are reasonably available (whether privately or NHS hospitals) in the area served by that hospital.

Investigation and findings

3. In February 1976 the Department of Health and Social Security (the Department) wrote to Area Health Authorities saying that, subject to Parliamentary approval, 1,000 pay beds would be released to general NHS service within six months of the National Health Services Bill receiving the Royal Assent, and giving the proposed quota of beds to be released by each Area Health Authority. They were asked to obtain the views of their Area Medical and Dental Advisory Committees and staff organisations on the reductions; the Authority were advised that their quota was 16 out of a total of 70 private beds. The aim was to achieve a national daily occupancy of the remaining pay beds of 85 per cent in the Association's Health Districts and 75 per cent in the other Districts. The Department said that the calculations had been based on pay bed occupancy during 1972 and 1973 as occupancy in later years was believed to have been distorted by disputes. On 6 May, 28 May and 12 August the Department again wrote to Area Health Authorities offering further

opportunities to submit any additional evidence from interested bodies which might affect the reduction. Area Health Authorities were told that they would be required to make recommendations to Regional Health Authorities as to how the bed reductions were to be apportioned within their areas. The final quota for the Authority was 15 beds.

4. The Authority consulted the interested bodies and on 21 October, their officers put to a meeting of the Authority a paper showing how the reductions might be apportioned within the Area. Following the meeting a paper (the October paper) was circulated to interested bodies for their comments. The Authority considered a further paper (the January paper) at their meeting on 20 January 1977, and resolved that the recommendations therein be submitted to the Regional Health Authority (the Regional Authority).

(*a*) *The complaint that the October paper was inadequate*

5. In their letter to me, and in an interview with my officers, the Association said that the October paper circulated to key interests, including a member of the Association, was misleading. The document proposed the reduction of four beds in District A, six beds in District B, two beds in District C and four beds in District D. In support of this proposal the document had shown the bed occupancy figures for 1975 and the population figures for each district. Numbers of non-NHS beds were not shown, and there was a note on the paper to the effect that the exact figures of available non-NHS beds were not known. The Association considered that the document had therefore been misleading because the bed occupancy figures for the wrong period had been used, and incomplete because it had excluded details of non-NHS accommodation.

6. A member of the Association pointed out to my officers that 1975 had been a year in which trade union activity had affected the use made of private beds. Members and officers of the Association said they were generally unhappy about the use of average bed occupancy as a yardstick. They said that a high proportion of private patients chose to be day cases, and many of them preferred, where possible, to have their treatment so as to avoid being in hospital over weekends; for these reasons average occupancy would appear to be lower in the private beds than in the NHS ones. They said that, had the Authority asked the Association or its individual members to supply details of non-NHS beds in the area they would have done so. One member felt that in proposing the bed reductions in Districts A and D, where there had been militant trade union activity in the past, and where there were no alternative private facilities, the Authority were giving in to the potential threat of further trade union militancy and had not sought to make the reductions on an equitable basis.

7. In their written comments to me the Authority did not accept that the October paper was misleading or incomplete. They agreed that they had used the 1975 occupancy figures instead of those for 1972 and 1973 but contended that, had the same arithmetical method been used with the correct occupancy figures there would have been little difference in the outcome. They agreed, too, that the non-NHS facilities had not been shown in the document, but said that it was a consultative document only, and it was not intended that firm conclusions should have been drawn from it. They pointed out that the details of non-NHS beds had been shown in the January paper upon which the decision had been taken about the reductions to be recommended to the Regional Authority.

8. In interviews with my officers, the Authority's associate administrator and the area medical officer (AMO) said that the Authority had been concerned to meet the requirements of the Health Services Act in achieving the bed reduction within the time specified. The 1975 bed occupancy figures had been used because at the time it had seemed best to use up to date figures. The associate administrator acknowledged that this had been an error. The AMO emphasised that the occupancy of private beds had been relatively low and they were 'taking away only that which the consultants did not use'. The associate administrator agreed that average bed occupancy was not an ideal yardstick, but this had been really the only one available. As to the availability of non-NHS beds, both the AMO and the associate administrator said that they did not consider it was justifiable for the Authority to seek such information from private business concerns, and pointed out that when the Health Services Act referred to reasonable alternative facilities, this included the private beds remaining in NHS hospitals after the reductions, as well as those in private nursing homes. The associate administrator said that for the January paper, he had obtained the numbers of non-NHS beds from the register kept by the Authority, but he had no information about how the beds were used.

9. My officer examined the calculations made by the Authority's officers in order to arrive at the proposed reductions set out in the October paper. The method used was to calculate for the Area as a whole the average number of private beds unoccupied during 1975; to express the number of beds required to be withdrawn as a percentage of this figure; and to apply this percentage to the average number of unoccupied private beds in each district. The figures so obtained were each rounded to the nearest integer and these became the figures, district by district, for the numbers of private beds proposed to be withdrawn. My officer made a similar calculation using the bed occupancy figures for the two years ended on 31 December 1973 and found that the results were, in fact, different from those produced by the Authority.

10. The associate administrator agreed that the initial calculation had been an arithmetical one based on average bed occupancy, but that population figures and numbers of non-NHS beds had been shown in the January paper so that members of the Authority could also take these factors into account. The threat of trade union militancy in the Districts A and D had not influenced the proposed apportionment of the reductions, although he had certainly been aware of the problem.

11. It seems to me to be quite clear that in their consultative document the Authority should have used the bed occupancy figures for 1972 and 1973 since this was the criterion specified in the Health Services Act. I can see no justification for their having used different figures. I do not criticise them for using bed occupancy figures as such, although I acknowledge that they probably do not completely reflect the use of private facilities. I consider, however, that they should have included in the October paper the figures of beds in private nursing homes; I cannot see the point of issuing a consultative document as a basis for discussion, which does not present the relevant information that is available and to this extent the paper was incomplete. I am satisfied, however, that the proposed reductions shown were calculated on an arithmetical basis, and I have found no evidence that the threat of trade union militancy was taken into account.

(*b*) *The complaint that the views of Association members were not taken into account by the Authority at their meeting on 20 January 1977*

12. In their letter to me and in interviews with my officers, the Association said that they had formed the view that the comments made by their members had not been taken into account when the Authority had approved the apportionment of the bed reductions at their January meeting. They pointed out that one of their members in District B who was an elected Council member of the Association (the Council member) was also a member of the Area Joint Staff/Management Negotiating Committee (the Committee), and had been invited to comment to the Committee. Unfortunately he had been unable to attend the meeting concerned, but he had written to the secretary of the Committee on 15 November 1976, setting out his comments on behalf of the Association. He had also written in January 1977 to the area administrator, enclosing a copy of his letter to the Committee. He and the Association believed that these comments had not been considered by the Authority.

13. The points made by the Council member were that bed occupancy figures were not an accurate way of assessing the usage and value of beds; that the bed occupancy figures for 1975 were not representative; that the availability of non-NHS beds needed critical examination and, in particular, the beds in a private nursing home in District B should not be considered by the Authority as 'alternative accommodation' because the nursing home was at a distance from the city centre; and that other nursing home beds should be regarded as only suitable for custodial and institutional care. He also pointed out that the units serving the Region as a whole needed to be treated separately from other beds in district general hospitals; and he cited the special case of the orthopaedic beds in one hospital which were used by patients referred from far afield. And in his letter to the area administrator on 7 January 1977 he had passed on additional comments from Districts A and D that beds should not be withdrawn until they had alternative facilities. (In another document it was pointed out that if pay beds were allocated in proportion to population, District A would need an *increase*.) Yet despite these protests, the Authority had agreed the apportionment of reductions exactly as suggested in October.

14. When my officer spoke with the Council member he said that he had originally addressed his comments to the management side secretary of the Committee, but realised later that he should have written to the staff side secretary. But his views had not been considered despite his letter to the area administrator enclosing a copy. In any event, he felt that it had not been sufficient for the Authority to have before them at their meeting in January only the summarised comments of the objectors but that they should have had the opportunity of seeing the full text of the letters from those who had commented.

15. In their written comments to me the Authority said that the views expressed by interested parties were included in the January paper. They had not thought it necessary to repeat every comment made if there had been similar comments from other people. The area administrator told my officer that, in retrospect, he considered that the Authority had underestimated the strength of feeling amongst the medical staff, and that they could have done more in the way of consultation before the January meeting. But he pointed out that, after the meeting, efforts had been made by the Authority's officers to explain the decision to the medical staff, and the associate administrator said that a

further paper, which had been put to the Authority in May, did incorporate a further résumé of the objections which had been raised.

16. The management side secretary of the Committee told my officer that he had received the letter from the Council member and had passed it to the staff side secretary, but it had been mislaid. The associate administrator told my officer that both the minutes of the Committee and the letter which had been sent to the area administrator had reached him too late to be included in the papers for the Authority's meeting on 20 January. But the points contained in the letter had been made by other interests, and had been reported at the meeting.

17. The January paper does, in fact, mention several of the points raised by both the Council member and other interests. But it does not mention the use of the 1975 bed occupancy figures; the view that the beds at the nursing home in District B should not be regarded as alternative facilities; or the comment that the population figures for District A justified more private beds and not less. In general, I think that the summaries of the comments were so brief as not to reflect the strength of feeling demonstrated by the objectors, nor the detail of some of their objections.

18. I consider it unfortunate that the Council member's comments were mislaid within the negotiating Committee's machinery and that they thus did not reach the area administrator until mid-January. A copy of his comments was received on 13 January and I see no reason why a full summary of these strongly held views could not have been provided for the Authority's meeting on 20 January, even though some of his comments coincided with those of other parties and were reported. I do not agree with the Council member that the full text of all the letters received should have been shown, but I think it unsatisfactory that they were summarised so briefly and that some of the points raised by the objectors were omitted.

(*c*) *The complaint that Association members who wrote to the Authority about the closures did not receive satisfactory explanations*

19. The Association complained that after the Authority's January meeting, the Council member and an Association member in District A (the District A consultant) had written to the Authority asking how the decision about the apportionment of the reductions had been reached. They complained that the replies received had been inadequate and that the questions put had not been answered. The Council member told my officer that, although he had written three times to the area administrator personally, he had not received a personal reply.

20. My examination of the correspondence shows that in response to the Council member's letter of 7 January (paragraph 13) he received a reply dated 24 January from the area personnel officer (who was also the management side secretary of the Committee) acknowledging his letter and saying that he had also received his letter of 15 November (paragraph 12) and had passed it to the staff side secretary. In answer to the specific questions that had been raised, he said that the Authority had seen the issue as one of complying with Government legislation and as a matter over which they had no choice; it followed, therefore, that the questions raised had not been considered. But he also received a

letter dated 25 January from the associate administrator telling him of the Authority's decision about the withdrawal of beds and assuring him that a summary of all the comments received, including his own on behalf of the Association, had been considered by the Authority before they reached their decision. On 28 January the Council member wrote to the area administrator asking whether he had received the letter of 7 January and saying that he was looking forward to receiving his own comments on the letter he had written to the Committee.

21. From then until the end of March he wrote a number of letters to the Authority's officers questioning whether the Authority had taken his observations into account and seeking an explanation of the fact that the Authority had, at their meeting in January 1977, agreed the same reductions as they had proposed in October 1976. The District A consultant also wrote on 8 February 1977 to the associate administrator saying that no notice appeared to have been taken of the view that the number of private beds in that district should have been increased (paragraph 13). The responses of the Authority's officers to these letters were merely to the effect that the Authority were aware of the number and location of non-NHS beds but that they could not put a weighting factor on them; that only summaries of the comments had been put to the Authority; and that the questions about the effect of the reductions on the care of NHS patients and the length of waiting lists was a matter for the clinicians.

22. I can understand the Association's dissatisfaction with the replies their members received. I think the Authority were wrong to say that the points raised by the Council member's letter were matters over which they had no choice. Whereas the overall reduction of 15 beds was such a matter the way the reductions were apportioned between the districts was clearly a matter within their discretion; and the effect of the reductions on the quality of the patient care and the waiting lists are matters which, I agree, could not have been predicted at the time, but which I certainly hope the Authority would keep under review in consultation with medical staff.

23. In my view the Authority's letters are misleading in that not all the points raised by the Council member were put to the Authority, and the letter of 25 January from the associate administrator appears to contradict the letter of 24 January from the area personnel officer. Neither had the District A consultant's contention that the private bed complement should have been increased and not decreased been put to the Authority.

24. The area administrator is clearly entitled to delegate to his staff the responsibility of replying to correspondence, but bearing in mind that the Council member asked specifically for his own comments, I consider that he should have sent him a personal acknowledgement or, at least, asked his officers to explain to him that they were replying on his behalf.

General conclusions

25. As a result of my investigation, I have generally upheld the complaints made by the Association. I think the Authority owe them an apology for the shortcomings my enquiries have revealed.

Case No W36/77–78—Unsatisfactory handling of complaint

Complaint and background

1. On 18 October 1975, while playing football, the complainant suffered a compound fracture of his leg. He was admitted to hospital where he received emergency surgery and he remained there until 24 December 1975 when he was discharged. Following his discharge the complainant continued to receive treatment at the hospital as an out-patient and on 13 June 1976 he was re-admitted for further surgery. He was discharged on 7 July 1976 but had to attend the hospital every two days for the dressing to be changed.

2. The complainant wrote to the consultant orthopaedic surgeon (the consultant) and to the hospital administrator about the medical treatment and nursing care he received. But he was dissatisfied with the replies he received from them on behalf of the Area Health Authority (the Authority).

Jurisdiction

3. I cannot investigate complaints about the action taken by doctors solely in consequence of the exercise of clinical judgment and this meant that I could not look into most of the complaints. But I told the complainant that, if he wished me to do so, I could undertake an investigation into the way his complaint was handled, and this he asked me to do.

Investigation

(*a*) *The complaint to the consultant*

4. In the correspondence he sent me and in an interview with my officer, the complainant said that on Thursday, 15 July 1976 he went to the hospital for a routine change of dressing. He told the nurse that he felt unwell and she had diagnosed flu and had advised him to take aspirin. She had assured him that his condition was not related to the wound and explained that no doctor was available to see him. When he returned to the hospital ward on Saturday, 17 July for a further change of dressing his leg was inflamed and swollen. He had asked to see a doctor but the nurse had told him that there was no doctor available. She had advised him to continue exercising but, if his leg got worse, to report back the next day. Because he felt very unwell on the Sunday, he had telephoned the hospital; a nurse had told him that there was no ward doctor on duty but that he could either report to the casualty department that day or come in on the Monday to see the consultant. He decided to see a family practitioner locally who diagnosed septicaemia and ordered him to bed immediately.

5. The complainant said he thought the advice he had been given by the nursing staff had been 'appalling' and was at least a contributory, if not the major, cause of the septicaemia that had developed. On Tuesday, 20 July, whilst still feeling very unwell, he wrote to the consultant to complain about the treatment he had received and to try to secure an improvement in the standard of nursing care. He also told the consultant as a matter of protocol that he was receiving treatment elsewhere. He told my officer that he was dissatisfied with the consultant's reply because he felt the consultant had not looked into his complaints properly and, ignoring the fact that the events had happened at a weekend, had commented only that, if he had got in touch with his secretary, something could have been arranged.

6. The consultant told my officer that because he had been on holiday for the whole of August he had been unable to deal with the complainant's letter until 6 September. He said that he had not treated the letter as a complaint about the nursing staff. Had he done so he would have passed it to 'Matron's office'. His understanding was that the events described by the complainant had taken place over a Thursday, Friday and Saturday, and in his reply he had suggested simply that the complainant should have telephoned his secretary about his problems and, had he done so, she would have been able to obtain help for him from himself, a registrar or a casualty officer.

7. I have seen a copy of the letter of 20 July 1976 which the complainant wrote to the consultant. In this he related the events which took place over the weekend of 17–18 July (paragraph 4), but did not mention his visit to the hospital on 15 July. He concluded his letter by saying—'In view of the extremely unsatisfactory advice that I was given and [of the fact] that doctors are unavailable for urgent consultations I have decided to seek medical advice elsewhere'.

8. The events to which the complainant referred in his letter of 20 July took place at a weekend and it is likely that even had he telephoned the consultant's secretary she would not have been available. I consider too that, because the complainant clearly complained about the non-availability of doctors, he should have been told that had he attended the hospital on the Sunday as had been suggested to him, he would have been seen by a casualty officer and that an emergency consultation would have been arranged if it were thought necessary. From later correspondence it is clear that the complainant was also concerned about the advice that he had been given to continue exercising. But I do not think this is clear from his letter to the consultant and I am not surprised that this part of his complaint was not recognised as such. As to the delay in the reply I think that if the consultant could not deal with it before his holiday he should have asked someone else to reply.

(*b*) *The complaint to the hospital administrator*

9. The complainant told my officer that on 16 November 1976 he had written to the hospital asking a number of questions about the care and treatment he had received. He enclosed with this letter copies of his correspondence with the consultant and a four-page typed medical history and questionnaire from the time of his accident.

10. The complainant said he felt it was scandalous that he had not received a reply to this letter from the sector administrator until 2 February 1977 and that even then it was unsatisfactory and contained nothing to show that his complaint had been thoroughly investigated. He could not accept the reassurances about the care he had been given and there were no comments at all on the questions he raised on his medical case history. On 16 March he had therefore written to the district administrator (DA) about his care and treatment and the way his complaints had been handled. The complainant said that the DA's reply of 6 April was most helpful, although he had said he had been unable, because of the lapse of time, to resolve the complaint about the advice the complainant said he was given by the nursing staff in July 1976. The complainant told my officer that he had written to the consultant nine months previously, immediately after the incident, and the lapse of time which had prevented the health authority from pursuing his complaint was entirely their own fault.

11. I have seen the medical history and questionnaire sent to the hospital by the complainant in which he outlined the circumstances of his accident and the treatment he had received. His questions were largely of a clinical nature. In particular he said that he learned that he had suffered a vascular spasm which had produced a 'claw foot' and the only remedy for this was to cut the tendons within twelve hours; he asked why this was not done. The complainant also asked about the site of the incision which was made to insert a plate into his leg, and why the decision to remove the plate was delayed when it became known that he might be reacting against it. The complainant's other questions concerned the lack of advice he was given about cleaning the wound with an antiseptic, the type of dressing which was used at the hospital, and the reasons why he was not given antiseptic baths before the operation (which he later had at another hospital). He also repeated his questions about the advice he was given to exercise his leg.

12. The unit administrator told my officer that in the absence of the sector administrator she had dealt with the complainant's letter. She said that she sent a copy of the letter and the questionnaire to the consultant and had asked him for his comments. The secretarial staff told my officer that they believed they had copied and sent the enclosures, but the consultant said he did not remember seeing them and nor did his secretary. In his reply of 31 December to the sector administrator the consultant commented only on the site of the incision, which the complainant had mentioned in his covering letter.

13. The unit administrator said that due to an oversight she had not sent a copy of the complainant's letter and enclosures to the nursing administration for comment; and the sector administrator told my officer that it was not until he saw the consultant's reply that he realised that the nursing staff had not been consulted. He wrote on 11 January 1977 to the senior nursing officer (SNO) who in turn asked for a report from the nursing officer concerned. The SNO replied to the sector administrator with her comments on 24 January. The sector administrator told my officer that he accepted that mistakes had been made which resulted in unreasonable delay in investigating the complaint and replying to him.

14. On the evidence, I find that the investigation carried out was not adequate. I have been unable to establish whether the consultant received a copy of the medical history and questionnaire which the complainant sent to the hospital. But since the complainant's covering letter contained a reference to the enclosure, I am surprised that the consultant did not himself enquire about it. I criticise the sector administrator for not enquiring why the consultant had commented on only one part of the complaint and the unit administrator for the initial failure to obtain comments from the nursing staff. I realise that because of the delay the sector administrator was anxious to write to the complainant as soon as he could but I consider that the reply was inadequate and I am not surprised that the complainant was dissatisfied.

Conclusions

15. I do not find fault with the Authority's laid down procedure for dealing with complaints. But, in this case, a series of human errors caused the complainant to receive inadequate replies to his representations and they took many months. The Authority have told me that they will shortly be writing to the complainant to repeat their apologies for these shortcomings.

Case No W37/77–78—Supervision of a mentally handicapped hospital patient

Complaint and background

1. The complainants' daughter suffered from severe epilepsy and was an informal patient at a hospital for the mentally handicapped. Her epileptic condition was controlled by drugs administered by the nursing staff of the hospital. On 31 December 1976, then aged 41, she left the hospital with a male patient, who had been compulsorily admitted under Section 60 of the Mental Health Act, and with whom she had become friendly. They did not return, and on 12 January 1977 her body was found in a derelict house.

2. Through their Member of Parliament, the complainants claim that:—

(*a*) the hospital did not take effective steps to prevent their daughter from continuing an undesirable relationship with the male patient;

(*b*) their daughter was inadequately supervised in that, although they had to obtain the written permission of the hospital when they wanted to take her away for weekends or holidays, she was nevertheless allowed to leave the hospital with the male patient;

(*c*) when, on 31 December 1976, their daughter did not return to the hospital in time for her routine medication, the staff did not seem to be particularly concerned; and

(*d*) following their daughter's death, the hospital did not express any regret for what had happened.

Jurisdiction

3. Under the Act which defines my powers I am not permitted to investigate the actions of a coroner. I was thus unable to look at the complainants' other grievance that the local coroner had declined to hold an inquest into their daughter's death.

Investigation

(*a*) *The complaint that the hospital did not discontinue the patient's relationship with the male patient*

4. The father told my officer that his daughter had been very excited initially about her friendship with the male patient. He and his wife said they knew that the male patient had been referred to the hospital by the court but they had thought he had been involved in some relatively trivial criminal offence. It was not until after their daughter's death that they had discovered he had been convicted of a sexual offence and they thought it entirely wrong that someone of his sort should have been sent to the hospital among vulnerable and handicapped people. But they did think, at the time, that the male patient might have been an unsuitable companion for their daughter. In one of the telephone calls she made to them, their daughter had told her father that the male patient had spent some time in a special security hospital; and in another call she had said that 'he had his things packed' and was ready to be sent back there. The father told my officer that he had advised his daughter to have nothing to do with the male patient and that she had promised to take his advice.

5. The father said that the consultant psychiatrist at the hospital (the consultant) had telephoned him shortly before Christmas 1976 to say that he was unhappy about the relationship between his daughter and the male patient. In order to bring this to an end, the consultant had suggested that his daughter should be transferred to a similar hospital (hospital X) which was very much closer to the family home. The complainants told my officer that they had resisted this suggestion because their daughter had been at the hospital for nearly two years and was settled and happy there, so much so that she had decided to stay there over the Christmas holiday rather than to come home because she did not want to miss the social events the hospital had organised. The complainants had felt that if someone needed to be moved it should have been the male patient, who had only been at the hospital for a few months. They said that, had they known it would turn out to be a matter of life or death, they would of course have agreed to their daughter being moved anywhere, but equally, if the hospital had known this, it would have affected their attitude since the male patient had, they knew, been moved to another hospital after their daughter's death.

6. The male patient was in the hospital as a result of a Court Order made by a Magistrates Court in August 1976 after he had been brought before them on three charges of indecent exposure. A court may make an order under Section 60 of the Mental Health Act 1959 provided they are satisfied (on medical evidence which complies with the requirements of the Act) that the offender is suffering from a mental disorder and that, of all the available methods of dealing with him, admission to and detention in hospital is the most suitable.

7. The principal social worker at the hospital (PSW) told my officer that the male patient had a long history of overt, non-violent homosexuality. In a report dated 2 August 1976 which had been made available to the court the PSW stated that during his previous period as an in-patient at the hospital (from November 1975 to April 1976) there had been 'no significant behavioural problems but he was not placed in testing situations'. The report went on to say that it was understood that 're-admission to [the hospital] has been offered. This is felt to be a positive suggestion in regard to his future'. However, it also made the point that there was no secure accommodation at the hospital and the regime and staffing levels were commensurate with the policy of rehabilitating low dependency mentally handicapped persons and not the containment of difficult patients. It is not within my jurisdiction to comment upon the professional judgments made nor on the court order resulting in the re-admission of this patient.

8. The consultant told my officer that, when he had been re-admitted in August 1976, the male patient had quickly and unexpectedly developed a relationship with the complainants' daughter, which he had disapproved of from the outset. He thought the male patient was in every respect an unsuitable companion for the complainants' daughter, but there was not a great deal that he or the hospital staff could do to prevent the relationship or to intervene in its development. They had been accommodated in different buildings and, on his instructions, the staff had done what they could to keep them apart but the hospital was neither designed nor staffed to segregate its patients. On the contrary, emphasis was placed on patients mixing freely with one another as an

important aid to their social rehabilitation. The consultant said that, when he became aware that the complainants' daughter was infatuated with the male patient, he knew that the only way of breaking up the relationship was to move one of them to another hospital.

9. The consultant said that, after the complainants' daughter had been admitted to hospital in February 1975, a new unit had been completed at hospital X which was only a few miles from her parents' home, and where he himself also held a consultancy appointment. The new accommodation at hospital X was up to the hospital's standards and the general practitioner who served hospital X was the family's own doctor, who knew the patient well. Taking all these factors into account, he thought that to move the complainants' daughter to hospital X would be a good solution. He added that he also had a responsibility to do what he thought was in the best interests of the male patient, who, he said, had done well at the hospital considering his past history. To have moved him away from the one relative who cared for him, who lived only a few miles from the hospital, would have been a retrograde step.

10. The consultant said he had telephoned the complainants in the week before Christmas and had put to them the proposition that their daughter should be moved to hospital X, primarily to break up her undesirable relationship with the male patient, but also to facilitate their visiting her; and he had offered to meet them at hospital X with their daughter and to show them round. But the father had been hostile to this suggestion and had said that if his daughter was at hospital X she would always be running home, and it had not been possible to reason with him because he had lost his temper and become abusive. The consultant had resolved to try out the suggestion again later on, as he was sure it was in the best interests of all concerned.

11. A nursing officer who had been with the consultant when he had made the telephone call told my officer that, though he had been unable to hear what the complainant had said, it was obvious that he had reacted strongly against the suggestion. The nursing officer also said that the consultant had previously given directions to the nursing staff to do what they could to keep the complainants' daughter and the male patient apart and what little it had been possible to do had been done. But the nursing notes for 23 December 1976 record that the complainants' daughter displayed a desire to be with the male patient 'practically the whole time'.

12. The hospital administrator told my officer that before Christmas the complainants' daughter had twice told him that she intended to marry the male patient; and soon after Christmas they had visited him together and had said that they intended to get married and that, if the hospital tried to stop them, they would discharge themselves. The complainants' daughter, he said, had done all the talking; the male patient was not articulate. He had told them that, although she was free to discharge herself, being an informal patient, he, as a Section 60 patient, was not. He said he could not remember the date on which these exchanges had taken place but he had told the consultant about them.

13. When my officer discussed with the consultant the complainants' daughter's declared intention to marry the male patient he said the the complainants' daughter herself had told him many times of her intention and he had told her that the male patient was not free to leave the hospital and that,

anyway, she could not get married until they had got her 'turns' under control. He explained to my officer that the complainants' daughter had an obsession about getting married and that, indeed, it was common for mentally handicapped patients to regard marriage as representing the ultimate in normality. He had not told the complainants' daughter that she would never be well enough to get married as this would have deprived her of her main source of hope and anticipated happiness. He told my officer that he could not remember the hospital administrator telling him of his conversation with the complainants' daughter and the male patient but it was very probable that he had done so and that he (the consultant) had not taken particular notice of it as it was 'such a familiar tale'.

14. In response to my officer's question, the consultant said that since there had been no secure accommodation at the hospital, the only way of restraining patients, if necessary, was to put them in their nightwear and to take their day clothes away. But this is an extreme measure and is adopted very rarely. Had he thought there was any real danger of the complainants' daughter and the male patient absconding, this was the course he would have adopted. He also told my officer that, had he felt that the male patient should be moved from the hospital, he would have had to obtain from the court a variation of the Section 60 Order but he had not considered this since the male patient was a gentle person and he had not thought that he posed any threat to the safety of the complainants' daughter.

15. The nursing records show that the male patient returned to the hospital from Christmas leave in the late evening of 29 December. His meeting with the complainants' daughter and the hospital administrator must therefore have taken place on either 30 or 31 December, the day or the day before they left the hospital.

Findings

16. Taking account of the aims of the hospital and the regime by which it seeks to achieve them, I can understand why it was not always practicable to keep the complainants' daughter and the male patient apart since they were determined to pursue their relationship. I believe that the proposal made by the consultant to move the complainants' daughter to hospital X was clearly the result of careful and sympathetic consideration for both his patients. The complainants' daughter's obvious happiness at the hospital gave the father grounds for questioning the consultant's proposal but I think it unfortunate that he turned it down without visiting hospital X and discussing it further with the consultant.

17. I consider that the hospital tried to take the most appropriate step open to them to end the relationship between the complainants' daughter and the male patient but were discouraged from doing so by the opposition of the parents (and also their daughter herself). It is clear that the hospital is neither designed nor staffed to impose physical restrictions on patients and the general aim is to encourage social relationships as a help to their rehabilitation. But I am satisfied, in any case, that the consultant's view that, in the light of their medical condition and their behaviour over the previous few months, no restraint was warranted was formed as a result of his clinical judgment. It is, as always, easy to be wise

after the event but I believe that no one could have foreseen the tragic events which arose from their association. It is of course true that the male patient has now been moved. But I do not think that that fact invalidates the consultant's clinical judgment before the event that the right course was to move the complainants' daughter.

(*b*) *The complaint about supervision and the formalities for the complainants to take their daughter out*

18. The complainants told my officer that their daughter had apparently been able to come and go from the hospital more or less as she pleased. The father had made it clear to the hospital that he had heartily disapproved when his daughter had been allowed to travel some distance with another patient to see a football match during the winter of 1975–76 and he said he had had 'a real row' with one of the male nurses about it. And when the complainants' daughter had left the hospital with the male patient on the afternoon of 31 December there had been nobody to stop them wandering off. This, he said, contrasted oddly with the procedure he and his wife had had to go through before they could take their daughter away from the hospital for weekends or holidays when they had had to write about a week in advance seeking permission. They said that the hospital had explained to them that written notice was required mainly so that drugs could be provided; but they could not understand this as their daughter would have been taking the same drugs if she had stayed in the hospital. On one occasion they had arrived at the hospital to take her out but had been refused permission to do so because drugs had not been available.

19. During their interview with my officer, the complainants went through their daughter's history. This included a stay of 14 years between the age of 16 and 30 at a home for epileptics where, they said, patients had been efficiently controlled. They added that their daughter had then been discharged home and had lived with them for the next 10 years until their own failing health had made it impossible for them to cope any longer with the problems she presented. It was early in 1975 that a social worker had instigated moves which had led to their family practitioner requesting their daughter's admission to the hospital as a 'voluntary' patient. The complainants told my officer that nobody had explained to them the status of a voluntary patient and in reply to my officer's questions they said that they had expected their daughter to receive treatment and supervision similar to that which she had had at the home for epileptics.

20. The consultant told my officer that it was not his practice to explain to voluntary patients or their relatives what their status was under the Mental Health Act 1959 and how this would affect them in the hospital. By definition, a voluntary (or informal) patient was exercising an option to come into hospital, and he thought it was the task of the family doctor, who requested the admission, to explain to the patient and relatives what it entailed. He did not think it reasonable for the hospital to be expected to check that these explanations had been given.

21. With regard to the adequacy of the supervision, the consultant said that there was always at least one nurse in each of the ward blocks and, in the workshop where the patients did their selected work, there was a nurse as well as a work supervisor. There were also nursing officers on duty and he himself was 'often around'. In a typical working day the patients would get up at about

7.30; they would attend the workshops between 9.00 and 12.00 and from 2.00 until about 3.45; they would be expected to attend for medication at specified times and would be sought if they failed to do so. Otherwise their time was their own and they were free to do much as they liked. Patients received their weekly pay at lunch-time on Friday and this signalled the end of the working week. Many of the patients would go into the village on a Friday afternoon to spend or bank their money (and the complainants' daughter was one who normally did this). Although there was a deliberate lack of restriction on patients there were limits, and patients were aware that they should make it known to the staff if they were contemplating some special outing. The complainants' daughter and a fellow patient had sought and received the consultant's permission to make the trip to the football match which had upset her father. After the consultant had heard about his reaction, he had advised her not to go there again.

22. The consultant told my officer that the requirement for the complainants to write when they wanted to take their daughter home was mainly because of the provision of drugs. They did not have to seek permission or authority to take their daughter home, merely to give notice; and the hospital preferred the notice to be in writing in order to avoid mistakes. Drugs had to be tightly controlled, particularly in a hospital for the mentally handicapped, and when a patient was to go on leave the hospital had to apply 24 hours in advance to a central pharmacy for special 'leave packs' to be issued. The consultant thought the drug service to be generally efficient but he conceded that a leave pack might have failed to arrive in time and for the complainants' daughter thus to have been unable to go home. However, he could not recall the occasion and it is not recorded in the case notes. The written notice of patients' absences also helped the hospital to keep track of their movements. But there would have been nothing to have prevented the complainants from visiting their daughter without warning and taking her out, so long as she was back in time for her medication. The consultant expressed his surprise that they had not understood this.

23. The hospital administrator told my officer that he had had an interview with the mother on 11 January 1977 when her daughter was still regarded as missing. She had asked him why her daughter had just been allowed to walk out of the hospital on 31 December. He had explained the basic provisions of the Mental Health Act 1959 and had said that her daughter had been at liberty to discharge herself at any time because she was an 'informal' patient. The mother, he said, had refused to accept that this was so.

Findings

24. My investigation of this complaint has shown that the complainants did not understand the basis on which their daughter was admitted to the hospital but that the staff of the hospital assumed that they did. This misunderstanding did not matter a great deal so long as their daughter's life at the hospital was going well, but it became very important when things began to go wrong. The complainants clearly believed that it should have been possible for the staff to have prohibited their daughter from walking out of the hospital by tightening up on discipline and supervision. It is probable that their expectations of how the hospital would look after their daughter were influenced by their experience of the relatively strict regime at the home for epileptics where she had previously spent 14 years.

25. The hospital did not see it as part of their duty to ensure that the complainants fully understood their powers in relation to voluntary patients. I do not think it unreasonable of them to have assumed at the outset that the family doctor would have explained the position to the complainants. But I think that it should have become apparent as time went on that they did not understand their daughter's status and that the hospital then had a clear duty to explain it to them.

26. It is easy to see, however, how some of the actions of the hospital could have fostered the complainants' misunderstanding. For instance, when replying to letters from them asking if it would be all right for them to take their daughter home for weekends and holidays, the hospital used a standard letter which includes the following phrases: 'Thank you for your letter requesting leave . . . It will be quite in order for you to have [your daughter] home with you . . . It is, of course, necessary for you to accompany her to and from the hospital'. I think it was reasonable for the complainants to infer from this letter that their daughter needed a high degree of supervision and, therefore, to infer that the hospital exercised a greater degree of control over their voluntary patients than, in reality, they were able to do.

27. One of the consequences of this was that the father, in particular, believed that the hospital were failing to do their duty in certain respects and, understandably, this antagonised him. I urge the Authority to review the wording of their standard letters so as to avoid giving the impression that they exercise a degree of supervision which they do not, and indeed cannot, do and that when there is any doubt whether relatives understand the obligations of the hospital to voluntary patients, they should explain them.

(*c*) *The complaint about the hospital's lack of concern when the complainants' daughter did not return to the hospital*

28. The father told my officer that, when the consultant had telephoned him at about 6.30 pm on 31 December 1976 to tell him that his daughter had not returned to the hospital for her medication, he had sounded off hand and unconcerned. Although the consultant had told him not to worry, that the police were being informed, and that everything possible was being done, his manner had inspired no confidence. The father said that because of this he had telephoned the police himself.

29. In his interview with my officer, the consultant, who lives at the hospital, said that he had been alerted not long after 6.00 pm on 31 December by the nurse (SEN) who had been waiting to give the complainants' daughter her medication. He had telephoned her father at about 6.30 because he was in no doubt that her parents had to be told without delay. Nevertheless he did not want to cause unnecessary anxiety, and he was conscious of the fact that the father had a heart condition; also, experience had shown that he was short tempered. For these reasons, and also because, at that stage, the complainants' daughter might have returned at any time, the consultant made a deliberate attempt to be calm and reassuring, but the father had, he said, lost his temper and been abusive about both the hospital and him personally. Following his

call to the father, the consultant instructed the SEN to telephone the police to inform them that two patients were missing and to stress the urgent need of medication for the complainants' daughter.

30. The SEN told my officer that she had raised the alarm quickly because the complainants' daughter had previously been so good about turning up promptly for her medication (which she received four times a day at 8.00 am, noon, 6.00 pm and 10.00 pm). She confirmed that, as instructed by the consultant, she had telephoned the police station shortly after 6.30 pm, that she had given descriptions of the two patients and had explained that the complainants' daughter was a severe epileptic in urgent need of drugs. The police had called at the hospital later in the evening to take further information—mainly about what they had been wearing—but by the time the police constable had arrived the SEN had gone off duty and he had spoken to a nursing assistant, who told my officer that she had supplied the details the police had requested.

31. I obtained copies of the missing persons reports compiled by the police on 31 December 1976 and of the telex message which they sent out that evening. The report on the complainants' daughter says—'Is a chronic epileptic who has to be treated with drugs to stop her going into a fit'. The telex message includes the following: '[the woman] is an epileptic who has not been given drugs today and it is feared she may fit'. Both the telex message and the missing persons report on the male patient actually contain exaggerations. The complainants' daughter had had two of four daily doses of drugs; and the male patient was described as a sexually violent former special security hospital patient. I have no doubt that the police recorded what they were told or what they inferred. That the facts were somewhat exaggerated suggests clearly that the hospital certainly did not understate the situation in the messages they gave the police.

32. The consultant said he had himself telephoned the police on 3 January to satisfy himself that they had a proper grasp of the complainants' daughter's urgent need for drugs.

33. Further evidence of the hospital's alleged complacency came, the mother told my officer, from the administrator whom she had seen on 11 January. She said he had told her that the male patient was a 'sharp young man' who would have had no difficulty in getting the drugs her daughter needed, and that they would be all right for money because he felt sure that they had had outside help when they had run away. The mother said it had distressed her to hear these remarks when she herself was convinced that her daughter had not intended to run away. She had not even taken her handbag with her.

34. The administrator said that he had made these remarks to try to calm and reassure the mother because she had obviously been very worried. He said that what he had said to her had been told to him by the consultant and the PSW. The PSW told my officer that despite the male patient's low intelligence he was very cunning and could be very plausible in trying to get what he wanted.

Findings

35. On the evidence I have no doubt that the hospital gave the police all the information they could as soon as they could, and that they did not fail to stress the urgent need for drugs for the complainants' daughter.

36. I am satisfied by the consultant's explanation of what the father described as his off-hand manner on the telephone. At the same time I can understand why the father should have interpreted a calm manner as an uncaring one, because it had been only a week or so before that he had had a disagreement with the consultant over the proposal to move his daughter to hospital X. I cannot, however, uphold this complaint.

(*d*) *The complaint that the hospital expressed no regrets after the death of the complainants' daughter*

37. The father said there had been no word from the hospital about his daughter's death, no letter of condolence from the hospital or the Authority, and no wreath or floral tribute at the funeral from anyone connected with the hospital. The complainants regarded this as further evidence of a total lack of sympathy or interest. The first letter they had received from the hospital had been from the hospital administrator dated 21 January forwarding some money which had been sent to their daughter in which, they said, he had expressed his personal condolences almost as an after-thought. Following their complaints about this 'shabby treatment' they had received two letters from the chairman of the Authority inviting them to go to his office to discuss them; but the damage had been done and, in their opinion, the remedy offered was too little and too late.

38. The consultant said that it was an easy criticism to make that he had not himself written to the complainants on their daughter's death. But, he said, at the time relations between the father and himself were somewhat strained and a letter from him might not have been acceptable. He knew that the police had informed the complainants of their daughter's death, and there seemed to be nothing more to be said. As for the absence of a wreath and flowers, it was not the practice of the hospital nor of the Authority to send official floral tributes.

Findings

39. I recognise that there had been differences between the father and the consultant and that the father was not entirely happy with the way the hospital had looked after his daughter. But I do not think that this was a good reason for the hospital to remain silent about her death until the administrator mentioned it in his letter of 21 January. In view of the anxiety to which the complainants had been subjected by the harrowing circumstances of their daughter's death, I consider that one of the Authority's officers should have expressed their condolences to them as soon as possible afterwards.

Conclusions

40. I have a great deal of sympathy with the complainants. They looked after their daughter at home until the increased severity of her epileptic condition coupled with their own failing health made it necessary for her to go into hospital, where she was very happy for nearly two years. The terrible anxiety they suffered during the period when their daughter was missing and the grief and shock when her death was discovered were intensified, I am sure, by their belief that the hospital could and should have prevented it.

41. The question of how much restriction to place on patients represents a continuing dilemma for those responsible for hospitals such as this one. If patients who are not considered to be a danger to themselves or others are to live a life as near to normal as possible they must be given a reasonable degree of freedom and, for the vast majority, such freedom gives them a sense of fulfilment and dignity and very little risk attaches to it. But there is inevitably some risk and it is highlighted by a case such as this. Whilst I realise that this offers little comfort to the complainants, I do not think that, without the benefit of hindsight, the actions of the hospital can be said to have been ill-judged. And I am satisfied that they took all proper steps once the complainants' daughter went missing. I do criticise the hospital, however, for not making their daughter's informal status and its implications clear to the complainants and for not writing a prompt letter of sympathy to them when her death became known. These omissions undoubtedly accentuated their feelings that the hospital were unconcerned (though I do not myself believe this to be so) and the Authority have asked me on their behalf to express their apologies for them.

Case No W41/77–78—Attack on patient by another psychiatric patient and subsequent delay in admission to hospital for treatment

Complaint and background

1. On 22 February 1977 the complainant's sister, who was an informal patient at hospital A, was attacked by another patient and sustained a fractured femur. She was taken to hospital B and admitted for treatment to her injuries. She was discharged from hospital B on 30 May 1977.

2. The complainant claims that:

(*a*) a potentially violent patient was inadequately supervised by the nursing staff of hospital A; and

(*b*) when her sister arrived at hospital B there was a delay of over two hours before the staff agreed to admit her for treatment.

Investigation

(*a*) *The complaint about inadequate supervision*

3. In her letter to me of 3 May 1977 the complainant said that, on 22 February 1977, when she and her husband arrived at hospital A to visit her sister, they were told by the ward sister that she had met with an accident and, after enquiring about the circumstances, they learnt that she had been attacked by another patient and was suffering from a suspected broken leg. The complainant said that the patient who had attacked her sister was still acting in a menacing manner, and she and her husband had been told by other patients that several of them had also been attacked or menaced by the same patient. The complainant also said that she felt that the ward staff were not in control of the situation and that there was inadequate supervision of a potentially violent patient.

4. The complainant's sister told my officer that on 22 February she had been kicked by a male patient and, after reporting the incident to the ward sister, she had gone to the dormitory to lie down. She said the ward sister came to

see if she was all right and told her to stay in bed. She thought she must have dozed, and the next thing she knew, she was being attacked by the patient who occupied the bed next to hers and found herself on the floor. She screamed for help, and the ward sister and another nurse came and sent the patient who had attacked her out of the dormitory.

5. When interviewed by my officer, the ward sister said that earlier that evening she had recognised that the patient who had attacked the complainant's sister in the dormitory had been in an aggressive mood but, although there had previously been an argument between her and another patient, she had not thought that she would become violent and had seen no need for close supervision. Indeed, she had thought this in itself might have been provocative. The ward sister said that, since she believed that the outburst was over, she had returned to her office to write up her reports before going off duty. Another nurse was in the doctor's room reading patients' notes, leaving a further nurse on duty in the ward dayroom. She said that the ward was quiet and she had no cause to suspect there would be any further trouble.

6. The ward sister told my officer that, when she heard screaming, she and the two nurses went to the dormitory and found the complainant's sister on the floor and in obvious pain. The other patient was still there, glowering, but otherwise not aggressive. She said she left the other nurses to care for the complainant's sister and went to call for medical help. When the doctor examined her he decided to send her to hospital B and prescribed sedatives for the other patient.

7. The consultant psychiatrist, in whose care the patients were, told my officer that the patient who attacked the complainant's sister was known to be aggressive but, until this episode, her acts of violence had always been in public, and she had no previous record of attacking anyone in a quiet place away from other people. He said that her case was a very difficult one and he had tried all kinds of treatment without success. He also said that he doubted whether it would have been possible for the staff to have prevented the incident even if they had been in the dormitory at the time the attack began.

8. I examined the case notes of the patient who attacked the complainant's sister and it is clear that she had periodic aggressive outbursts, which were usually contained by the use of sedatives; but on four occasions, she was kept in seclusion for short periods until the episode had subsided.

9. The evidence of the consultant is that the patient who attacked the complainant's sister was not normally aggressive in a place of comparative seclusion such as the dormitory. And that of the ward sister is that the ward had been quiet after the patient's previous outburst and she thought that all was well; and this is an opinion which she formed as a result of her professional judgment. It seems clear that even if the patient concerned had been kept under closer supervision, there was no guarantee that what was evidently a spontaneous and quite unprovoked attack could have been prevented; but, no doubt it would have been better had she been more closely supervised.

(*b*) *The complaint about the delay before the complainant's sister was admitted to hospital B*

10. The complainant told my officer that she and her husband accompanied her sister and a nurse escort in the ambulance from hospital A to hospital B.

She said that, when they arrived, the ambulance crew went into the hospital and returned to tell them that there seemed to be some doubt whether hospital B would accept her sister. After about ten minutes her sister was taken into the accident and emergency department and a nursing sister told them that she would have to be seen by a surgeon, who was then in the operating theatre. The complainant's husband told my officer that he later heard someone, whom he took to be a doctor, telephoning another hospital about his sister-in-law; but he and his wife did not themselves see any doctors and it was not until more than two hours later that the sister told them that they had decided to admit her to hospital B, at least for that night. The complainant's sister herself said she thought that it was about 11.00 pm when the sister told her she would be admitted to hospital; but it was not until about 5.00 am that she was taken to a ward.

11. The ambulance crew told my officer that when they received the call to collect a patient from hospital A, they were instructed to take her to hospital B, but when they arrived there they found that the hospital was closed to all admissions. They said that as far as they could remember they did not know about the closure before they arrived at the hospital, and they could not recall what took place or how long the complainant's sister was kept in the ambulance before being taken into the accident and emergency department. The ambulance service records show that the call from hospital A was received at 8.49 pm and that the vehicle arrived there at 8.58 pm and left at 9.20 pm. It arrived at hospital B at 9.29 pm and remained there until 10.01 pm. There is a note on the emergency call record that the ambulance was delayed at the hospital because it was closed to all admissions. The central ambulance control record bears a note, timed at 9.43 pm that '[Hospital A] did not make arrangements. [Hospital B] cannot accept patient. They are making arrangements now for admission to [hospital C]'.

12. The nursing officer on duty in the accident and emergency department at hospital B remembered the complainant's sister arriving in the department with her relatives. She said that she had understood that the ambulance crew knew that hospital B was closed but that they had thought special arrangements had been made for the complainant's sister. She said that the casualty officer had telephoned other hospitals without success to see whether they would accept her. She had explained to the complainant that her sister might have to be transferred to another hospital and, when they left at about 11.30 pm, she had suggested that they should telephone the hospital the following morning to find out what had happened.

13. The nursing officer told my officer that, after the complainant and her husband had left, she arranged for a bed to be put up for the complainant's sister in the accident and emergency department and that at about 12.45 am the surgical registrar examined her and ordered her leg to be put on traction. She said that the complainant's sister was then allocated to a ward; but by this time, she was sleeping and she decided to nurse her for the night in the department. The complainant's sister woke up at 4.30 am and, after giving her a cup of tea, the nursing officer arranged for her to be taken to the ward.

14. The casualty officer at hospital B told my officer that when he spoke to the ambulance crew they had not known that the hospital was closed. He had

asked them to take the complainant's sister elsewhere, but when the ambulance crew explained that they could only take her back to hospital A he agreed that she should be examined and x-rayed at hospital B to establish the extent of her injuries. He said that, when he had confirmed that her leg was broken, he sent a message to the surgical registrar, who was in the operating theatre, and was told to try other hospitals. This he had done, but none of them could accept the complainant's sister and the surgical registrar had then agreed to admit her. He also said that he later telephoned the duty medical officer at hospital A to complain that he had not been warned about the complainant's sister in advance of her arrival.

15. The duty medical officer at hospital A told my officer that after he had examined the complainant's sister and found that she had required treatment at another hospital, he telephoned the casualty officer at hospital B who told him that the hospital was closed for admissions. The duty medical officer said he then tried another hospital and, when they were unable to help, he again telephoned the casualty officer at hospital B who then agreed to accept the complainant's sister.

16. I have to record a conflict of evidence about whether the duty medical officer at hospital A did make prior arrangements for the complainant's sister to be admitted to hospital B. But since hospital B was clearly not expecting her, and in view of the contemporary entries in the ambulance control records, I think the duty medical officer is mistaken in his recollection, and that no such arrangements were made. I believe that the ambulance crew were not aware of the closure of hospital B. But I have found that the ambulance service were told at 8.26 pm of the temporary closure for admissions and it was only very shortly after this that the ambulance for the complainant's sister was sent to hospital A. It is unfortunate that the call came before the ambulance stations had been warned.

Conclusions

17. The complainant, her husband and, of course, her sister were justifiably upset by the unprovoked and violent attack on the complainant's sister by another patient and I have a great deal of sympathy with them. But, on the evidence, I do not find that the staff were neglectful of their duty or that the sudden incident could have been foreseen.

18. I do not criticise the ambulance service for the delay that occurred at hospital B, but I believe that the duty medical officer at hospital A did not make special arrangements for her admission to an acute hospital and that, had he done so, the transfer would probably have been effected a good deal more smoothly. The Authority have asked me to apologise on their behalf for this shortcoming.

Case No W47/77–78—Refusal by a consultant to treat a patient

Complaint and background

1. In February 1973 the complainant's wife underwent a mastoidectomy at hospital A and subsequently attended the out-patient clinic for follow-up treatment on a number of occasions. On 20 January 1977 she suffered a discharge from the ear which later became very painful. Her family practitioner

referred her to the consultant ENT surgeon at hospital A (the consultant) on 24 January. Through his Member of Parliament, the complainant wrote and told me that, although the letter from the family practitioner had requested treatment for his wife that day, the consultant refused to examine her or discuss his refusal with either of them, and that a receptionist at the hospital was rude to his wife.

Investigation

2. The complainant's wife told my officer that after the operation in February 1973 she had regularly attended the out-patients clinic for follow-up treatment but she had not attended an appointment in September 1976. On 20 January 1977 she developed a discharge from her ear and, although she was not at that time in any pain she telephoned the hospital and was given an appointment on 7 February. She also visited her family practitioner who prescribed some antibiotics. On Saturday, 22 January her ear became extremely painful and her family practitioner told her that if her condition did not improve over the weekend, she would need to see a specialist and he would give her a note to take to a hospital. As there had been no improvement by the Monday morning (24 January), the complainant, on his wife's behalf, went to see the family practitioner. The complainant told my officer that the letter given to him by the family practitioner was addressed to hospital B but, when he explained that his wife had been treated at hospital A and that all her notes were there, the doctor changed the address on the letter.

3. The complainant's wife told my officer that while her husband was obtaining the letter from their family practitioner she had telephoned hospital A, because she knew that the consultant there held his weekly clinic on a Monday afternoon. She spoke to his secretary who told her that the afternoon clinic was fully booked. The complainant's wife then asked to be seen privately and the secretary told her that if she arrived at the hospital shortly before the clinic was due to begin she was sure she would be seen. The complainant's wife told my officer that after this conversation she had no doubt that the consultant would see her.

4. The complainant and his wife arrived at the clinic at about 1.30 pm and, the complainant said, there were three people in the reception booth, a receptionist, a woman who they took to be the consultant's secretary and the consultant. The complainant's wife handed the letter from the family practitioner to the receptionist who gave it to the consultant. The consultant read the letter but then shook his head, indicating that he would not see her. The receptionist came out of the booth and said that the consultant could not see the complainant's wife because she already had an appointment for 7 February. The complainant told my officer that he had then gone to the booth in an attempt to talk to the consultant, but the consultant had used a gesture indicative of washing his hands of the matter and had said through the glass window 'I don't want to talk to you'.

5. After this, the complainant told the receptionist that his wife was in pain and that immediate treatment was needed; but the receptionist said that the consultant could not see her and pointed out that, in any case, she already had an appointment for 7 February. The receptionist also referred to the fact that

the letter from the family practitioner did not indicate that the complainant's wife was in need of urgent treatment.

6. The complainant's wife said that she then begged the receptionist to tell her where she could go for treatment, but the only advice the receptionist gave her was to return to her family practitioner if she was dissatisfied. The complainant's wife told my officer that she had said to the receptionist that she 'might be dead by then' and the receptionist had replied 'your GP would have you admitted before then'. Both the complainant and his wife regarded this as rude and unnecessary. In the end they had left hospital A without treatment, taking with them the letter from the family practitioner on which the receptionist had written 'refused appointment 7 February'.

7. The family practitioner told my wife that he had originally addressed the letter to hospital B because he had professional contacts there, but he re-addressed the letter at the request of the complainant. The opening sentence of the letter reads 'I should be obliged if you would see the above-named patient of mine this morning'.

8. The consultant discussed the complaint with two of my officers. He explained that he held a regular clinic at hospital A on Monday afternoons and saw an average of about fifteen patients at each clinic. He normally dealt with new patients himself, and his registrar saw the follow-up patients. He said he was always prepared to see patients who were in pain and in need of urgent attention; indeed, he was generally regarded as being over sympathetic in this respect. But, in these cases, it was the custom for the family practitioner to telephone the hospital in advance. He would normally see such patients at the end of the clinic.

9. The consultant told my officers that the appointments secretaries prepared the clinic lists and he did not know in advance which patients he would be seeing. He said that before starting his clinic it was his practice to go to the reception area to see whether there were any queries. He remembered that on this occasion he had been confronted with a letter which he had read and which, in his view, did not constitute a request for urgent treatment. The consultant held the view that, in addition to sending the letter, the family practitioner should have telephoned the hospital, and he had said this in a letter of 28 February to the hospital A secretary when the complaint was originally raised. He also said that he had been under the clear impression that the complainant's wife wanted to be seen immediately, and he had no intention of allowing her to take precedence over patients with appointments who were already waiting. He added that he did not know until afterwards that the complainant's wife had been in touch with his secretary that morning.

10. My officers quoted to the consultant the statement made by the specialist who had treated the complainant's wife, in his letter to the family practitioner, that she had 'a grossly inflamed, discharging mastoid cavity'. The consultant agreed that, had he examined the complainant's wife, he would probably have treated her. But he said he was not prepared to put her in front of everybody else, as she had seemed to expect, and she and her husband had left the hospital abruptly and before any compromise could be reached. He denied having used any dismissive gesture towards the complainant or having spoken the words attributed to him.

11. My officer interviewed the secretary who had spoken to the complainant's wife on the morning of 24 January (who has since left hospital A). She said that the complainant's wife had telephoned in something of a panic and had asked if she could be seen in the consultant's clinic that afternoon. The secretary had explained that this was not possible as the clinic was full. Although she could not remember precisely what she had said, she had no reason to suppose that she had not followed her usual practice of referring the patient to the accident and emergency department. However, the complainant's wife had asked if it would be possible to see the consultant privately and the secretary told her that it might be. She emphasised to my officer that she would never commit a consultant to seeing a patient in this way. She said the complainant's wife had accepted this. She had later tried to telephone the consultant to let him know what was happening but was unable to get in touch with him as he was on his way from one hospital to another.

12. However, I have seen that the administrator of patients services at hospital A interviewed the secretary when the complaint was first received and quoted her as having said to the complainant's wife that 'she felt no doubt that the consultant would see her'.

13. In an interview with my officer the receptionist said that the consultant had decided not to see the complainant's wife and he had in fact told the complainant through the glass panelling of the reception booth—'If you wish to see me please make an appointment'. She therefore told the complainant's wife that she could not be seen and offered her an appointment on 7 February; it was only afterwards that she discovered this to be the date already offered to the complainant's wife as a result of her telephone conversation the previous week.

14. The receptionist told my officer that the normal practice, if immediate treatment was requested, was to refer the patient to the accident and emergency department, but she did not refer the complainant's wife there on this occasion because she was aware that such a referral would ultimately bring in the consultant who, she knew, wanted to leave hospital A early and who had already decided that the complainant's wife was not in need of urgent treatment. She had therefore recommended that the complainant's wife go back to her family practitioner. She denied that she had been rude or unsympathetic to the complainant's wife; but although she could not recall saying that 'she would be admitted by her GP before then' after the complainant's wife said she could well be dead by 7 February she agreed that she might have said it. She acknowledged that, although it would not have been said with any rude or malicious intent, the complainant's wife might have found it a tasteless remark.

Conclusions

15. I cannot say exactly what the consultant's secretary told the complainant's wife on the morning of 24 January. But, on the evidence, I think it likely that the complainant's wife had been wrongly led by the consultant's secretary to believe that she would be seen immediately before the start of the clinic and it was this belief that started the series of misunderstandings that caused her not to be seen at all. I can understand the refusal of the consultant to see the complainant ahead of the patients who had definite appointments. But, considering that she had a letter from her family practitioner asking for her to

be seen 'this morning' and that she said she was in pain, this did not justify her being allowed to leave without being examined either in the ENT department or in the accident and emergency department and with the sole advice that she should return to the family practitioner who had referred her in the first place. I think the Area Health Authority owe the complainant and his wife an apology for their failure to provide a service and I invite them to consider what steps they can take to ensure that such a failure does not recur.

Case No W48/77–78—Rudeness by hospital staff

Complaint and background

1. The complainant's wife was invited to attend the dental department of a hospital on 8 September 1976. On attending that day she was told her appointment had been for 7 September. The complainant states that:

(*a*) the receptionist insulted his wife and accused her of being muddled;

(*b*) the consultant oral surgeon whom his wife saw by appointment at a later date shouted at her and ordered her removal from the department;

(*c*) the reply dated 21 January from the district administrator failed to deal with his complaints in a satisfactory manner and contained a mis-statement about an apology from the consultant.

Investigation

(*a*) *The complaint that the receptionist insulted the complainant's wife and accused her of being muddled*

2. The complainant's wife told my officer that, while attending the diabetic clinic at the hospital on 25 August 1976, an appointment had been made by telephone for her to attend the dental department, and she was handed a card bearing the date 8 September. She had attended with her husband at the correct time on that date, but discovered that the appointment had, in fact, been made for the previous day, 7 September. She and her husband were not concerned at what they accepted as a human error on the part of the hospital staff in transcribing the date onto the card, but they were upset when the receptionist suggested that it was the complainant's wife, and not the hospital, who was at fault. They were caused further annoyance when the receptionist, during discussion about instructions given on a previous occasion by the resident dental surgeon, accused the complainant's wife of telling lies.

3. The receptionist told my officer that when the complainant's wife arrived a day late for the appointment she had explained the error and apologised. The complainant had then asked why his wife had to attend at all and she explained that she had been referred to the resident dental surgeon by the diabetic clinic. At this point the complainant's wife became abusive, referring to the previous appointment with the resident dental surgeon and commenting on the advice he had given. The receptionist said that she had tried to calm her and suggested that she had misunderstood what the resident dental surgeon had said. She denied that she had called her a liar. In an effort to make amends for the confusion over the dates she then offered to help by trying to arrange another appointment at another hospital to see if that would result in an earlier appointment, but she was not at the time able to give a firm date and the complainant's wife had left the department.

4. The regional dental officer told my officer that he had been writing up some notes in an adjoining surgery, when he became aware that a voice was being raised. He could not remember actual words or phrases, but said that the complainant's wife was shouting at and abusing the receptionist, who was doing her best to calm her and who in his view conducted herself in an exemplary manner.

Findings

5. The confusion over the date of appointment was unfortunate, but, as the complainant has accepted, it arose from a simple error in transcription. The receptionist says she apologised for this, but it would be understandable for the complainant's wife to feel some sense of grievance at her unnecessary journey. As a result, she may have reacted more strongly to the receptionist's suggestion that she had misinterpreted advice previously given about her dental treatment. I am unable to determine what words were exchanged, but I am satisfied that the receptionist was not deliberately rude to the complainant's wife.

(*b*) *The complaint that the consultant oral surgeon shouted at the complainant's wife and ordered her removal from the department*

6. The complainant's wife told my officer that on 9 September she had received notification of an appointment made for her with the consultant oral surgeon on 21 September. She attended at the appropriate time with her husband but the surgery was running late and they were asked to go and have some coffee whilst waiting. When they returned to the department they were shown into the consultant's surgery. As they approached the door they heard the consultant say he did not want the complainant in the surgery. Once inside the complainant's wife sat in the dental chair and the complainant sat in a chair on the other side of the room. The complainant told my officer that there were two other people in the surgery in addition to the consultant, who was writing at a small side table. The consultant then turned from his papers and asked the complainant's wife what the trouble was. As she started to explain he had propelled himself across the room on a chair on wheels, put his face close to hers and demanded why she had 'got uppity' with his staff. The complainant's wife said that she had been upset by this and had left the surgery. The complainant then spoke to the consultant about the way he had treated his wife. The consultant asked the complainant to take his wife out of the department.

7. The consultant told my officer that he had agreed to see the complainant's wife because she was obviously in need of dental treatment and had refused to see the resident dental surgeon. He could not remember whether he had known that the complainant was coming with his wife but said that it would not have made any difference if he had, as he was quite happy to have both in the surgery at the same time. He thought that a dental nurse had been present and possibly a senior student from a teaching hospital but he could not be sure about this. He had studied the case notes carefully and then examined the complainant's wife to confirm the diagnosis. After completing his clinical examination he had mentioned the difficulties that had arisen on her previous visit and asked her to refrain from upsetting his staff. (In a report made on 17 January, of which I have seen a copy, the consultant confirmed that he had apologised to the complainant's wife for the mix-up over the appointment.) He could not remember

the actual words that he had used but was sure that his manner had not been provocative, and he had been surprised by her reaction in leaving the surgery shouting. He told the complainant, who had remained behind, that he was sorry he had upset his wife but that he was not prepared to let patients be rude to his junior and ancillary staff. The complainant had appeared to accept this and the consultant had offered to see his wife again.

8. The dental nurse told my officer that she had been the only other person in the room with the consultant when he saw the complainant and his wife. He had greeted them normally and invited the complainant's wife to sit in the dental chair and the complainant on a spare chair. She showed my officer the surgery and he was able to confirm that the table at which the consultant had been sitting was about four feet from the dental chair. The dental nurse said that the consultant had crossed to the dental chair in his wheel-chair and examined the complainant's wife in his normal manner. The complainant's wife showed herself to be anxious and tense, but this was not unusual in patients attending for extensive dental surgery. When the consultant had finished his clinical consultation he had referred to the earlier incidents and asked the complainant's wife to bring any future difficulties to him as he was the best person to deal with them. At this, the complainant's wife became very agitated and had left the surgery shouting. The nurse followed her, leaving the complainant and the consultant in the surgery.

Findings

9. There is a complete conflict of evidence about what happened in the surgery and I cannot resolve it.

(c) *The complaint that the reply from the district administrator was unsatisfactory and contained a mis-statement*

10. The complainant wrote to the district administrator of the local Health District on 11 December 1976. He was sent an acknowledgement on 15 December and a full reply on 21 January. He spoke on the telephone on 2 February to the district administrator, who confirmed in writing, the same day, arrangements for a meeting on 8 February. In a letter to me the complainant said that he declined to attend that meeting because the consultant was to be there and he did not feel any useful purpose would be served by seeing him again. He also said that the consultant did not at any time apologise for his behaviour towards his wife.

11. The correspondence I have seen shows that when the complaint was received those involved were asked to write statements. As soon as these were completed a full reply was sent to the complainant, containing an apology for the confusion over the original appointment and an expression of regret for the misunderstandings which resulted from it. It also suggested a meeting to discuss the complaint informally. The statement about the apology from the consultant reads 'I understand from Mr . . . (the consultant) that he apologised also to [the complainant] for the mix-up over the appointment . . .' and was taken from a report written by the consultant on 17 January in which he confirmed that he did apologise to the complainant's wife (paragraph 7).

Findings

12. The district administrator gathered all the information he required to reply to the complainant without unreasonable delays and his reply to the complainant was conciliatory containing an apology and an offer of an informal meeting. It is unfortunate that the complainant and his wife should have refused to take up this offer, as in my experience I find this is the most effective means of clearing up misunderstandings of the kind which occurred in this case. The district administrator's statement about an apology from the consultant was written in good faith and, while the consultant is not now able to recall the words used during the interview, I have no reason to doubt that he made the statement believing it to be true.

Conclusion

13. I have investigated these three separate complaints as far as I was able to do so and I have given my findings in respect of each of them. The whole affair started with a misunderstanding and it is best regarded as such.

Case No W51/77–78—Complaints about unkind treatment in two accident and emergency departments

Complaint and background

1. Following an accident on 11 March 1977 the complainant attended the accident and emergency department (A and E Department) of hospital A four times. She complains that a doctor was rude to her on her fourth visit on 21 March. The complainant met with another accident on 17 March when she was taken by ambulance to the A and E Department at hospital B. She complains that the ambulance crew did not report that she had been unconscious, that she was discharged from hospital although she could not walk, and that a nurse threw her clothes at her and told her to get dressed.

2. Complaints were made about these incidents, soon after they occurred, to the administrative staff at both hospitals, but the complainant was dissatisfied with the replies she received.

Investigation

The complaint about hospital A

3. The complainant told me in her letter of complaint that she had injured her left arm in an accident on a bus on 11 March 1977. She had gone to the A and E Department at hospital A where her arm was x-rayed and was found to be severely bruised but unbroken. On 14 March, the complainant returned to the hospital because of swelling and pain in her left hand. The doctor who saw her seemed to think that she was making a lot of fuss about nothing. On 16 March the complainant went to the hospital again because of pain in her left foot (which she said had been painful since an operation in April 1975). The complainant told me that a different doctor had bandaged her foot and told her to return on 21 March. She said that when she returned, as she had been told to do, a nurse had just finished unbandaging her foot when the doctor who had seen her on 14 March had looked into the cubicle and said

loudly—'this is the fourth time I have seen you in the last few days—you keep coming in here with trivial complaints'. He had also told her that there was 'nothing at all wrong' with her and that she ought to be at work; and he had not examined her foot. She complained to the hospital's assistant administrator after she left the A and E Department and was dissatisfied with a letter she subsequently received from him because it contained no apology from the doctor.

4. Because the doctor who saw the complainant on 21 March now lives abroad I have not been able to obtain his account of what happened. But the assistant administrator told my officer that he had spoken to the doctor, who had denied making the comments attributed to him by the complainant and had told the assistant administrator that each time he had touched her foot she had accused him of hurting her. The doctor had said that after several attempts to re-dress the complainant's foot, he had told her that, if she would not allow him to touch it, he could not do anything for her.

5. I have seen the record card which the doctor completed at the time. He noted that she was histrionic and unreasonable, that she would not allow him to make an examination and that he had authorised her discharge.

6. My officer met four of the five staff nurses who had been on duty in the A and E Department on 21 March (the fifth nurse is now abroad). None of the nurses seen could remember much about the complainant's visit and none of them recalled the doctor being rude.

7. The most important witness—the doctor concerned—was not available for interview by my officer. But he was seen by the assistant administrator who, following their discussion, wrote to the complainant saying that the doctor had had no intention of being rude to her and that he was sorry she felt he had been. In the circumstances, I do not think he could have done more.

The complaint against the ambulance service

8. The complainant told me that on 17 March when she had fallen in the street she believed that she had lost consciousness. She told my officers that she had learnt from a letter she had received from the administrator of hospital B dated 20 April 1977 that the ambulance crew who took her to the hospital had not told the staff that she had been unconscious.

9. In his written comments to me the Chief Officer of the London Ambulance Service (LAS) said that the ambulance crew concerned were sure that the complainant had not lost consciousness whilst she had been in their care; and they had not had any information to suggest that she had been unconscious before they had arrived on the scene. Had they been told that she had been unconscious, they would have reported the fact to the hospital staff. The Chief Officer provided me with copies of witnessed statements made by the ambulance crew which described what had happened after they arrived on the scene.

10. On the evidence I am sure that the ambulance crew had no reason to suppose that the complainant had been unconscious before they arrived to take her to the hospital.

The complaints about hospital B

11. The complainant told me that in the accident of 17 March she had injured her foot and her head. When she was examined on arrival in the A and E Department at hospital B the doctor had grabbed her injured left arm and had said—'this is not a recent injury'. She said she had then described her accident and told him that she was only complaining about her head and foot, which were both painful. But the doctor had still insisted on trying to find the whole range of movement in her arm, so causing her unnecessary pain, and had tried to insist that her arm should be x-rayed; but she had refused to allow this to be done. The doctor had then told her that she should go because there was nothing wrong with her. The complainant said that a nurse had then come to her, tossed her clothes across the trolley and told her to get dressed and to go. Her foot had then been bandaged and she had asked the nurse to get someone from the firm where she worked to collect her by taxi; and this had been done. She told my officers that she had been discharged even though she had made it clear that she was unable to walk. She also said she had been in a state of shock at the time and there were gaps in her recollection of what had taken place.

12. I have not been able to obtain evidence from the doctor concerned because he now lives abroad. But I have seen the record card which he completed on examining her; he recorded that the complainant had had a fall and sustained injuries to her head, neck, left ankle and left shoulder. He also noted the old injury to her left elbow. The notes record that he examined the complainant's eyes, neck, spine, arms, chest and shoulder, and left ankle, which he found was tender. He ordered an x-ray of this, and the report states that there was no fracture identified in the ankle.

13. The staff nurse who had seen her told my officer that the complainant had become very anxious soon after her arrival. She said that she had gone to the complainant when she had heard a lot of noise from her cubicle and had found her shouting at the doctor and saying that she did not want to be treated by him. The doctor left after asking for an x-ray to be taken, but the complainant was reluctant to stay. The staff nurse had persuaded her to remain for the x-ray and when it had been done the doctor told the complainant that it showed that there was nothing wrong with her and that she could go home. The staff nurse said that the complainant had told him that he should also have x-rayed her arm, and he had said that that was not necessary. The complainant had then become hysterical and shouted about inadequate treatment, and pushed the doctor away. The staff nurse said that, after the complainant's foot had been bandaged, she had given her her clothes, but she denied that she had thrown them at her. When she had asked the complainant where she worked so that she could get a colleague to go home with her, the complainant, because of her distressed condition, could not remember. The staff nurse had, with some difficulty, managed to trace the firm's telephone number and to arrange for a colleague to come for the complainant with a taxi. She recalled that the complainant had at first said she could not walk but, after she was offered a wheelchair, had said that she could. In the event she had left the hospital, but with some difficulty. Other nurses confirmed to my officer that the complainant had been very distressed and had seemed incensed about the doctor.

14. On the evidence it is clear that the doctor did examine the complainant and took such action as he considered appropriate, including the decision to discharge her. In this, he clearly acted solely in the exercise of his clinical judgment which is not for me to question. As to what happened subsequently, the complainant herself acknowledges that there are gaps in her recollection of events. For my part I have found nothing in the evidence to suggest that the complainant was treated with any less consideration or skill than she was entitled to expect.

15. I have seen from the correspondence files that, when the administrator became aware after he had spoken to the complainant, that she was still dissatisfied, he had suggested that she should meet the doctor who had seen her and the sister in charge of the department; but the complainant had declined to do so. I think this offer was an entirely reasonable attempt to resolve the complaints.

General conclusions

16. I have been unable to uphold the complaints. I think the complainant is mistaken in her view that the staff at the two hospitals and those of the ambulance service dealt with her either inefficiently or unkindly.

Case No W68/77–78—Use of 'means test' by NHS

Complaint and background

1. When the complainant's mother enquired about chiropody treatment under the National Health Service she found she would have to complete an application form giving details of her income and expenses in order to establish her entitlement to the service. The complainant claims that the Area Health Authority (the Authority) are applying a means test and that they are not empowered to do this. The complainant wrote to the area administrator on 30 May 1977 about his complaint but he was dissatisfied with the reply dated 8 June from the area general administrator and asked me to investigate.

Investigation

2. In his letter to me the complainant said that his mother had been told that before she could be considered for chiropody treatment under the National Health Service, she would have to fill in a form giving details of her income and expenditure. The complainant's mother told my officer that she had been to a local private chiropodist for treatment to a large corn on her foot. He had told her that it would require twice weekly treatment for several weeks. This would cost £2·20 per visit. She could not afford this, and when she asked him whether treatment was available under the National Health Service, he had given her a form to fill in. When her son had seen the form he had refused to allow her to complete it, saying that chiropody treatment should be provided free for elderly people.

3. The complainant wrote to the Authority on 30 May 1977. Their reply of 8 June expressed regret that the demand for chiropody under the National Health Service far outstripped their means to provide it. The only method of

ensuring cover to the priority groups was to define the financial circumstances of applicants. It was not a system they were happy to operate but they considered it reasonable in the circumstances. It did not necessarily rule out the provision of treatment on the basis of urgent clinical need.

4. The Authority told me that they had taken over the administration of chiropody services from local authorities on the reorganisation of the health service in 1974. There had been no change in the system since then. The bulk of those treated were old age pensioners and were non-urgent medical cases seen for routine treatment such as nail cutting. Patients requiring treatment urgently would either be treated by their family practitioner or referred to hospital. All those given routine treatment had been subjected to the 'means test'.

5. A broad outline of the organisation needed by each Authority in order to take over the chiropody service was given by the Department of Health and Social Security in circular HRC(74)33, from which the following is an extract:

> 'Chiropody services should be organised primarily on a district basis; there should be a District Chiropodist, accountable to the District Community Physician, who should be responsible for the running and organisation of chiropody services throughout the district whether provided in hospitals, health centres, clinics, old people's homes, in the patient's own home, in chiropodists' surgeries, schools or elsewhere. District Chiropodists will also normally undertake some clinical work.'

6. The circular recommended the appointment of district chiropodists, with an area chiropodist to undertake functions for the area as a whole. In the area named in this complaint, no area chiropodist has been appointed and, at the time of my enquiry, there was only one district chiropodist in post. The district in which the complainant's mother lives had no full-time chiropodist and services were provided by private practitioners on behalf of the Authority.

7. The Authority's files show some concern for the standard of chiropody services provided. In June 1975 a working party was set up, consisting of senior representatives of the medical, nursing and social services and of administration, as well as chiropodists, to advise the Authority on the development of the service. Their report, completed in June 1976, made a number of recommendations, including the abandonment of the assessment of means as a method of determining the need for chiropody. The working party considered that the chiropodist should decide, on the basis of his clinical assessment, whether or not to treat a patient. This recommendation has not been implemented by the Authority.

8. As a result of a meeting of senior Authority staff in January 1977, the Department of Health and Social Security were asked for their attitude towards the use of a means test. The relevant passage in the letter of enquiry reads as follows:

> '. . . I spoke with you recently about chiropody and the procedure used in [the area] which in fact is a means-tested scheme. Because facilities do not match demand, this is considered to be the best way of ensuring, as far as possible, that those with priority needs are not debarred when financial circumstances could be a relevant factor to obtaining treatment.

I was grateful for your referral to the relevant circulars. I should be further grateful if the views of the Department could be conveyed in writing on the system outlined, as it is not altogether clear whether it is covered under the provisions of the above-mentioned circular . . . '.

In their reply the Department stated,

'. . . As you know Circular HRC(74)33 asked Area Health Authorities to continue the former Local Health Authorities' practice of restricting NHS chiropody treatment to certain priority groups, viz the elderly, the handicapped, expectant mothers and school children. We know that many [Authorities] do not have the manpower or other resources to provide a satisfactory service for even the elderly and have therefore decided to introduce their own criteria for determining priority amongst this and other groups. It is implicit in paragraph 11 of HRC(74)33 that decisions as to level of provision rest with individual [Authorities] and if your [Authority] considers that a "means" type test is the best way of determining priority amongst those seeking treatment that is entirely a matter for the Authority . . .'.

Conclusions

9. The Authority have been advised by the Department of Health and Social Security that they are acting within their responsibility in imposing financial criteria for the selection of patients for non-urgent treatment. They are not in breach of any statutory requirement, and I cannot conclude that the system, based on proper criteria consistently and fairly applied, represents maladministration or failure in providing a service. As the complainant's mother did not in fact apply for treatment, and therefore gave the Authority no opportunity to decide on her eligibility, I have had no occasion to examine the criteria or the way in which they are applied. I do not criticise the manner in which the Authority dealt with the complaint: their reply of 8 June was a sympathetic explanation of their policy, though I can understand the complainant's dissatisfaction with its content.

Case No W79/77–78—Disagreement over mode of treatment

Complaint and Background

1. The complainants' mother was a patient at a hospital from 6 December 1976 until her death on 28 December. The complainants wrote to the Area Health Authority (the Authority) on 27 January complaining about failures of communication on the part of the medical and nursing staffs; of the inexperience, rudeness and apparent lack of supervision of junior medical staff and of the inadequate nursing care given to their mother while a patient on the medical ward. The complainants were dissatisfied with the reply they received and asked me to carry out an investigation.

Investigation

(*a*) *The complaint about failures of communication on the part of the medical and nursing staff*

2. The complainants told me that they considered, after they had indicated that they were unhappy about the prospect of chemotherapy treatment for

their mother and in view of her poor prognosis, that the consultant should have discussed her case with them. They said that whenever they asked to speak to a doctor they were usually seen by a medical student who had informed them that, in his view, chemotherapy was of no value to their mother but on the following day had changed his mind. They recalled that on one occasion arrangements were made for one of them to see the first assistant in medicine but it had never been suggested by anyone that they should discuss the case with the consultant. The complainants told me that on the day of their mother's death, they had both thought she was about to die because of her jaundiced appearance. They asked the medical student for his opinion, and he told them that their mother was fine. They also informed me that later that day, when they attended for evening visiting, a nurse asked them to stay in the waiting room because their mother required changing. Some 20–25 minutes later they were told that she had just died. They considered that they should have been informed earlier of the deterioration in her condition and given an opportunity of being with her when she died.

3. In its reply of 14 April to the complainants the Authority said that the consultant was of the opinion that their mother might have derived benefit from chemotherapy and planned to administer it when her general condition improved. It was understood that the complainants were against this approach and her condition never improved. The Authority went on to say that the medical student in question was in his final year and was attached to the consultant's firm to carry out normal locum duties in the absence of the pre-registration house officer. At the request of the nursing staff, who had reported that the complainants were unhappy about the care their mother was receiving, the medical student spoke to them on at least three occasions to explain the rationale behind the consultant's management, but it was obvious that they disagreed with the intention to use cytotoxic drugs as part of this. Accordingly both the first assistant in medicine and the medical student asked the complainants to discuss the matter themselves with the consultant.

4. The consultant told me that he did not usually ask relatives before following a particular course of treatment on a patient but he was always willing to discuss his reasons for doing so if relatives requested it. Unfortunately, he said, the complainants never approached him directly to discuss their mother's treatment with him so that he was unable to indicate the benefits, and on no occasion, as far as he knew, was any attempt made to make an appointment to see him. He told me that it was his policy to rely on relatives to make the approach and express their views. He said that, particularly in view of the fact that the sons were themselves professional people, he would not have thought there was any reason for them to feel diffident about approaching him. The consultant also informed me that it was a well-established practice in teaching hospitals for senior medical students to carry out locum duties in the absence of housemen. It was expected that they would do the clerking of patients, inform relatives of diagnoses, prognoses and deal with any queries as they arose.

5. The first assistant in medicine told me that his meetings with the complainants had been arranged by the medical student and the nursing staff. He had spent a considerable amount of time with them in giving them detailed information. He said that during his meeting with one of the complainants he

had explained that the consultant hoped to start chemotherapy when his mother's general condition improved and had invited him to discuss this with the consultant. He also said that at none of his meetings with the complainants had they made any complaints or expressed doubts about chemotherapy. But he detected that they hoped that their mother's life would not be prolonged unnecessarily. He also thought that they did not fully understand the modern methods of treating terminal cases.

6. The medical student, who has since qualified as a doctor, told me that, during his second meeting with the complainants they informed him of their objections to the use of chemotherapy in their mother's case. He stated that he had pointed out that he was a medical student and was not in a position to change the consultant's plan for their mother's management and advised them to discuss the matter with the consultant. Although he recalled that he had been asked for his view on chemotherapy he was certain that he had always defended the consultant's decision and that he had not said that he thought it was of no value. He also remembered that he himself had telephoned the consultant's secretary in an attempt to arrange an interview for them with the consultant, but a time could not be found which was convenient for both parties. As an alternative, a meeting was arranged with the first assistant in medicine for 25 December. The former medical student assured me that during his interviews with the complainants, he had repeatedly told them to discuss their misgivings about the use of chemotherapy in their mother's case with the consultant.

7. The student recalled that, on the day of the complainants' mother's death, before he had even had an opportunity to examine her, the complainants approached him on the ward and commented that their mother looked jaundiced, to which he replied that she had not been so when he last saw her.

8. Both the divisional and senior nursing officers informed me that they did not consider that the nursing staff on duty on 28 December should have summoned the sons to the hospital when they had already visited the ward earlier in the afternoon. They were aware of their mother's condition and were expected again that evening. They pointed out that relatives of patients with terminal or critical conditions were informed by the nursing staff that visiting hours were unrestricted and, as the complainants were aware of their mother's terminal condition, it would have been insensitive to have repeatedly restated the position. The consultant agreed with this view. However, one complainant told my officer neither he nor his brother had been informed that there was unrestricted visiting in his mother's case.

9. The staff nurse on duty in the ward on the evening of the complainants' mother's death told me that shortly before evening visiting, when checking to make sure that patients were comfortable, she had found her dead and, because the student was not authorised to do so, it had been necessary to send for the qualified house physician from the male medical ward to certify death. This resulted in some delay. The staff nurse said that as far as she could recall she had told the relatives that the patient required the attention of a doctor and had asked them to remain in the waiting room.

10. Both the consultant and the senior nursing officer confirmed that death could only be certified by a qualified doctor and the consultant added that it would have been inappropriate for the complainants to have been present when

the house physician certified death. It was also pointed out that it was the hospital's practice to ensure that a doctor informed relatives of patients' deaths.

11. From my examination of the nursing notes I have established that a deterioration in the complainants' mother's condition was noted at 6.00 pm and at 6.25 pm she was found dead. At 6.55 pm she was examined by the house physician who certified her death. He could not remember where he was at the time he was summoned to see her. But the senior nursing officer's investigation showed that the house physician had been on wards 9 and 15 which were located at the opposite end of the hospital to the female medical ward and were some 5–10 minutes walk away.

12. It is not clear why the complainants thought that they had not been advised to see the consultant about their mother's case but I am inclined to agree with him that the onus was upon them to make the approach and I am of the opinion that they misunderstood the medical student's remark about their mother's condition on the day she died. I also consider that, in view of the circumstances mentioned in paragraphs 8 and 9 above, the nursing staff's decision not to contact them was the correct one. However, I can well understand their feelings at the unfortunate sequence of events which prevented them being with their mother at her death and for which I have sympathy.

(*b*) *The complaint about the inexperience, rudeness and lack of supervision of junior medical staff*

13. The complainants told me that they considered that it was improper for a medical student to discuss patient management with relatives and thought that there should have been greater supervision. On the day of their mother's death they said that they had been upset when the medical student told them they were meddlesome and they got the impression that he would not or could not consult his seniors. The complainants also stated that they considered that the house physician was grossly inexperienced because he said to one of them following their mother's haematemasis, that he did not know whether to transfuse or not and asked him for his opinion. He was then heard to have asked the nursing staff what the consultant wanted done in the event of a big bleed. The complainants got the impression that the house physician was reluctant or frightened to consult his senior colleagues.

14. The Authority, in its reply to the complainants, acknowledged that the medical student was unqualified and inexperienced, but strongly rejected their claim that the medical student was inadequately supervised and stated that all junior staff were supervised by the first assistant in medicine and the consultant. They added that, as the medical student had requested them to discuss their mother's management with the consultant and they had chosen not to do so, it was hardly surprising that a modicum of frustration crept into his approach and it was very regrettable that they interpreted this as offensiveness, particularly in face of the great burden of personal grief they had to bear at the time. They went on to say that the house physician was attached to the consultant's firm and attended all ward rounds on the unit. On one of his nights on call he was asked to see the complainants' mother who had had an episode of haematemasis and on examination he considered that the clinical indications were such that a transfusion was not necessary. He was totally aware of the management plan and kept his seniors fully informed at all times.

15. The consultant told me that junior members of his firm were encouraged to consult either the first assistant in medicine or himself if they were ever in doubt about a patient's treatment but added that the house physician had no need to seek advice on the occasion the complainants' mother had a small bleed, his handling of which both he and the first assistant in medicine agreed was faultless. The consultant informed me that when a patient had a bleed, as the complainants' mother did, a doctor did not transfuse automatically. It was necessary to reserve judgment and review the case to establish what happened to pulse and respiration rates. He commented that it was not unusual for doctors who were called to a patient to ask the nursing staff what the position was. The consultant informed me that the house physician may not have known whether to transfuse at the stage when he saw the complainants because he may not, for instance, have known her haemoglobin result. This interpretation was quite different to that of the complainants who had implied that the house physician did not know whether to transfuse their mother because he was not conversant with the case. I also learnt from the consultant that without his prior knowledge the complainants had introduced an outside doctor into the case. He regarded this action as unprofessional.

16. The medical student told me that he was given excellent supervision and had been encouraged to consult the first assistant in medicine or the consultant at any time. He stated that on the day of their mother's death when he met the complainants he had treated them sympathetically and was adamant that he had not told them they were meddlesome. But he thought that he might have told them that they were being critical of the consultant's management of their mother. He assured me, however, that, although he had been frustrated because it had been repeatedly necessary to tell them to see the consultant, he had not been angry.

17. The house physician told me that, when he was called to the female ward on 25 December following the episode of haematemasis, he realised that the complainants' mother had only lost a comparatively small quantity of blood. Her general condition was fairly good and her pulse and respiration rates had only slightly altered. He explained that in the event of haematemasis it was necessary to monitor and review a patient's general condition to determine whether there was any deterioration. At the time he saw the complainants' mother there was no question of a transfusion. Although he could not clearly recall his conversation with the nursing staff, the house physician said that he thought it was likely that he had asked whether she was to be transfused in the event of heavy bleeding and told them to monitor her general condition for signs of deterioration. But had she suffered heavy loss of blood the house physician stated that he would have consulted the first assistant in medicine or the consultant. He was unable to remember precisely what he said to the complainants on that day, but, because he knew they were professional people, he said that he had thought that they would value a discussion. As far as he could recollect, he had explained to them that their mother had had a small bleed and thought that, as basis for discussion, he may have gone over the procedures for dealing with haematemasis. But he was sure that he had not asked either of them whether he should transfuse her. Such a decision, he said, could not have been taken immediately and was dependent on whether her condition deteriorated. He said that there had been no need to consult anyone

and his remarks to the complainants were meant to convey that consultation was unwarranted and not that he was unable or reluctant to seek advice. The house physician commented that the incident had been misrepresented and, with hindsight, he should not have discussed the matter in the complainants' presence.

18. Although there is no dispute about the inexperience of the former medical student, it is inevitable in teaching hospitals that students will come into contact with patients' relatives and I can find no evidence to suggest that either the medical student or the house physician were inadequately supervised, or, in fact, required supervision on the incidents in question. I am unable to resolve the discrepancy between the complainants' statement that the medical student was rude and his own account of the incident. It has been established that the house physician was acquainted with the case and that his management of the episode of haematemasis is without criticism. It has also been pointed out that it is not unusual for medical staff to ask nursing staff about situations into which they are brought. As for the house physician's conversation with the complainants, I am inclined to believe that, because of their distress at the time, they have misunderstood his remarks and I cannot uphold this aspect of the complaint.

(*c*) *The complaint about inadequate nursing care on the medical ward*

19. The complainants told me that because their mother was so weak and critically ill, she was unable to reach the bell behind the bed to call for attention and she was unable to call out. They themselves had asked the nurses to go into her cubicle when passing to make sure that she was comfortable and to ensure that the door was left open. Their mother, they said, had told them that the nurses were rough with her and begged to be taken off the ward.

20. The Authority in its reply to the complainants stated that the allegation of lack of adequate nursing care was strongly refuted by the nursing staff. There was no evidence that the complainants had expressed any dissatisfaction with her treatment to the nursing staff and the records and information gathered indicated that she received all the necessary nursing care. After their mother died it was noted that they returned to the ward to thank a staff nurse for the care she gave.

21. I was informed that it was the practice on the medical ward to place the call bells beneath patients' pillows and that cubicle doors were left open except when visitors were present or when a patient was nursed in isolation. My officer visited the medical ward and confirmed that cubicle doors were left open and that call bells were placed beneath pillows. The nursing staff told me that when the complainants' mother was transferred from the surgical ward on 23 December she had been very drowsy and would not have used the bell. After 25 December, when she became very ill, the nursing staff thought that she would have been too weak to have made use of it. A student nurse who was on duty from 24–28 December did recall her using the bell before her condition deteriorated. It was pointed out by the nursing staff that the complainants' mother was given hourly fluids and turned every two hours. Although I was assured by the nursing staff that they were not rough with her the senior nursing officer pointed out that it was inevitable that the complainants' mother, in view

of her condition, would have experienced discomfort when turned. She commented that the slower and more gentle a nurse was, the more protracted and intense was the pain the patient experienced.

22. Nursing staff told me that they were trained to glance automatically through the cubicles' observation windows when passing by to ensure that patients were comfortable. Apart from providing the nursing care a patient required, nurses would sit with them whenever they had a free moment. The senior nursing officer confirmed that there were five nurses on duty on the medical ward and, on the basis of a nurse walking along the corridor only twice every hour, patients were observed on average every six minutes.

23. Not one of the nurses interviewed could remember the complainants' mother complaining about lack of attention or of being treated roughly. From my examination of the nursing notes I observed an entry on 27 December which stated that the complainants' mother was: 'very restless and frightened at times'. The enrolled nurse who made the entry in the notes told me that as far as she could now remember the complainants' mother had been very frightened at being left alone in the cubicle and thought that it was because of her fear of death that she had wanted someone to hold her hand. On that night the nurse told me that she had spent as much time as possible with the complainants' mother and added that the other staff on duty had also kept a close eye on her.

24. My officer observed that there was a marked difference in layout and atmosphere between the surgical and medical wards on which the complainants' mother was nursed. The surgical ward is open-plan and very bright and cheerful. In contrast, the medical ward, which is much less bright, is a cubicled ward where patients are nursed in thier separate cubicles. On first impression, the medical ward is not so cheerful. It is quite possible that the complainants' mother preferred the company of other patients and disliked being in a room on her own, in spite of the considerable nursing care which she received.

25. During my investigation I have been unable to find any evidence to support the view that the nursing care given to the complainants' mother was inadequate. And, although she told them of her preference for the surgical ward, I think her preference was more indicative of her psychological state than a reflection on the quality of nursing care she received.

Conclusion

26. The complainants' mother suffered from advanced cancer for which surgery was not considered effective. The consultant physician intended to treat her with cytotoxic drugs and would have done so but for her sudden deterioration. The complainants however believed that their mother's suffering should be minimised and felt at variance with the consultant's proposals. I believe that this difference of opinion together with the introduction of an outside doctor into the case by the complainants created an unsatisfactory climate for relationships. Although I understand the complainants' distress arising from their natural anxiety about their mother's care I have not found cause for criticism of the medical and nursing staffs.

Case No W83/77–78—Discharge from accident and emergency department

Complaint and background

1. On 14 October 1976 the complainant and her brother-in-law were involved in a road accident whilst travelling from London to Leeds and were taken by ambulance to the Accident and Emergency Department of a hospital. The complainant received treatment for her injuries and was discharged; her brother-in-law was admitted to the hospital.

2. The complainant claims that:—

(*a*) she was discharged from hospital in wet and bloodstained clothing and inadequate attempts were made by the staff to get in touch with her relatives; and

(*b*) the investigation into her complaint by the Area Health Authority (the Authority) took too long to complete and the reply she received was inadequate.

Investigation

(*a*) *The complaint about the complainant's clothing and the failure to get in touch with her relatives*

3. In a letter of 24 October 1976 which was sent to the local Health District of the Authority through two Community Health Councils, the complainant said that on the journey from London to Leeds her brother-in-law's car had suddenly swerved off the road, overturned, and landed in a flooded field. She said she crawled out of the car and sat beside it in blood, water and mud. When the police arrived they had looked after her until the ambulance took her to hospital, where it was found that she had cut her face and right hand in the accident.

4. In an interview with my officer the complainant said that she arrived at the accident and emergency department of the hospital at about 11.45 am and was put on a trolley and wheeled into a cubicle where two nurses cleaned her face, treated a cut above her left eye, and gave her an anti-tetanus injection. She was then examined by a doctor and after this, nurses helped her to undress and she was taken for an x-ray. When she returned to the cubicle, the nurses helped her to get dressed again. The complainant said she was in no fit state to argue about the condition of her clothes which were wet, muddy and bloodstained, but no suggestion had been made that she could be lent some dry clothes or that her own clothing could be dried at the hospital.

5. The complainant told my officer that after she had dressed and had had a cup of tea she went to see her brother-in-law who was in the next cubicle and, while she was there, a nurse told her she could go home and suggested that, if she wished, she could wait in the accident and emergency department until someone came to collect her. She said the nurse asked whether there was anyone with whom they could get in touch but at the time she had said there was no one. She told my officer that her son-in-law was working in Keighley and she did not know his precise whereabouts and, although her daughter was on the telephone at home, she did not finish work until 3.30 pm. But, the complainant said, she felt the staff should have made more effort to find out whether it was possible

to get in touch with her relatives because she had not been in a fit state to take the initiative. She also said that it had been suggested to her that she could continue her journey by train, but after discussing with her brother-in-law what she should do, they had decided that she should travel by taxi. This she had done and had arrived at her daughter's house at about 4.15 pm.

6. The complainant's daughter told my officer that she did not know until her mother arrived at her home that she had been involved in an accident. She described her clothes as bloodstained and muddy, and her appearance as 'degrading'.

7. When interviewed by my officer, the sister who was on duty on 14 October said that she herself had tried to telephone the relatives in either Leeds or London, but without success. She recalled that a member of the ambulance crew had washed the complainant's shoes, which were very muddy, but could not remember whether her clothes were so wet or soiled as to be unwearable. She said that, had they been so, she would have discouraged the complainant from leaving the hospital or, alternatively, would have asked the social work department if some clothes could be lent to her.

8. My officer also interviewed the two nurses who had looked after the complainant, both of whom had previously made statements. They said that they could not remember the condition of the patient's clothes, or enquiring whether a relative could be contacted, although it would have been routine to have done so. They said that if the complainant's clothes had been unwearable and it had not been possible to contact a relative to come to the hospital to collect her, dry clothes could have been obtained from the social work department. The nursing officer and other members of the nursing staff confirmed that this was the usual procedure.

9. In a statement, the police officer who attended the scene of the accident said that, shortly after his arrival, the ambulance took the complainant to hospital and he had no recollection of the condition of her clothes at this stage. He had not gone to the hospital himself but had seen the complainant at the police station later on when she collected her personal property before leaving in the taxi to go home. He did not notice that her clothing was excessively wet, muddy or bloodstained. The taxi driver who took the complainant home confirmed there was blood on the front of her blouse but he was sure that, although the bottom of her slacks might have been damp, her clothes were not wet.

10. I do not doubt the complainant's belief that, as a result of the accident, the condition of her clothes was such that she should not have been sent home in them; but this was a subjective judgment made at a time when she was very distressed. I would have expected, even with the passage of time, that either the nurses, the police officer, or the taxi driver would have remembered the state of her clothes had they been obviously unwearable. However, I cannot reach a firm conclusion whether they were so wet and soiled that it was unreasonable to expect her to travel in them. As to her complaint that inadequate attempts were made to contact her relatives, the complainant has said that she told the staff that there was no way of getting in touch with her daughter or her son-in-law and I do not think the hospital could have been expected to pursue this any further.

(*b*) *The complaint about the way the Authority dealt with her original complaint*

11. In her letter to me the complainant said that after a very long delay the Authority had replied to her complaint and that, although she was offered an apology, they did not seem to accept as true what she had said about her condition on discharge and had been unable to give an adequate explanation of what had happened. The complainant said that at the time she felt the only thing to do was to accept the apology offered to her but later she decided to ask me to investigate her complaint.

12. I have established that the complainant's letter of complaint of 24 October 1976 addressed to her local Community Health Council was received by the Health District of the Authority on 10 November, but it was not until 23 November that it was acknowledged. The assistant district administrator at the time told my officer that this delay occurred because the member of staff who dealt with complaints was then working only part-time and a backlog of work had built up.

13. On 23 November the consultant was asked for his comments on the complaint. He told my officer that he spoke to the nursing officer responsible for the accident and emergency department and also to the sister on duty at the time of the incident and left it to them to make enquiries of the nursing staff. But no one could remember much about the complainant (or her brother-in-law) and he said that, since the department dealt with about 90–100 casualties a day, he would have been surprised if anyone had remembered them.

14. On 6 December the consultant submitted his comments to the district administrator who told my officer that he was not satisfied that the complaint had been properly investigated, and did not consider that he had enough information to give a satisfactory reply to the complainant. He therefore asked his assistant to see the consultant and ask him to make further enquiries. The consultant told my officer that he asked the nursing officer and the sister to speak to the nursing staff again, and on 4 February he submitted his further comments.

15. The district administrator told my officer that on 10 February he spoke to the consultant and satisfied himself that no member of the staff could remember exactly what had happened on the day in question; and he replied to the complainant the same day. He said he understood that the delay in dealing with it had been caused by absence of some of the nursing staff. He also said that if the complainant's clothing had been in so bad a condition, he could not understand why other clothes had not been lent to her. And he asked her to accept the Authority's apologies.

16. I have seen the rosters of nursing staff who were on and off duty during the period when the consultant was looking into the complaint. These show that the staff who were on duty while the complainant was at the accident and emergency department were in fact available and could have been questioned about the incidents much sooner than they were; the evidence does not therefore support the explanation for the delay offered to the complainant by the district administrator. It is unfortunate that it took so long for the matter to be dealt with since, with the passage of time, the possibility of establishing exactly the

circumstances of the complainant's discharge would clearly diminish. I consider that the Authority should review the procedure for dealing with complaints to ensure that in future they are dealt with more promptly.

Conclusion

17. I have not been able to establish the state of the complainant's clothes when she was discharged from hospital. I have no doubt that they were blood-stained but I cannot say whether they were so wet that it was unreasonable to expect her to wear them. I think the investigation into her complaint took too long to complete and the Authority have asked me to apologise for this again on their behalf.

Case No W86/77–78—Death of elderly man following inter-hospital transfer

Complaint and background

1. The complainant's late father was admitted to hospital A on 6 April 1977. On 12 April he was transferred to hospital B, where he died the same day. The complainant, who was concerned about her father's care at hospital A, claims that:

(*a*) hospital A was inappropriate to her father's condition;

(*b*) despite repeated requests to nursing staff, she and her husband were not able to meet a doctor to express their concern about her father's condition;

(*c*) unsuitable food was given to her father;

(*d*) her father's condition was allowed to deteriorate and when he was eventually transferred to hospital B his chances of survival there were reduced.

2. The complainant put her complaints to the Area Health Authority (the Authority) and arrangements were subsequently made for her husband and herself to meet the general administrator at the Health District and the consultant who was responsible for the treatment of all patients at hospital A. The Community Health Council was represented at this meeting but the complainant was not satisfied with the outcome and she complained to me.

Jurisdiction

3. Under the Act which defines my powers I am precluded from conducting an investigation in respect of an action when the person aggrieved has or had a remedy by way of proceedings in any court of law, unless I am satisfied that, in the particular circumstances, it is not reasonable to expect him or her to resort or have resorted to it. As both the complainant and her husband assured me that they did not intend to take legal action, I decided to carry out an investigation.

Investigation

The complaint that the hospital was not suitable

4. The complainant told my officer that her father who was aged 65 had been ill at his home and his family practitioner had called in the consultant

after visiting him on 6 April. His admission to hospital A was arranged that day. She and her husband had visited hospital A every evening and it had seemed to them to be more like an old people's home than a hospital. There had been no medical equipment on the ward, and although they had been told at the meeting they later attended that the hospital was staffed by local family practitioners, on no occasion had they seen a doctor on the ward.

5. My officer was told by the unit administrator that hospital A had 106 geriatric and psycho-geriatric beds. It had no resident medical staff. The consultant was based at hospital B, but he approved all admissions. Other medical cover was provided by local family practitioners who visited each day, usually in the morning or afternoon. In addition, a family practitioner was always on call if required in an emergency. All wards had supplies of medical equipment but this would not be seen by visitors unless it was in use. My officer visited the ward and noted that medical equipment was kept in a side room. The consultant for his part said that after visiting the complainant's father at home he had decided that he needed immediate hospital care and that hospital A had been quite appropriate for his condition.

6. The complainant said that hospital A was more like an old people's home. But I am satisfied that medical equipment was available when required. I think that the apparent absence of medical staff, which reinforced her concern, was due to the fact that she and her husband visited the hospital in the evenings. I am satisfied that the decision to admit the complainant's father to hospital A was taken by the consultant solely in the exercise of his clinical judgment, which I cannot question.

The complaint that despite repeated requests to nursing staff the complainant and her husband were not able to tell a doctor of their concern about her father's condition

7. The complainant told my officer that her father's condition had appeared to deteriorate from the day after his admission. Every evening they had told nursing staff that they wanted to see a doctor. This had been not only to express their concern about his condition, she told my officer, but to pass on details of his medical history. As well as being a diabetic, he had been treated for a blood clot in 1973 in a London hospital, and before his admission to hospital A they understood he had been receiving treatment for bronchitis. No arrangements had been made, however, for them to see a doctor.

8. At the meeting with the consultant and the general administrator they were told that there was only one record of their request, which was an entry in the ward diary on 11 April, the day before the patient was transferred. And in a follow-up letter to this meeting the general administrator had said:

> 'You will remember that you were unable to specify either the occasions on which you requested to see the Consultant-in-Charge of the late [patient's] case, or the names of the particular nursing staff concerned. It has been necessary to speak to the nursing staff who were on duty at visiting times during the period [the complainant's father] was a patient at [hospital A].
>
> As a result of this investigation, I regret to inform you that no record of such a request, other than the entry on 11 April 1977, can be substantiated.

Nursing staff do, however, recall your discussions with them concerning the social implications of [the complainant's father] being discharged back into the community'.

9. The complainant's husband said this reply was inaccurate as he and his wife had made it clear at the meeting that they had asked to see 'a doctor', not specifically the consultant. And they had specified the dates of the requests, by saying that they had spoken to nurses every evening.

10. The consultant assured my officer that he had been fully aware of the complainant's father's medical history, which he had been given by his family practitioner before his admission. He explained that when relatives asked to see a doctor, and one was not available, nursing staff made an appropriate entry in the ward diary. His secretary picked this up on her daily visit to each ward and she made the necessary arrangements.

11. My officer spoke to nursing staff who had been on duty at this time and more than one remembered speaking to the complainant and her husband. A ward sister said that on 10 April they had initially requested to see a doctor but she had formed the opinion after talking to the complainant's husband that he really needed to see the hospital's social worker as he was concerned about arrangements following the patient's discharge. She had made an appropriate entry in the ward diary. A state enrolled nurse remembered that on 11 April the complainant and her husband had expressed their concern to her about the facilities at hospital A. She had reassured them on this point but as they had specifically asked to see the consultant responsible for the patient's care, she had entered this request in the ward diary.

12. The general administrator's own report of the meeting with the complainant and her husband (a copy of which I have seen) includes the sentence: '[The husband] emphasised very strongly that during the first few days following his father-in-law's admission, he had asked to see the doctor in charge, on a number of occasions'. I do not know exactly what was said at the meeting and I am not able therefore to say whether the criticisms of the general administrator's reply are justified. The evidence of the ward diary, a copy of which I have seen, supports the ward sister and the state enrolled nurse. On the other hand, the complainant and her husband are quite clear that they asked every day to see a doctor. I am afraid that I cannot reconcile this difference.

The complaint that the condition of the complainant's father was allowed to deteriorate and that when he was eventually transferred to hospital B his chances of survival there were reduced

13. The complainant said she had been told by the consultant that her father's condition had deteriorated from 24 hours before his death and that when he did see the patient on 12 April he immediately transferred him to hospital B. She and her husband told my officer that they suspected that her father had not been seen by any doctor from the time he was admitted to the day he was transferred. They could not understand why he had not been transferred to hospital B on 11 April if his condition had deteriorated from that date (they also believed, as I stated in paragraph 7 of my report, that his deterioration had begun on 7 April). They reported that, when they had called at hospital B

on 12 April, a ward sister had told them that, if he had been transferred sooner, hospital B might have had a better chance of doing something for the complainant's father.

14. The consultant told my officer he was satisfied that the complainant's father had not been neglected in any way by medical or nursing staff. He had always been available at hospital B if required, and the family practitioners of hospital A had the authority to transfer patients to hospital B if they thought it necessary. A doctor had seen the complainant's father after his admission on 6 April and had requested certain tests to be done. These had all been carried out. He personally had seen him on 7 and 12 April when, after a routine visit to the ward, he had decided it would be in the patient's best interests to transfer him. The doctor who had admitted him saw him again on 9 April and he was seen by another doctor on 11 April. My officer spoke to this doctor and he said he thought he had also seen the complainant's father on 8 April. He said he did not believe on 11 April that he would benefit from a transfer to hospital B even though his condition was poorly.

15. I have seen the hospital notes and there is written evidence that the complainant's father was seen by a doctor on each of the above dates except 8 April. It is also apparent from the notes that various tests were carried out and that the patient received the drugs prescribed for his condition. The decision whether or not to transfer him would have depended solely on the clinical judgment of the doctor at the time and, as such, is not for me to question.

16. The alleged remark by the ward sister at hospital B is not borne out by a statement she prepared at the time the Authority was investigating the complaint. In this statement, a copy of which I have seen, she denied making the remark although she remembered talking to the complainant and her husband. It is not possible for me to reconcile these different versions of what was said.

The complaint that unsuitable food was given to the patient

17. The complainant said that on one occasion, she thought either 8 or 9 April, a nurse had asked her and her husband if they would help feed her father. It was the only time they had seen one of his meals. In their opinion it was quite unsatisfactory for a person in his condition (it consisted of meat, potatoes and peas) and he had been unable to eat it. Some soup was obtained from the food trolley and this he had managed to drink.

18. The unit administrator informed my officer that from 1 February 1977 patients had been able to choose their meals from a selection of three menus. The divisional nursing officer and senior nursing officer said that with diabetic patients, such as the complainant's father, nurses always took extra care that enough nourishment was received. If such a patient had not eaten it would have been noticed by nursing staff and alternative liquid nourishment would have been given, but most probably after visitors had left. The state enrolled nurse to whom I referred in paragraph 11 remembered that the complainant's father had not eaten his breakfast on one occasion and milk and glucose had been given later.

19. I have no reason to believe that the incident remembered by the complainant meant that her father had been receiving unsuitable food throughout his stay on the ward. I have been assured that there was a choice of menu and that other alternatives were available and, on at least one occasion, were given to him.

Conclusion

20. I sympathise with the complainant and I understand the distress she must have felt following the death of her father so soon after his admision to hospital on 6 April. Her main complaints are about the suitability of hospital A and the treatment he received there. These involve questions of clinical judgment, on which I cannot comment, but I have been able to ascertain certain facts which may go some way to reassuring her. There was medical equipment on the ward and a doctor did visit every morning or afternoon. Clinical notes which I have seen establish that the complainant's father was seen by a doctor on 6, 7, 9, 11 and 12 April.

21. Some of the complaints I have not been able to determine with certainty because they depend on differing oral accounts. But I myself have found no evidence of lack of care.

Case No W112/77-78—Failure to provide ambulance within time requested by family practitioner

Complaint and background

1. Two sisters (Mrs X and Mrs Y) state that their mother was taken ill at Mrs Y's home on 5 February 1977 and the family practitioner called an ambulance shortly after 9.00 am to take her to hospital. The ambulance arrived just after 11.00 am, but their mother had died at about 10.40 am.

2. Through their Member of Parliament they complain that:—

(*a*) the Regional Health Authority (the Regional Authority) failed to provide an ambulance within the time requested by the family practitioner; and

(*b*) the response from the Regional Authority to their complaint was unsatisfactory.

Investigation and findings

(*a*) *The complaint about the ambulance delay*

3. In an interview with my officer Mrs Y said that on Monday, 31 January her mother had been taken ill. The family practitioner had visited her once at her own home and twice at Mrs Y's home during the week and had diagnosed angina and diabetes. At about 8.30 am on the morning of Saturday, 5 February her mother's condition deteriorated and at 9.00 am Mrs Y telephoned the family practitioner who told her that he would arrange for an ambulance to take her mother to hospital. She then telephoned Mrs X who immediately came. When Mrs X arrived at her home at about 9.10 am the family practitioner had just telephoned back to say that he had spoken to the hospital who would see their mother in the accident and emergency department but would not agree to admit her as an in-patient.

4. Whilst the complainants' mother was waiting for the ambulance her condition deteriorated still further and at 9.30 am Mrs X telephoned the hospital who advised her to get in touch with the ambulance service. This she did, and was told that an ambulance had been requested and she then spoke to the

family practitioner who asked them to wait for half-an-hour. At about 10.15 am the sisters telephoned the family practitioner again to say that their mother had lost consciousness and that they had revived her after her heart had stopped. The family practitioner said he would telephone for an ambulance to be sent immediately and that he would come at once himself. Mrs X told my officer that her mother had died at 10.40 am and and the family practitioner had arrived about five minutes later. She said he had wanted to cancel the request for an ambulance but she would not agree to this. She had noted that it arrived at 11.02 am.

5. In an interview with my officer the family practitioner confirmed this sequence of events. He said that shortly after 9.00 am, after he had received a call from one of the relatives, he had spoken to a registrar at the hospital and arranged for the patient to be seen in the accident and emergency department. (And the registrar confirmed this.) The family practitioner also said that it was certainly before 9.30 am when he telephoned the control centre and asked for an ambulance to take the complainants' mother to hospital 'within an hour' —by which he meant that he wanted her to reach hospital within this time. At about 10.45 am following the further deterioration of the complainants' mother's condition he had telephoned the control centre again and asked for an ambulance to be sent immediately. He said he believed that he reached Mrs Y's home at about 11.00 am and he had been surprised to find that the ambulance was not already there.

6. The Chief Metropolitan Ambulance Officer (CMAO) explained to my officer that requests received in the control room for ambulances are recorded by the control assistants on a form AS1 for an 'Emergency' call and a form AS2 for an 'Urgent' call. The control assistant who took the first call from the family practitioner said she remembered that 5 February 1977 had been a very busy day. She obtained the usual particulars from the family practitioner who said that the patient had acute diabetes and told her that an ambulance was required 'within the hour' and these details were recorded on a form AS2, timed at 9.46 am. The CMAO told my officer that if a second call had been received from the family practitioner asking for an ambulance immediately the AS2 would have been amended; but there was no record of such a call.

7. At the time of this incident the operation of the ambulance service was being disrupted by an industrial dispute. An officer in the Regional Authority personnel department explained to my officer that this had its origins at the time of the reorganisation of the National Health Service when the Metropolitan ambulance service was formed from 11 separate local authority services. Under the terms of reorganisation ambulance staff were allowed to retain their former terms and conditions of service where these were more favourable than post-reorganisation conditions and this had resulted in unresolved pay anomalies. As a consequence, except in the case of 999 calls, the crews were (and still are) refusing to cross the boundaries of the former local authority ambulance service areas.

8. The CMAO explained that the area covered by the ambulance service is divided into three divisions, central, eastern and western. The complainants' mother had been in the central division, which had four ambulance stations. Of these, two stations are some distance away from the district where the

complainants' mother was and, because of the need to maintain adequate emergency cover in their localities, it would not have been practical to send a vehicle from either of them to take her to hospital. Another station in the division and a further one from the western division, which were geographically better placed to deal with the call, would not have done so because of the industrial dispute. This left only one station to respond to the call for an ambulance to take the complainants' mother to hospital. Between 9.36 am and 10.27 am this station, which had three ambulances on call, responded to six emergency (999) calls and the first vehicle which became available (at 10.44 am) was sent to collect the complainants' mother. The central division as a whole which had ten ambulances on call responded to 14 999 calls and five urgent calls between 9.06 am and 10.42 am.

9. The duty control officer told my officer that normally his job is to maintain supervision over the control room; but on 5 February 1977, because of the pressure on the ambulance service, he had assumed operational control. He said that his interpretation of 'within the hour' was that the ambulance should arrive to pick up the patient within an hour of the request. He said that at 10.07 am an ambulance had been sent in response to a 999 call to a road traffic accident not far from where Mrs Y lived. It was not known how seriously injured the person was, and it was left to the discretion of the crew whether to collect the complainants' mother as well. But the crew found that the patient was a pregnant woman and decided to take her straight to hospital. Immediately on completion of this journey the ambulance was sent, at 10.47 am, to collect the complainants' mother. I have seen a copy of the ambulance journey record which confirms this sequence of events and records that it arrived at Mrs Y's house at 11.01 am. And a note on the form AS2 records that at 11.02 am the crew radioed in to report that the patient was found to be dead on arrival.

10. The duty control officer said that he could not say whether, had there not been an industrial dispute, an ambulance could have been sent more quickly because the deployment of ambulances might then have been completely different. But in a report on the complaint during the Regional Authority's investigation the regional ambulance officer (RAO) says—'until such time as the vehicles can be fully deployed across the Metropolitan conurbation, the efficiency and effectiveness of the Service will be impaired'.

11. I have been unable to resolve the discrepancy about the time the first call was made by the family practitioner to ambulance control; but I think the weight of evidence suggests that the family practitioner did make a second call which he classified as 'immediate' although there is no record of it. The ambulance arrived to collect the complainants' mother just after 11 am and it is a matter for criticism that this was later than the family practitioner had intended. The fact that the complainants' mother died shortly before the ambulance arrived was naturally very distressing to her relatives. It is probable that the delay was partly attributable to the industrial dispute. I doubt whether in this case the confusion about the meaning of the phrase 'within the hour' had any effect on the train of events. But I think it regrettable that such confusion exists.

(*b*) *The complaint about the response of the Regional Authority to their representations*

12. In his letter to me the Member of Parliament said that he had made enquiries into the time it had taken to obtain an ambulance for the complainants'

mother and he had received replies from the Regional Authority and from the Minister of State for Health. Mrs X and Mrs Y told my officer that they were dissatisfied with the replies because of the discrepancy in the timing of the request for the ambulance and because of the delay before it had actually arrived.

13. I have examined the correspondence. This shows that the Regional Authority forwarded to the Member of Parliament, with a letter of 15 April 1977, a report of the RAO's investigation and findings which states that the call was received from the family practitioner at 09.46 hours and the request was relayed to the vehicle at 10.47 hours ('. . . one minute outside the Doctor's request for removal within the hour.') And the Minister, in his reply to the Member, said that 'The Ambulance Service failed, by 16 minutes [ie 10.46 am to 11.02 am], to provide an ambulance within the time requested by [the family practitioner]'. It went on to explain in detail the difficulties under which the service was working.

14. Mrs X and Mrs Y believe, and the family practitioner is certain, that the first request for an ambulance was made about 30 minutes before the time recorded by the control centre. This, as I have said (paragraph 11), I have not been able to resolve. But the response to the complaint reinforces my view that there is some doubt whether the time within which an ambulance is requested refers to the time of picking up the patient or the time the patient should arrive at the hospital. Clearly the ambulance control and the family practitioner adopted different interpretations and I am not surprised that Mrs X and Mrs Y were dissatisfied when this point was left unresolved.

Conclusion

15. It is a matter of concern that because of an industrial dispute it is not possible to operate a fully integrated ambulance service in the area. It is inevitable that, with the exception of 999 calls, the result will be that the public will sometimes suffer delay and inconvenience or worse, but I cannot say to what extent the dispute contributed to the delay in the arrival of the ambulance to pick up the complainants' mother.

16. I have unfortunately been unable to resolve the discrepancies about the time the ambulance was first requested, or the making of the second request. But I think the family practitioner did make a second request which was not recorded in the control room, as it should have been, although I have no reason to suppose that this was other than an error.

17. My investigation has shown that there was a difference of opinion between the family practitioner and the ambulance service about the precise meaning of the time limit the family practitioner set for the complainants' mother's transport to hospital. I think it important that there should be no confusion about this and I invite the Regional Authority, as a matter of urgency, to define the time limit, possibly in consultation with the Department of Health and Social Security, and to ensure that members of the ambulance service and family practitioners alike are in no doubt whether it relates to the time of collection of the patient or the time of delivery to hospital.

18. The Regional Authority have asked me, on their behalf, to repeat the apologies already given to Mrs X and Mrs Y for the distress they have been caused by their failure to provide an ambulance before their mother died.

Case No W145/77–78—Failure to inform relatives of patient's condition

Complaint and background

1. The complainant's father was admitted to hospital in February 1977, having suffered a stroke. He died there on 18 June 1977, and the complainant claims that neither he nor his relatives were warned of his father's deteriorating condition. He raised his complaint with the Area Health Authority (the Authority) but was dissatisfied with the explanations given to him.

Investigation

(*a*) *The complaint that the patient's relatives were not warned of his deteriorating condition*

2. The complainant, who was employed at the hospital, told my officer that his father had been visited every day by at least one member of his family. His condition had appeared fairly stable, but when he was allowed home for Easter he had lain on the settee unable to move. The complainant had seen his father at about 7.30 am on the day of his death, and had been told by a nurse that nothing more could be done for him. His mother had visited the hospital at around mid-day and thought her husband looked much worse. At about 4.30 pm his brother, who also worked at the hospital, telephoned to say that his father was deteriorating quickly and that relatives should go to the hospital. When he arrived on the ward, the complainant said he was again told by a nurse that nothing more could be done, but neither she nor anyone else had said his father was going to die.

3. The complainant's brother told my officer that he had noticed a gradual deterioration in his father's condition, and observed that when he saw him on the morning of the 18 June he seemed much worse. He left his telephone number with the nurse in charge and asked to be called if there was any further deterioration. He was later called and asked to notify relatives that they should come to the hospital. This he did by telephoning his wife. Later another nurse gave him a similar message, which he again passed on.

4. The senior registrar concerned with treatment of the complainant's father told my officer that in 1976 the patient had suffered a stroke which had necessitated admission to hospital. He was allowed home after treatment, but was readmitted in February 1977 having had another stroke, this time affecting the other side of his body. He had at first shown some improvement and had been allowed home for Easter, but on return to hospital had shown signs of having had yet another stroke. Thereafter a gradual deterioration in his condition became apparent. He said that the relatives had been kept informed about his condition, though the final deterioration had been rapid and unpredictable. The consultant physician in charge of treatment of the patient told my officer that he had not met any of the relatives until after the patient's death, although he would have been willing to do so had he been asked. He was, however, satisfied that members of his medical team had been in regular contact with them. The house officer who decided on 18 June that the patient's condition was causing concern and that relatives should be sent for, said that she had told the patient's wife that he was unlikely to survive much longer. The symptoms

of decline were, in the view of all the doctors interviewed, obvious to all who knew the patient, although it would not have been possible at any time to say how long he might survive.

5. The nurses on duty on 18 June confirmed the account given by the complainant's brother that he had been asked to notify relatives of the worsening in his father's condition. The staff nurse said that she had told the complainant that nothing more could be done for his father. The sister in charge of the ward said that she had observed a large number of the patient's relatives in the ward at the time of his death at 7.40 pm—possibly as many as 16.

Findings

6. The evidence is that the condition of the complainant's father steadily worsened after his return to hospital after Easter and that adequate opportunities were given to relatives to discuss his illness with medical and nursing staff. The final deterioration was rapid and I have been told it was unpredictable, but nevertheless it was possible for relatives to be notified of it in time to be present at his bed side when he died. The fact that they were summoned, and the comments made by nursing and medical staff to the effect that nothing more could be done for him, clearly indicated the expected outcome, but I am satisfied that it would not have been possible for the staff, even at that time, to have predicted the time of death. I therefore cannot uphold this complaint.

(*b*) *The complaint that explanations given by the Authority were inadequate*

7. The letter of complaint to the Authority, dated 9 August, referred to the complainant's concern at the failure of staff to warn him and his relatives of his father's imminent death, and asked for an opportunity of discussing this and other unspecified complaints. The area administrator asked the district administrator to investigate. The general administrator entrusted with this task told my officer that he had first interviewed the complainant himself and, having ascertained that the additional complaints related to his father's nursing care, arranged for him to see the district nursing officer and the consultant physician in charge of the case. As a result of his interview with the district nursing officer, the complainant withdrew his complaints about nursing care, but he was not satisfied with the outcome of his meeting with the consultant physician and persisted in his contention that he had not been properly informed about his father's condition. In his letter to me of 3 October 1977, the complainant showed particular concern about a statement made to him by the district nursing officer that a 'sick note' had been issued in respect of his father, whereas no such document had been received by him or any other relative.

8. The consultant physician told my officer that, at the meeting which took place on 24 August 1977, he had explained at length and as simply as possible the medical aspects of the patient's deteriorating condition. The interview had lasted over an hour. He felt that the complainant's shock at the loss of his father had made it difficult for him to accept the fact of his death and therefore fully to understand the circumstances leading up to it, and in particular the impossibility of predicting the time of death.

9. The district nursing officer told my officer that she had investigated the complaints about nursing care and, at a meeting with the complainant on

24 August, he had expressed himself satisfied with the explanations she was able to give him. During their discussion, however, she had referred to the 'sick note' by means of which relatives were notified that a patient was seriously ill and could be visited at any time. She subsequently discovered that this procedure was no longer used at the hospital.

Findings

10. The complainant's request for an interview to discuss his misgivings was complied with promptly by the Authority, and his specific points were investigated thoroughly and, with one exception, to his satisfaction. I am unable to say precisely what was said during his long discussion with the consultant, but I am satisfied that this interview represented a genuine attempt to allay the complainant's misgivings. It is unfortunate that the use by the district nursing officer of the expression 'sick note' should have misled him into thinking that relatives should have received a document rather than an oral intimation of the patient's critical condition, but I have already established that the relatives were, in fact, warned in good time. The Authority have asked me to express their regret to the complainant for any misunderstanding caused by the reference to a procedure no longer in use.

Conclusion

11. With the minor exception mentioned above, I have found no reason to criticise the Authority or their staff in respect of the complaints. The complainant was naturally deeply shocked by his father's death, but I feel that he asked too much of the medical and nursing staff in expecting them to predict the event with more certainty than they did. In fact, I have found no reason to believe that the staff concerned failed in any way to show the sympathy, understanding and patience to be expected of them in such circumstances.

Case No SW40/76–77—Communication between medical staff and patient's father

Complaint and background

1. The complainer's son, who was at the time a college student aged 18, was admitted to the psychiatric unit of hospital A on 20 February 1975. He was discharged on 22 August and was subsequently a patient in hospital B from 16 October to 12 November 1975. On 8 December the complainer wrote to the Secretary of the local Health Board (the Board) expressing his concern about the 'medical handling' of his son's case. The district administrator of the Board replied on 20 January 1976.

2. On 26 July 1976 the complainer wrote to the Scottish Home and Health Department expressing his dissatisfaction with the Board's reply which he felt was largely an uncritical summary of his son's case. The Department replied that his complaints seemed to stem from distrust of the consultant's clinical judgment and pointed out that it was open to his son to approach his general practitioner if he wanted a second opinion. There followed a prolonged exchange of correspondence between the complainer and the Department until he was eventually informed that if he felt there were aspects of the matter which required further investigation, other than those of clinical judgment, he should write to me. This he did on 29 December 1976.

3. On 14 January 1977 I informed the complainer that although I could not investigate matters concerning the clinical judgment of doctors there were certain aspects of his complaint which I might be able to look into, but before I could reach a decision I would require more specific information. After a further exchange of correspondence and a visit to the complainer by one of my officers I decided to look into the complaints about:

(*a*) the uncommunicative and uncooperative attitude of medical staff;

(*b*) failure to inform the parents when their son was discharged from hospital B;

(*c*) a consultation with a psychiatrist arranged without the complainer's son's consent when he was a patient in a medical ward in December 1975; and

(*d*) the Board's reply.

Investigation

4. I learned early in my investigation that the consultant who had been responsible for treatment of the complainer's son and who was the person principally involved in the complaint had since died. The complainer told my officer that his son, who was still under psychiatric care, did not know of his complaint and he did not wish him to be informed. He felt it would not be good for his son's state of mind to know of it or of his father's lack of confidence in the doctors at the two hospitals. In view of these difficulties I considered whether I should discontinue my investigation, but decided to continue in an attempt to resolve the complaint as far as possible.

The complaint about uncommunicative and uncooperative medical staff

5. The complainer said he had always found it most difficult to get information from doctors about his son's condition. He told me that he had a brief interview on 27 February with the consultant who, understandably, could tell him little apart from the fact that his son was in a depressed state. He said he also had occasional interviews with the house officer which he felt were of little value. She either knew very little or was unwilling to communicate what she knew. He had a further interview with the consultant on 27 March during which the consultant was not prepared to venture any diagnosis, and at another interview on 24 April the consultant was still uncertain of the diagnosis but said that it might be a psychotic depression. On 29 May the consultant expressed the view that the complainer's son might be suffering from schizophrenia. The complainer also said that on two occasions, once at interview and once on the telephone, the consultant had shouted angrily at him.

6. The complainer said that, in his experience, parents or next-of-kin of mentally ill patients are interviewed and asked if they can give any information about the patient's home life and past history which might help to cast some light on the illness. As this had not happened in his son's case he offered to give all the information he could at his meetings with the consultant on 27 March and 24 April, but, he said, the consultant did not respond to this. He also wrote to the consultant on 28 April repeating this offer, but received no reply. He told me there were other occasions when the consultant or members of his staff failed to reply to his letters and telephone calls. He recalled one incident

in particular when on 30 June he had asked a doctor if his son, who had appeared to do well during his weekends at home, could come with the family on holiday. The doctor said he would consider this and let the complainer know. As he had heard nothing by 2 July the complainer telephoned the ward but the doctor was not available and did not call back in response to his messages. The complainer therefore travelled to hospital A on 3 July when he saw a different doctor who turned down his request.

7. In a statement made to the district administrator in respect of the original complaint the consultant said the complaints about lack of communication from medical staff were self-evidently unrealistic. The complainer had a habit of bringing a written list of questions and noting answers, cross-checking each report against colleagues' answers. This was time consuming and unpleasant for junior staff and the consultant therefore saw him more often than other doctors and more often than most relatives were seen. Nevertheless the complainer was also interviewed on other occasions by other members of the medical staff.

8. The acting physician superintendent of the district psychiatric service told my officer that he did not consider that staff in the hospital A unit would be unhelpful and uncooperative, but pointed out that it was not uncommon for psychiatrists to be reluctant to give a diagnosis unless it was very clear cut. As the complainer's son had been a new patient the staff would wish to know him better before reaching firm conclusions about the type of his depressive illness. He said that another reason for reluctance to give a firm diagnosis is that once it is made and passed on to relatives a patient can be labelled for life, for example as schizophrenic or manic depressive, and it can be harmful to the patient if someone unwittingly relays such a diagnosis back to him. Other doctors confirmed that the condition of the complainer's son had fluctuated considerably whilst he was in hospital and this had made it difficult to reach the final diagnosis.

9. The senior house officer (SHO) remembered two specific interviews with the complainer and thought that other meetings with him had just been casual encounters on the ward. She told my officer that the first interview had taken place the day after his son's admission. During this interview she obtained some background information which had confirmed his son's version of his family history. At the second interview on 18 March the SHO told the complainer that his son was suffering from manic depressive psychosis, but, as she recorded in the notes, the complainer did not agree with this; his view was that his son's depression had worsened because he was in a psychiatric ward. The SHO said that on this and other occasions when she spoke to the complainer both on the ward and by telephone he had asked a lot of questions, of a kind which sounded as if he had been referring to a psychiatric textbook. She also remembered the complainer referring to notes and making additional notes in the course of an interview. Because of his continual enquiries the consultant had eventually decided to deal personally with him in future.

10. Neither the SHO nor the other doctors interviewed could remember anything about unanswered telephone calls but it was accepted by the acting physician superintendent that a response to the occasional telephone call could have been missed. The senior registrar who saw the complainer on 30 June is no longer with the Board and was only briefly involved with the complainer's

son when he provided psychotherapy for him as an adjunct to his treatment. He had no responsibility for his day to day management and said his own role was defined so that he should not be drawn into the stream of telephone calls and letters from the complainer. He believed he had seen the complainer on one occasion when he attempted to explain his position in the course of a general interview. He could remember no conversation about the complainer's son going on holiday, but said that if the complainer had asked him about this he would have suggested that he speak to one of the members of the ward team responsible for his son's treatment. The honorary senior registrar who saw the complainer on 3 July told my officer that he had oversight of the consultant's beds while the consultant was away. He remembered the complainer asking during an interview if his son could go on holiday with him and his wife. As the staff were worried about the son's mental state at this time he had refused the complainer's request. The complainer had said nothing to him about failure to answer telephone calls or an earlier request to take his son on holiday.

11. There were 12 letters from the complainer to the consultant filed with the case notes and there was no indication on the majority of these whether they had been acknowledged or answered. Nor is there any evidence in the records of the incidents when the consultant allegedly 'shouted angrily' at the complainer. But in his written statement the consultant told the Board that where he was said to have shouted he would prefer 'exclaimed'.

Findings

12. It is evident that his doctors did not feel they could make a firm diagnosis until they had got to know the complainer's son well, and that the changing pattern of his illness caused uncertaintly about the original diagnosis. I do not think there was any intention to keep the complainer in the dark about his son's condition, and there is some evidence that he was on occasions reluctant to accept what he was told. The amount of background information required in order to treat a patient is a matter for doctors to determine in the exercise of their clinical judgment and it is not for me to comment if the consultant failed to accept the complainer's offer of further information; I note however that his son's case records contain extensive notes about his background and family history.

13. Because of the complainer's frequent enquiries the consultant decided he would deal personally with him, and it is possible this may have led to difficulties when the complainer telephoned wishing to speak to a member of the medical staff. After this length of time and without oral evidence from the consultant I am unable to say why some of those enquiries remained unanswered. On the available evidence it seems that some of the complainer's letters also remained unanswered, but I am unable to say why this should have been so. It is possible that the consultant considered he had dealt with them when speaking to the complainer. Of the occasion when the complainer asked about taking his son on holiday I can only conclude there was some misunderstanding between the complainer and the senior registrar to whom he spoke. Of the incidents when the consultant is said to have shouted angrily, I could not obtain corroborative evidence of this but I have noted the consultant's own recollection of his manner.

The failure to inform the parents when the patient was discharged from hospital B

14. The complainer claimed that he was not informed or consulted when his son was discharged from hospital B on 12 November 1975. He told my officer that in his view the parents of a mentally disturbed boy should be informed in such circumstances, and in his opinion his son had still been far from well. He said that if his son had not telephoned home two days before his discharge he and his wife would have known nothing about it. He was also concerned that his son was being discharged to a hostel where he would be at risk from, and a risk to, others.

15. The secretary of the Board informed me that it would not be normal practice to notify parents when an adult patient was fit to be discharged. He said this was a matter for the complainer's son to decide. He was a voluntary patient of full majority who had to be accepted and treated as such by the staff. This was supported by members of the medical staff to whom my officer spoke. The acting physician superintendent said that some patients, particularly students, often did not want their families to know of their discharge as they wanted to work things out for themselves.

16. The registrar told my officer that the complainer's son had not wanted to return home when he was discharged on 12 November. Because of his wish to seek accommodation and employment in the local area he had been found a place in a hostel which was used as a 'halfway house' by former psychiatric patients where he would have some degree of supervision. The registrar said there had been no question of the complainer's son being advised to go into the hostel in preference to returning home. The decision to accept a place there had been his. The case notes record that medical staff were aware that he had informed his father of his discharge and of his decision to go into the hostel.

Findings

17. I appreciate the complainer's concern as a father but I cannot find fault with the hospital for following their normal procedure. The complainer's son was by then aged 19 and as the doctors considered him fit for discharge it was up to him to decide whether or not to inform his parents, and whether to accept the place in the hostel.

The complaint that the complainer's son was seen by the consultant psychiatrist without his consent

18. On 2 December 1975 the complainer's son was admitted to a medical ward at hospital A following a drug overdose. Whilst the complainer was visiting the hospital that day his son was called to see the consultant psychiatrist. The complainer informed the medical registrar that earlier in the day, on hearing of his son's admission, he had asked the family doctor to arrange for a further psychiatric opinion on him. The registrar told him that only his son could make such a request as he was of age and responsible. It later occurred to the complainer that as his son was of age and had previously been discharged from the care of the consultant psychiatrist he could only be seen by the consultant at his own request. The complainer therefore telephoned the medical registrar who told him that although his son had not asked to see the consultant he had agreed to do so. The complainer later put the same questions to his son who said he had not agreed to see the consultant but had merely been told that the consultant would be seeing him.

19. The Board commented that it is not unusual for one clinician to consult another about a particular case and such an arrangement is an essential part of any patient's treatment when readmitted after previous treatment. It is quite a different matter for a patient to indicate that he is dissatisfied with his treatment and that he wants a second opinion. At no stage is there any record of the complainer's son indicating any such dissatisfaction. The district medical officer told my officer that physicians do not routinely seek psychiatric assistance in all cases of self-poisoning but must judge each case on its merits. If a physician decided that psychiatric advice were needed he would be expected to consult the patient, and in this case the patient had not objected to the suggestion when it was put by the medical registrar.

Findings

20. In deciding to seek advice from the psychiatrist who had been treating the complainer's son for most of the year the medical registrar was using his clinical judgment, which I do not question. Without evidence from the complainer's son I cannot say exactly how the suggestion was put to him, but it seems that he did not object to seeing the psychiatrist and in the circumstances I cannot uphold this complainant.

The complaint about the Board's reply

21. The Board replied to the original complaint on 20 January 1976, but the complainer was not satisfied. He felt it was largely 'an uncritical summary of the record of [my son's] case as supplied by some of the medicals who were involved in it'. He also pointed out what he considered to be inaccuracies in the Board's reply namely:

(*a*) that he had wanted his son to come home instead of staying in hospital. He told my officer that this was untrue as he had encouraged his son to stay in hospital and have treatment;

(*b*) that his son had resumed his studies on the advice of his teachers. The complainer said that his son had decided to resume his studies purely on the consultant's recommendation that he was fit to do so; and

(*c*) that the hospital had supported an application which his son made for a place in a hostel on his discharge in November. The complainer said his son had not known of its existence and must therefore have gone there at the suggestion of the consultant.

22. The district administrator told my officer that the complaint had been investigated by himself and the district medical officer (DMO). In addition to obtaining written comments the DMO had discussed the case with the consultant psychiatrist. The administrator said it had seemed to them that the complaint principally concerned the complainer's disagreement with the consultant's diagnosis and treatment of his son's illness and that the other matters mentioned in the complaint were side issues. Because of the vagueness of the complaints about, for example, uncommunicative and uncooperative staff, it had not been possible to reply to these in detail, but the administrator wished the complainer had come back to them on specific points if he had been dissatisfied with the reply.

23. The administrator said the comment in the Board's reply that 'it was understood that you wanted [your son] to come home and work at home instead of staying in the hospital' had been intended to refer to the later part of the complainer's son's stay in hospital A and was based on the available evidence including the consultant's statement. The SHO said that at one point, when the staff were still concerned about his son's condition, the complainer had started to talk about taking him home and I have seen an entry in the case notes where the SHO recorded on 2 April that in the course of a telephone conversation the complainer had expressed the view that his son would benefit from being at home; but I have also seen a letter of 16 April to the consultant in which the complainer said that, whilst he and his wife were keen to have their son home, they had been careful to encourage him to stay in hospital until he was considered fit to come home for a visit or for good. In a letter to the consultant a month later the complainer said he thought it would be better for his son to stay at home and, with the help of the drugs prescribed for him and his parents, try to overcome his depression; but he added that he would feel responsible if he advised his son to stay at home and his condition then deteriorated.

24. In his report the consultant said that when the complainer's son was discharged home in August 1975 he was uncertain whether to resume his studies but that he eventually did so on the advice of his teachers; it was on this report that the administrator based his reply. The registrar told my officer that the consultant would not have advised the complainer's son on whether or not to resume his studies; he would merely have advised on his fitness to do so. The case notes show that when the complainer's son was discharged he was undecided about his future, but on 14 August the complainer wrote to the consultant asking whether his son was fit to restart his course, as a member of the college staff had advised that there would be a place for him. The consultant replied that the complainer's son might certainly recommence his course if this was what he wished.

25. The Board told me it was confirmed at the time of their original enquiries that the complainer's son was not encouraged by hospital staff in his wish to seek accommodation locally instead of returning home, and this was supported by the registrar (see paragraph 16). The DMO told my officer that the consultant would have suggested the hostel to the complainer's son because he had no other accommodation at that time. But the decision to accept a place had been his own.

Findings

26. The officers who dealt with the original complaint thought that it principally concerned his disagreement with the clinical judgment of the consultant, because it had referred to the 'medical handling' of the case; the administrator's reply therefore dealt mainly with the course of the complainer's son's illness and his treatment. From the evidence I have seen I do not believe there was anything factually incorrect in the parts of the reply specifically mentioned by the complainer but I think that, in referring to the complainer having wanted his son to come home, the reply should have acknowledged that, whilst the complainer had expressed this view, he had nevertheless encouraged his son to continue with hospital treatment.

Conclusions

27. It seems to me that the complainer's grievances arose largely from dissatisfaction with the consultant's clinical judgment. Many of the points touched upon by the complainer, such as his son's fitness for discharge or to resume college and whether he was responsible enough to make his own decisions, directly concerned the clinical opinion of the doctors treating him. I have explained why the doctors were reluctant to make a firm diagnosis of the complainer's son's condition, and have seen some evidence that when the complainer was given a diagnosis he was unwilling to accept it.

28. The consultant decided to deal personally with the complainer because of his frequent enquiries and perhaps because he had some knowledge of psychiatric illness. This probably resulted in some of the difficulties which the complainer experienced when he made enquiries at the hospital. I think on the available evidence that some of his letters and telephone calls were unanswered, but without oral evidence from the consultant I am unable to reach a firm conclusion about why this was so. With this reservation, apart from one minor criticism of the Board's reply which I mention in paragraph 26, I am unable to uphold the complaints about this case and the Board's enquiries into them.

Case No SW41/76–77—Lack of treatment and unnecessary medical intervention

Complaint and background

1. The complainer's 24 year old son had undergone major gastric surgery in childhood and had subsequently attended hospital periodically for blood transfusions to correct recurrent anaemia. He was admitted to hospital A on 29 October 1976 complaining of having vomited blood the previous night. On 4 November he was transferred to hospital B where he died two days later following a massive haemorrhage.

2. On 12 November the complainer wrote to the Health Board (the Board) asking that enquiries be made into the circumstances regarding his son's death. The complainer was not satisfied with the Board's reply of 21 December, and on 10 January 1977 he wrote to me with a list of questions to which he sought answers. In my reply I pointed out that I could not look into the points he had raised until the Board had been given an opportunity to investigate them and reply.

3. The complainer wrote to the Board on 28 January asking:

(*a*) why his son was allowed to be up and around the hospital and was given no treatment for six days after his admission;

(*b*) why the consultant physician put a tube down his son's throat against the wishes of his parents;

(*c*) why his son was transferred to hospital B; and

(*d*) why his son's case history was not transferred with him.

He remained dissatisfied with the Board's reply of 22 March and on 25 March asked me to investigate his complaints.

Investigation

The complaint about lack of treatment

4. The complainer claimed that his son was not given a blood transfusion when he was admitted on 29 October after telling the doctor that he had vomited blood. He said that until 3 November, his son was allowed to run around the hospital without being confined to bed or given any kind of treatment. The complainer told my officer that he did not in fact believe that his son had vomited blood the night before his admission. He considered that he or his wife would have been aware if this had happened. As it was, his son had left home on 29 October telling his parents that he was going to cash his social security girocheque. He later telephoned from hospital A to say that he had admitted himself. In the complainer's view his son had got himself admitted because he enjoyed being in hospital where he was well looked after and was generally popular with the nurses and his fellow patients.

5. The complainer said that, if hospital A had thought that his son really had lost blood, all he would have needed was a blood transfusion. The complainer claimed that his son's blood could not have been tested as this would have revealed whether he needed to be in hospital or required a transfusion. The complainer also said that if, as the Board stated, his son was considered to be at risk from a massive bleed he should surely have been lying down and resting instead of being allowed to wander through the hospital at will.

6. The records show that when the complainer's son presented himself at hospital A on 29 October he reported that the previous night he had vomited a cupful of blood and had a blackout. He was therefore admitted for observation, various tests were made, and he was given a saline infusion. The following day the infusion was discontinued and he was transferred to the care of a consultant physician who had known him from his early teens.

7. The complainer's son had previously been admitted to hospital A on 29 September and again on 24 October, and because this was his third admission in the space of a month and because of the reported repeated bouts of bleeding during that period the consultant considered there was a serious risk of a major bleed at any time. He told me however that between 29 October and 3 November there had been no indication of a need for blood transfusion, or for any other treatment, as the patient's haemoglobin level which was estimated daily had remained satisfactory, as had his pulse rate and blood pressure. For similar reasons complete bed rest was not necessary and would in any case have been unenforceable. I have been told that the complainer's son was never an easy patient to manage and tended to do very much as he pleased; for example, on several occasions he is said to have disappeared from the ward without the knowledge or permission of the nursing staff.

8. The ward sister confirmed that the complainer's son had been difficult to manage. She said he had refused to stay in bed or to part with his day clothes, and was continually wandering about. When he was reprimanded about this he threatened to discharge himself.

Findings

9. I have seen from the case notes that various tests were carried out on the day the complainer's son was admitted as a result of which the consultant considered that no blood transfusions or further immediate treatment was required.

This was a matter for the consultant's clinical judgment and is not for me to question. It is clear that the nursing staff found the complainer's son difficult to manage and that they were unable to prevent him from wandering about at will, but I note that the consultant has affirmed that bed rest was unnecessary.

The complaint that a tube was put down the complainer's son's throat unnecessarily and against his parents' wishes

10. The complainer complained that on 3 November the consultant put a tube down his son's throat against his and his wife's wishes. He explained that his son had undergone three major operations when he was a child, after which the surgeon had told him that nothing more could be done. He said the consultant therefore knew that no matter what his examination revealed no surgery could help his son, but nevertheless he went ahead and, in the complainer's opinion, put the tube down his son's throat to satisfy his curiosity about why he had needed to come into hospital regularly for blood transfusions. The complainer believed that this needless procedure had caused his son to have a massive bleed which was ultimately responsible for his death. He did not believe a statement in one of the Board's letters that his son had himself caused the bleed by pulling out the tube. The complainer said that he had asked to see the consultant on the morning of 4 November but that after waiting for an hour he had left without seeing him. He told my officer that he believed the consultant was deliberately avoiding him.

11. The consultant told me that the complainer's son's recurrent anaemia over the years had been considered to be due to oozing from oesophageal varices (varicose veins in the gullet). But when he had three bouts of bleeding in the four weeks up to 29 October (see paragraph 7) after a quiescent period of several years it had seemed clear that there was a serious risk of a major bleed. The consultant had therefore considered the possibility of surgery to reduce the pressure on the varices; location of the site of bleeding was an essential prerequisite not only for possible elective surgery (planned in advance) but also to enable prompt emergency treatment to be given should a major bleed occur. The consultant therefore asked the gastroenterology unit to arrange a fibroscopy examination so as to locate the source of bleeding.

12. The consultant and the lecturer from the gastroenterology unit who carried out the procedure both explained that fibroscopy is a standard diagnostic procedure; and the lecturer further explained that it is routinely used on any new patient admitted with bleeding from the upper gastro-intestinal tract. The consultant told me it is the only reliable way of diagnosing the presence of oesophageal varices and locating the site of bleeding. The consultant and the ward sister confirmed that the complainer's son had been given an explanation of what the procedure involved and its purpose and he had consented to it. The lecturer pointed out that this procedure could not in fact be carried out without the active consent of the patient, for although the patient was sedated during the procedure he was not unconscious, and it required a degree of cooperation on his part to pass the tube. The consultant added that if the complainer and his wife did object to this procedure they had not made their feelings known to any member of the medical or nursing staff. The complainer subsequently confirmed to my officer that he had not told any member of staff about his objections; he had merely advised his son against having the fibroscopy examination.

13. In his statement to me the consultant said that fresh blood was already present when the fibroscope was passed and that this had to be removed by syringing before the examination could proceed. The examination had then revealed the source of the bleeding which earlier x-rays had failed to identify. The lecturer told my officer that he had stopped the examination immediately he had located the varices. He confirmed that the complainer's son was already bleeding when he passed the tube, but he could not say whether the examination had been responsible for subsequent additional bleeding. The consultant told my officer that it was possible the instrument could have aggravated the bleeding as it might have dislodged clotted blood. The lecturer told my officer that whilst he did not know what had been planned for the complainer's son after the fibroscopy results were known, it was normal procedure in such cases to wait until the bleeding settled down and then operate.

14. The consultant said that the complainer's assertion that no matter what was found from the fibroscopy examination no surgery could help his son was quite untenable. The complainer's views were based on operative findings in 1959 when his son had been a young child. Since then he had developed physically, and surgical techniques and supportive therapy had improved greatly. The consultant felt there was every reason to conclude that surgery would have been successful.

15. The consultant said that it had been his intention to see the complainer on the morning of 4 November. His senior house officer (SHO) had spoken to the complainer in the intensive therapy unit (where the complainer's son was then being nursed) and had told him that the consultant would be available later that morning. But when the consultant visited the unit he found that the complainer had gone. He therefore left a message with the staff nurse that he would like to see the complainer when he returned, but the complainer did not contact him. The SHO confirmed that he had an interview with the complainer in the course of which he told him of his son's condition and explained why the fibroscopy was performed and that surgery was being considered. He told my officer that he had informed the complainer that the consultant would be coming to the unit in about two hours time and he had been under the impression that it was the complainer's intention to remain in the unit.

16. The assistant secretary who had prepared the Board's reply to the complainer told my officer that the comment in the letter about the complainer's son causing a haemorrhage by pulling out his tube had not been intended to refer to the fibroscopy examination but to a later incident which occurred at hospital B. He explained that in dealing separately with each of the complainer's questions he had mistakenly thought that the complainer was enquiring about the later incident. On re-reading the complainer's letter he agreed that the enquiry clearly related to the fibroscopy examination.

17. I have seen that in a statement given to the Board on 25 November when they were investigating the complaints the senior lecturer reported that infusion treatment at hospital B had appeared to control the bleeding but at 6.15 am on 6 November the complainer's son had vomited a large quantity of blood and had become shocked. Resuscitation measures were therefore started and a tube was passed to control the bleeding but the complainer's son pulled

out this tube and in so doing probably affected the gastro-oesophageal varices. Immediately following this, he began to bleed profusely and despite resuscitative measures, he died soon after.

Findings

18. I cannot say whether or to what extent the passage of the fibroscope may have resulted in any bleeding, but the evidence I have seen shows that the consultant was concerned that the complainer's son was at risk from a major bleed and that he believed that surgery was possible. I am convinced that the consultant's decision to locate the source of the bleeding was not taken out of mere curiosity, as the complainer thought, but was a clinical decision taken solely in the exercise of his professional judgment. It is not for me to comment further upon such a decision. I believe that fibroscopy was carried out after the procedure had been explained to the complainer's son and his consent obtained.

19. It seems to me that there may have been some misunderstanding between the SHO and the complainer about when the consultant would be available for interview on 4 November, and the unfortunate result was that the complainer did not remain at the hospital until the consultant was free to see him. But on the available evidence I do not believe there was any attempt by the consultant to avoid the complainer, and I cannot uphold this part of his complaint. However, I criticise the Board for the error in their letter of 22 March to the complainer which suggested that his son had himself been responsible for causing the bleed which he suffered following the fibroscopy examination. This mistake is likely to have caused distress to the family and could have been avoided. The complainer's son did remove a tube from his throat but this was on 6 November and it was not a fibroscope but a tube to control bleeding.

The complaint about the transfer of the complainer's son to hospital B

20. The complainer told me that he believed that his son was transferred to hospital B because the consultant at hospital A realised he had made a mistake. He told my officer that he did not believe the Board's explanation that the transfer had been arranged because of the possibility of further surgery.

21. The consultant told me that the complainer's son was transferred to a surgical unit at hospital B because of that unit's special interest and expertise in the type of surgery required. He told my officer that he had consulted a surgical colleague at hospital A and it was as a result of this that the complainer's son was subsequently transferred to hospital B. The case notes show that the complainer's son was examined by a member of the surgical team at hospital A on the evening of 4 November, who recorded at that time that his condition was stable and his bleeding had apparently stopped. The notes also record that the hospital A consultant surgeon then got in touch with a senior lecturer in surgery at hospital B about the possibility of the senior lecturer taking over the management of the case.

22. The senior lecturer at hospital B confirmed that he had been approached by a surgeon from hospital A about the complainer's son because of his unit's expertise in this particular field of surgery. He told my officer that it had been

his decision to have the complainer's son transferred to hospital B, and confirmed that his condition had stabilised at the time of transfer. It was the senior lecturer's opinion that surgical intervention could have helped; it would have cured the persistent bleeding, but the longer term prospects would not have been good because of two rare conditions of the liver from which the complainer's son was suffering. The complainer's son would not allow the doctors to carry out a biopsy examination which would have helped them establish the state of his liver before an operation was carried out.

Findings

23. I am satisfied it was the consultant's considered professional opinion that the complainer's son might be helped by surgery, as a result of which he sought the advice of his surgical colleagues at hospital A. The subsequent approach to hospital B was made by a surgeon, and the decision to transfer the patient to hospital B was made by the senior lecturer in surgery. From the contemporary documentary evidence I have seen I have no doubt that the sole reason for the complainer's son's transfer was the particular surgical expertise available at hospital B, and that it was arranged only in his interests.

The complaint that the case history was not transferred with the complainer's son

24. The complainer believed that his son's case history had not been transferred to hospital B with him. He told my officer that he had been led to understand this from a conversation he had with a doctor at hospital B on 5 November. The complainer said this doctor had indicated that he had not seen the earlier records and that they would be getting in touch with the surgeon who had been responsible for the earlier operations on his son and who had since retired.

25. The hospital A consultant told me that the current case record for the complainer's son was sent with him to hospital B. The earlier records, including operation notes from 1959, had been microfilmed and these were included in the case record folder. When my officer visited hospital A he observed that the microfilm of the earlier records were filed in the folder with the recent case notes. The senior house officer who accompanied the complainer's son on his journey to hospital B confirmed that he had taken the case notes with him in the ambulance, and that they had included the microfilm of the older notes. My officer examined the microfilmed records and confirmed that they contained the early medical history of the complainer's son.

26. The senior lecturer at hospital B told my officer that because of the passage of time he could not now recall whether or not he had seen the early medical records. He confirmed that the day after the complainer's son's admission he had spoken to the retired surgeon who had performed the earlier operations, but he said this discussion had nothing to do with records being missing. He had been seeing the surgeon at a meeting and he took the opportunity this gave to discuss the case with him.

Findings

27. Although the senior lecturer cannot now confirm whether or not he had seen the complainer's son's earlier operation records, these are currently filed, on microfilm, with the more recent records and I see no reason to doubt the

consultant's statement that they were so filed at the time of transfer. It seems to me that it was natural, and prudent, for the senior lecturer to discuss the case with the retired surgeon when the opportunity presented itself and I do not consider this to be an indication that any records were missing.

Conclusion

28. Although the parents had lived for years with the possibility that their son might not have a long life they believed his eventual death had been hastened by unnecessary medical intervention. I found however that the consultant at hospital A had believed that the complainer's son was at risk and could be helped by surgery and that his subsequent actions were taken solely in the exercise of his clinical judgment. I am certain that the efforts of all the doctors concerned were directed only towards helping the complainer's son and I hope the complainer and his wife will come to accept that this was so. I offer them my sympathy on the death of their son in such tragic circumstances.

29. I have been unable to uphold any part of the complaint as put to me, but I found in the course of my investigation that there was an error in the Board's letter to the complainer (see paragraph 16) which may well have caused additional distress to the family. The Board will be writing to the complainer to apologise for this.

Case No SW52/76–77—Conduct of a confinement

Complaint and background

1. The complainer gave birth to her son on 10 September 1976 in the maternity unit of a hospital. She discharged herself on 12 September, and on 13 September her husband wrote to the health board complaining about the attitude of staff in the unit. The complainer and her husband considered that due regard was not paid to what they considered to be their rights as parents to conduct the confinement as they saw fit and to their expressed wish that the baby should have a natural birth. Particular points made by the complainer's husband in his complaint were that:

(*a*) the complainer was asked for personal information while under sedation;

(*b*) a monitoring electrode was fixed to the baby's head against the complainer's wishes;

(*c*) a doctor was about to use forceps during the birth in spite of the parents' wish that she should not; and

(*d*) the day following the birth the complainer's husband was told he could not touch his son because 'his hands might be dirty'.

I learned during the course of my investigation that the complainer's husband was annoyed because a complaint about his behaviour had been made by a hospital consultant to a senior doctor at the base where the complainer's husband was stationed as an officer of the armed forces. I could not, however, look into this because the complainer's husband had not complained of it to the health board.

2. The district administrator replied to the complainer's husband on 25 October but he was not satisfied with her reply and informed her that he intended to lodge his complaint at a higher level. After the complainer's husband had written to the Secretary of State for Social Services in January 1977 he was advised by the Scottish Home and Health Department that his complaint came within my jurisdiction, and the complainer wrote to me on 7 March.

Investigation

The complaint that the complainer was asked for personal information while under sedation

3. The complainer's husband said that his wife was asked for personal details such as their accommodation and his occupation, which did not concern anyone other than his wife and himself. He told my officer that he had found one of the midwives asking his wife these questions and had 'sent her packing'. He objected on the grounds that the questions were irrelevant to the purpose for which they were there, and felt that they were an intrusion of privacy and no business of the hospital. The complainer could remember nothing of the incident.

4. According to midwifery staff to whom my officer spoke the information for which the complainer was asked was required for the infant record, which is prepared for the paediatrician. I have seen a copy of this form which is mainly concerned with details of the patient's labour and the new-born child. One of the sisters told my officer that as there was no urgency about completing this form it was not usually done at once if the patient arrived in labour but was filled in at leisure. But she pointed out that it was mostly compiled from information from the medical records; the only information for which the mother was asked concerned religion, father's occupation and the number of rooms in the home, and I have confirmed that this is so.

5. It does not seem unreasonable to me that information of this kind should be collected for a doctor. I appreciate that the complainer's husband may have felt that the hospital staff were prying when he found his wife being questioned while she was under sedation, but all that was being obtained were a few items of routine information which I think most people would be willing to give. I am aware that doctors need to know something of the social background of their patients because it has a link with the health of the individual. I therefore cannot uphold the complaint that this was an intrusion of privacy and not the concern of the hospital. However, in my view patients are entitled to withhold such information if they wish; for that reason, I think the complainer should not have been asked to give it while she was sedated but later, when she was fully aware.

The complaint that a monitoring electrode was fixed to the baby's head

6. The complainer's husband said that a monitoring electrode had been fixed to the baby's head during the course of birth despite a wish expressed by his wife, before she was sedated, that it should not. He told my officer that he had seen monitoring equipment in the delivery room and had asked the registrar about it, who had assured him that he would not use it. The complainer's husband later left the room while an internal examination was carried out, and when he

returned he found that the electrode had been attached. He protested and asked the registrar to remove it but the doctor was reluctant to do so. The complainer's husband said he was not going to let the matter rest but within a very short time the connections fell apart and the registrar changed to a different kind of monitor which the complainer's husband did not find so objectionable.

7. The consultant obstetrician told my officer that the use of the monitor was not a routine procedure, but after the complainer had undergone artificial rupture of the membranes the liquor obtained had been meconium stained and this was a sign of foetal distress. In this situation it was desirable to monitor the baby closely. The registrar told my officer that because of this he had suggested fixing a clip to the baby's head to monitor progress. The complainer had not been keen on the idea at first, but she was a trained nurse and had seemed to appreciate the significance of the meconium staining. After some discussion she had agreed that the monitor should be fixed.

8. The registrar said that when the complainer's husband returned to the room he had told him that he had no right to use the monitor, but that when he had informed him that his wife had requested it he had said 'all right'. The registrar could not understand why the complainer should subsequently complain about this. In his notes made at the time (which I have seen) he recorded that the complainer's husband, who was very keen on natural childbirth, had been against various procedures including the use of the monitor but that after his wife had agreed to them he had concurred. The acting nursing officer who was present at the time has confirmed that the complainer had agreed to the use of the monitor.

9. The complainer told my officer that she did not remember being asked for permission to use the monitor. She recalled the mention of meconium staining but said that the registrar had assured her that it was only slight.

10. It is clear from the evidence I have seen that the appearance of meconium staining gave the staff cause for concern and in the clinical opinion of the registrar (and his consultant) it indicated a need to monitor the baby closely. I am satisfied that the registrar did so only after the complainer had given her consent to the procedure. And I think the registrar, in telling her that the staining was only slight, was doing his best to prevent her from feeling anxiety for the baby.

The complaint that a doctor was about to use forceps against the parents' wishes

11. The complainer's husband said that at the time of his wife's admission he had carefully explained their wish that their baby should have a natural birth. However, during a somewhat protracted second stage of labour a doctor, without consulting his wife or himself, decided that she would use forceps. The complainer's husband told my officer that the doctor, who had been examining his wife, turned to the midwife and said something about getting ready for forceps. The complainer's husband told her that she was not to use forceps and she replied that she would use them if necessary. The complainer's husband then said that she was not using them without his authority. The doctor then explained that this stage was a bit difficult and that there was a strain on the baby, but the complainer's husband replied that the monitor indicated a steady heartbeat. The complainer's husband said the subject was then dropped.

12. The complainer's husband told my officer that he felt the doctor's desire to use forceps stemmed purely from her wish to 'get it over with' within a certain period of time. He said that at about this time another doctor had looked into the room and asked the doctor if she was coming for some tea. She had replied that she would be down in about half an hour. The complainer said that she also had gained the impression that the doctor wished to get the birth completed quickly for her own convenience.

13. The doctor involved, an assistant obstetrician, told my officer that she had heard generally of the complainer's husband's wishes, but did not know of any specific request that forceps should not be used. When she arrived the complainer had been in the second stage of labour for well over an hour and was having a slow delivery. After a short time she had told the complainer that as she had been going a long time and progress was so slow she would give her a little help with forceps. The complainer's husband had then stated that she was not to use forceps and had no right to do so against his and his wife's wishes. The doctor said she had explained to him that the baby was particularly at risk at this time and that any delivery should be completed within two hours of beginning the second stage. She told my officer that she had however decided to wait for a bit as the complainer's contractions were not very strong, and when the sister asked if she should bring the forceps trolley, she had told her to leave it for now.

14. The doctor informed my officer that she had been prepared to let labour continue for another half hour and then she would have felt obliged to carry out a forceps delivery; fortunately the baby arrived just in time. She assured my officer that the only reason she had suggested using forceps was because of the length of time the baby was at risk. The consultant told my officer that if the doctor had used forceps she would have had his full support. He confirmed that in the interests of a baby's safety it should be delivered within two hours of the start of the second stage. The usual duration of a second stage was between a half and one hour.

15. The sister on duty stated that because of the complainer's wish for a natural birth she had allowed the second stage to progress longer than she normally would before consulting a doctor about the possibility of using forceps. She was just on the point of sending for a doctor when the assistant obstetrician arrived. After the doctor had examined the complainer the sister told her that she had the forceps trolley ready outside. As far as the sister could recall this was what caused the complainer's husband to shout at the doctor about not using forceps. However a second sister, who had just come on duty at the time the doctor arrived, recalled that the doctor had 'scrubbed up' to deliver the baby and had then said something about 'giving it a wee help with the forceps'. It was her recollection that it was the doctor's remark which had caused the complainer's husband to react.

16. I am satisfied that the doctor was solely concerned for the safety of the baby during a protracted second stage which lasted one hour and 56 minutes. I have been unable to establish exactly what was said when the doctor decided to use forceps but I think that she mentioned her intention to the complainer and this prompted the complainer's husband's reaction, which resulted in the doctor deciding to defer their use for the present. It was of course for the doctor

in the exercise of her clinical judgment to decide whether it was necessary to use them. She could have consulted the parents first instead of simply mentioning what she proposed to do but it seems to me that her approach was intended to gain the cooperation of the complainer in a procedure which she judged to be necessary. This approach gave the complainer's husband the impression that he and his wife's wishes were being ignored. The doctor did however take heed of his objections with the result that forceps were not used.

The complaint that the complainer's husband was told not to touch his son

17. The complainer's husband said that while visiting his wife on the evening following the birth of his son he was reprimanded for lifting the blanket of the cot. He told my officer that he had merely been lifting the blanket in order to let another visitor have a good look at the baby when a nurse swooped on him and told him not to touch his son. He said that when he spoke to the sister he was told that he might bring dirt into the place. He was angry at the suggestion that he might be irresponsible enough to come in with dirty hands. He felt that if need be hospitals should provide washing facilities and robes for the use of fathers who might wish to hold their babies.

18. The sister to whom the complainer's husband had spoken told my officer that she had explained to him that, to prevent possible infection, it was a hospital rule that fathers were not to touch the babies. The senior nursing officer added that it was not simply a matter of possible 'unclean' hands, but visitors wore outdoor clothing from which there was a possible risk of cross-infection to new-born babies.

19. It is necessary for hospitals to take measures to protect new babies from the possibility of infection being brought in from outside, and I do not criticise the health board's policy on this. There is however some conflict of evidence about the way in which their policy was explained to the complainer's husband and I feel that the sister may not have phrased her explanation as diplomatically as she might have done.

Conclusions

20. The complainer and her husband wished their child to have a natural birth and to conduct the confinement as they thought fit, with as little medical and nursing intervention as possible. For medical reasons the confinement was not conducted exactly as the complainer's husband would have desired and I can understand their disappointment at this, but I did not find that any procedures were carried out without the prior consent of the complainer.

21. In paragraphs 16 and 19 I refer to communication between the complainer's husband and certain members of staff which could perhaps have been better. But in general I am satisfied that the staff went as far as they could towards meeting the parents' wishes, despite the critical attitude of the complainer's husband towards them. Indeed, I think they showed commendable restraint in a trying situation. I am aware that the complainer's husband caused distress to one member of staff whose custom it was to encourage husbands to remain with their wives during childbirth and that others also did their best to establish a rapport with him, without success. It is clear to me that the staff found it difficult to reconcile their over-riding concern for and responsibility

to the complainer and the baby with her husband's insistence that his wife should not undergo medical or nursing procedures, including the relief of pain, without his agreement. I think the complainer and her husband were fortunate to encounter staff who were able to exercise self-restraint and patience throughout the course of the complainer's labour and to help her as much as they could.

22. I have not upheld the complaint about the collection of personal details except that I think the information should have been requested when the complainer was not sedated.

Case No SW53/76–77—Communication with relatives

Complaint and background

1. The complainer's father was a patient in the orthopaedic department of hospital A from 3 December 1976 until 4 January 1977 when he was transferred to hospital B. On 5 January the complainer wrote to the Chairman of the Health Board (the Board) complaining of lack of information about his father's condition; that his father had been allowed to become incontinent because the staff did not realise his mental condition; that his father had been transferred without his or his mother's prior knowledge; and that some articles of his father's clothing had been lost.

2. The Chairman replied on 7 January that he had asked his officers to investigate, but in further letters dated 11 January and 9 February the complainer said he was not satisfied with the Chairman's attitude and that he expected the Chairman to reply personally. He also said in his letter of 9 February that he did not wish to pursue the complaint about missing clothing at this stage.

3. The Board's Assistant Secretary replied to the complainer on 17 February, but he was not satisfied and after a further exchange of correspondence he was advised by the Chairman that if he wished to pursue the matter further he could write to me. This he did on 15 March.

Jurisdiction

4. In his letter to me the complainer expressed dissatisfaction with his father's treatment and with the general standard of the health service in the area. I informed him that under the terms of paragraph 2 of Schedule 5 to the Act I am not empowered to look into the way in which doctors exercise their clinical judgment in the treatment of a patient or the diagnosis of his illness. And as I can only look into specific complaints his general dissatisfaction with the standard of the service was not something I could investigate.

Investigation

The complaint about lack of information

5. When the complainer first wrote to the Board he said he was disturbed by the lack of information he was given about his father whilst a patient in hospital A. He felt that the doctors either did not know what they were doing or did not wish to commit themselves and said he only learned on 18 January during a discussion with the professor in charge of his father's treatment that whilst in hospital A his father had become seriously ill due to renal failure. After that discussion the complainer wrote to the Chairman saying the professor had given him a comprehensive report on his father's condition and he was

completely satisfied with the professor's handling of the case. But he said his satisfaction did not extend to the other members of the medical staff who had looked after his father at hospital A because they had not told him of his father's serious illness due to renal failure. He told my officer that the professor had said his father had been in a critical condition and that at one point they had 'almost lost him'. The complainer said that on the three separate occasions when he had interviews with junior doctors at hospital A they had spoken only about his father's shoulder condition and had given no indication of any other problems.

6. In a letter to the Chairman dated 23 February the complainer rejected a claim by the Board that his mother had been informed when his father was seriously ill. But he later told my officer that it was possible his mother had been told and had not appreciated what the doctors were saying. He felt they should have given such news to him instead of to his 74 year old mother.

7. The professor of orthopaedics explained to my officer that the complainer's father had been admitted with pain and swelling of the left shoulder. Extensive tests had been carried out in an attempt to discover the cause but although the condition had been diagnosed as septic arthritis they had not been able to identify it, tests having excluded the likely causes such as Tb or a tumour.

8. The registrar told my officer he had seen the complainer's mother twice; on both occasions she had been accompanied by a male relative but he did not know whether this had been the complainer. On the first occasion he had explained that an aspiration of the patient's shoulder would be carried out, and on the second he had explained that they had carried out certain tests but were still uncertain about the cause of the patient's condition since the tests had revealed nothing. The resident houseman did not remember having met the complainer on any occasion, and the professor had been unable to identify any other doctor who might have spoken to him. The professor explained that the doctor who had been expected to take up post as their second resident houseman had had to withdraw at short notice and the vacancy had been covered by a series of locums during December and January.

9. The professor also explained that during the patient's first 10 days in hospital his general physical condition had deteriorated until on 12–13 December he was very ill and was suffering from pyrexia and uraemia. He said he had seen the complainer's mother on the ward at the time her husband was most seriously ill and had explained just how ill he was and that he was suffering from renal failure. The department's senior lecturer confirmed that the professor had explained the situation to the complainer's mother. He said he had actually been talking to her on the ward when the professor arrived. He had introduced the professor to the complainer's mother and had stayed with them whilst the professor spoke to her. The professor thought she had seemed receptive when he spoke to her about her husband's condition. In retrospect he agreed it might have been better to have talked to the complainer, but he had never seen him during the patient's stay in hospital A.

10. When my officer met the complainer's mother he thought she seemed very alert. However, she told him that although she remembered meeting senior doctors at hospital A she could not recall who they were, nor anything

being said about her husband being seriously ill or suffering from renal failure. As far as she could remember, the first time renal failure was mentioned was when she met the professor later at hospital B.

Findings

11. As none of the doctors interviewed could positively recall having spoken to the complainer I cannot reach a firm conclusion about whether or not he was given adequate information about his father's condition. But it is clear that the cause of the patient's condition remained a diagnostic problem for the doctors during his stay in hospital A, and I believe this was what led to the complainer getting the impression that they were unwilling to commit themselves. It is unfortunate that the complainer was not informed of his father's renal trouble (although understandable, since it was his mother's name which was on the medical records as the closest relative) but I think the professor did try to keep his mother fully informed at the time her husband was most seriously ill and that he believed she had understood what he told her.

The complaint that the patient was allowed to become incontinent

12. The complainer alleged to the Board that his father had become incontinent due solely to the inability of the hospital staff to realise his mental condition. He told my officer that his father's mental condition had been slowly deteriorating for about two years, but after his admission to hospital A there had been a marked deterioration. He said that when he mentioned this to the doctors he was told that his father was just confused and that this quite often happens to elderly people when they come into hospital. He said no effort was made to treat his father's mental condition.

13. The case notes show that from the time of admission the doctors were concerned about the patient's confused state. But the professor explained to my officer that it had not been clear at first whether this was due to his admission to hospital, to his pyrexia or some other physical condition, or to an unrelated mental condition. He said the complainer's mother had suggested that her husband's confusion was of recent onset, and the doctors at the hospital did not find out for some time that the general practitioner had recently requested a psychiatric opinion. The professor agreed it was possible that the patient's incontinence could have had some connection with his mental state, but said there was no treatment they could have given him for the latter other than sedation. And as he had wanted the patient to be assessed by a psychiatrist once his physical condition had improved he did not wish to sedate him.

14. None of the doctors to whom my officer spoke could remember making any remark to the complainer about his father being confused just because he was in hospital but they pointed out that this would not have been an unreasonable remark for a doctor to make. They had quite a lot of elderly orthopaedic patients, some of whom did become confused on admission to hospital.

Findings

15. From the evidence I have seen I am satisfied that the doctors were fully aware of the patient's mental state but were initially uncertain of its cause. The doctors' decision to avoid sedation until the patient had improved physically and could be seen by a psychiatrist is a matter of clinical judgment which I do not question.

The complaint that the relatives were not informed of the patient's transfer

16. The complainer told the Board that when he and his mother visited hospital A on the evening of 4 January they discovered that his father had been transferred to hospital B. He told my officer they had arrived at hospital A to find his father's bed empty. When he approached a nurse to ask what had happened she did not at first know anything about his father and she had to go and check through some papers before she could tell him of his father's move to hospital B. He said that whilst she was doing this his mother had been getting very anxious at the thought that something untoward had happened to her husband.

17. The complainer did not accept the Board's explanation that his father had been moved because of pressure on beds. He said that about 30 per cent of the beds in the area where his father was nursed had been vacant for three or four days before his move, and at the time he was moved there were still vacant beds. He considered that his father had been moved as a result of a mix-up or a quite arbitrary decision on someone's part. He also felt that the Board in their reply had tried to put the blame for an administrative matter on to the shoulders of the nursing staff.

18. The Board's district medical officer (DMO) told my officer that it was common for patients to be transferred from hospital A to hospital B, particularly in the specialties of general surgery and orthopaedics. He explained that hospital A is the acute hospital for the district, and in some specialties many patients who are admitted to hospital A as acute cases are transferred to hospital B once they have improved but are not quite fit enough to go home. This was confirmed by the professor, who explained that there were 40 orthopaedic beds at hospital A and 126 at hospital B. He said that because all acute cases were admitted to hospital A the beds there were always under pressure and as well as transferring patients to hospital B they usually had to 'board out' patients to other wards in hospital A. It was their policy to try to free two beds in the orthopaedic ward every morning for anticipated emergency admissions and if this could not be achieved by normal discharges, transfers or 'boarding out' had to be arranged. The daily return for 4 January 1977 shows that 38 of the 40 beds in the orthopaedic ward were occupied, but the professor pointed out that this would not be an accurate picture of the total number of orthopaedic patients in hospital A as 'boarded out' patients were not included.

19. The professor explained that the complainer's father had been 'boarded out' to another ward from 20 December, and the room he had occupied had been one immediately next to the orthopaedic ward. The orthopaedic ward and the other ward, in which the patient was accommodated, comprise single and four-bedded rooms, all of which are grouped in a 'racetrack' formation on one level of the building. The distinction between the wards would not, therefore, necessarily be noticed by patients' visitors.

20. By 4 January the complainer's father was physically fit for discharge but the professor wanted to keep him in hospital until his mental condition was diagnosed and treated. He had not himself made the decision to transfer him; he said this had been done by the doctor on duty. The registrar amplified the procedure by explaining that in some cases a decision was made in advance that a patient could be moved to hospital B, but when no such decision had been

made the ward doctors and nurses would consult about which, if any, patients could be transferred once they knew how many beds would be available at hospital B. He was fairly sure there had been no advance decision to move the patient and that the transfer had been decided upon by the senior nurses and the houseman in the light of the available beds on 4 January.

21. The senior nursing officer (SNO) whose responsibilities include the orthopaedic ward explained to my officer that there is an established system for arranging the transfer of patients between hospitals A and B. The orthopaedic secretary contacts hospital B to establish the number of vacant beds and, once it has been decided which patients are to move, the unit receptionist is responsible for notifying relatives by telephone and for certain other duties such as arranging ambulance transport. However, on a public holiday there is no orthopaedic secretary or unit receptionist on duty so all the transfer arrangements have to be made by the nurses. On 4 January (the Tuesday of the New Year holiday weekend) several members of the nursing staff were absent on holiday or sick leave and because the senior nurse was so busy she did not check the telephone directory when she found there was no telephone number on the patient's records. The SNO explained that if the hospital did not have a note of relatives' telephone numbers there was no way of informing them immediately because the police do not accept this type of message. In such circumstances the staff have to wait until the relatives telephone the ward or visit the patient.

22. The staff nurse in charge of the ward on 4 January told my officer that after she had ascertained the number of beds available at hospital B she had conferred with the houseman about which patients were to be moved, and the patient had then been brought to the orthopaedic ward to wait with the other two patients who were being transferred that day. When she went to telephone the patient's relatives she found there was no telephone number in the case notes. I have confirmed that this was so and that there was no record of the complainer's address and telephone number either. The staff nurse said she must have assumed the patient's wife was not on the telephone and she did not think to check in the telephone directory. She had not completed the transfer form which should have accompanied the patient to hospital B as the ward had run out of these forms. The form is normally sent to the receiving hospital and gives essential information about the patient, including whether relatives have been notified of the transfer. The SNO assured my officer that this oversight would not be allowed to happen again.

23. The Board's assistant secretary who replied to the complaint told me there had been no attempt to put the blame for administrative matters on to the shoulders of nursing staff. He had apologised on behalf of the Board for the failure to notify the next of kin of the patient's transfer and had simply tried to explain the circumstances in which this happened, not to apportion blame.

Findings

24. From the hospital A records I have seen that the complainer was correct in stating that about 30 per cent of the beds in the area where his father was nursed were vacant at the time of his transfer; but these beds were within, and were subject to use by, the ward adjacent to the orthopaedic ward from which his father had been 'boarded out'. The fact that there were vacant beds in that ward does not invalidate the Board's statement to the complainer that there

was acute pressure on the beds at hospital A for accident admissions, which would have been sent to the orthopaedic wards. I do not criticise the Board for their policy of moving patients to hospital B in order to free orthopaedic beds at hospital A for emergency admissions but as patients are regularly transferred to hospital B, sometimes at very short notice, I consider that more could be done to warn such patients and their relatives of this possibility—as a follow-up to the general warning about transfers given in the Board's excellent information booklet. If the complainer and his mother had been given advance warning she could have been spared the distress she felt on 4 January when she arrived to find her husband was no longer in the ward. And I think that when the staff nurse discovered that she had no means of informing the patient's relatives of the proposed transfer, consideration might have been given to negotiating with the adjacent ward for him to remain there until the relatives knew of the proposal. I have seen that there were ample vacant beds for him to stay there on 4 and 5 January. But I can well understand that the staff nurse was so busy she did not think of this possibility. I suggest that the Board should review their 'boarding out' arrangements in the light of this incident.

25. I am satisfied that the complainer's father was not moved because of an error nor as the result of an arbitrary decision. When the number of vacant beds at hospital B on 4 January was ascertained he was considered to be one of the patients fit to move. The failure to inform his next of kin could have been avoided if the admission form on his case records had included his home telephone number, or if the nurse had checked the telephone directory at the time of his transfer. The usual form did not accompany the patient when he was transferred and so the receiving hospital was not aware that his relatives had still to be informed. The Board have already apologised for the distress caused by this failure, and I think they should also remind their staff of the importance of obtaining and recording all necessary information about the next of kin, perhaps including where appropriate the details of another close relative.

The complaint about the way in which the Board handled the complaint

26. In his original letter of complaint, the complainer 'instructed' the Chairman of the Board to institute a full enquiry and furnish him with a competent report of his findings. He was annoyed to find that the final reply did not come from the Chairman, and he complained that the Chairman's attitude towards complaints was one of complete disregard. He felt this was indicated by the Chairman's statement in his letter of 7 January that ' . . . I do not accept instructions from members of the public, or from anyone for that matter'. The Chairman's letter went on to say that it was the Board's practice to make investigations and to submit a report to the complainer, and that the officers would write to the complainer in due course.

27. In a letter to the complainer dated 31 March I pointed out that health boards have established procedures for dealing with complaints and that I could not see any grounds for a complaint of maladministration arising from the Chairman's actions. Having completed my investigation I can confirm that the Board dealt with the complaint in accordance with their normal procedures, which is for the officers to make enquiries and for the Chairman to see all written complaints when first received and the reply when it is sent

to the complainer. In this way the Chairman monitors the complaints procedure.

28. The Chairman has explained to my officer that, despite what he said in his letter of 7 January, it is his view that chairmen of health boards take instructions only from their boards. I have seen the complainer's letters to the Chairman and I have no doubt that their tone was likely to irritate the recipient. The Chairman told my officer that the observations made in the original letter of 5 January would have been understandable and acceptable had the complainer previously made his complaint and felt he was getting no satisfaction. The Chairman said he had tried to indicate in his reply that the complainer would not get preferential treatment by writing in the way he did.

Findings

29. I do not uphold this complaint because I am satisfied that the Board made reasonable enquiries into the complaint in accordance with their normal procedures. I deprecate the peremptory tone both of the complainer's letter, and of the Chairman's reply. But the Chairman's attitude was not in fact to disregard complaints, despite the impression given by his letter, and I think he should have made it plain that whilst he did not find the tone of the letter acceptable he would in any case review the result of the officers' enquiries.

Conclusions

30. I was unable to uphold the complaints about lack of information and the patient's incontinence, nor the complaint about the Chairman of the Board although I understand why it was made. The failure to inform the complainer's mother of her husband's transfer was due to a human error for which the Board have already apologised. However, I consider that the Board could do more to give advance warning of the possibility that patients might have to be transferred from hospital A to hospital B at short notice and I invite them to consider how this could be achieved. I also invite them to review their 'boarding out' arrangements for the orthopaedic department, and to remind their staff of the importance of completing their records of next of kin.

Case No SW6/77–78—Inadequate explanation of condition

Complaint and background

1. The complainer was an in-patient in hospital A in September 1976 where she underwent an operation for the removal of a swelling near the base of her neck. Soon after the operation the swelling returned and she complained of having had considerable difficulty in finding out what had been done at the operation and the cause of the swelling, and of delays in reports being sent to her own doctor.

2. With the agreement of the consultant physician at hospital A the complainer sought the advice of surgeons at hospital B and hospital C only to be referred back to hospital A. Early in 1977 the complainer went to hospital D in London for examination but she complained that the medical file sent from hospital A did not contain the surgeon's report of the operation and even when this was requested it did not arrive in time.

3. The complainer also complained about her treatment as an in-patient at hospital C in July 1977 and about the Health Board's arrangements for assigning a family practitioner. She complained to the Health Board but considered their investigation to be inaccurate and inconclusive.

Investigation

The complaint about the difficulty in obtaining information about the operation and the cause of the swelling

4. The complainer told my officer that she had been attending hospital A in connection with a renal complaint when, during a visit to the clinic in April 1976, she drew the attention of the consultant physician (the physician) to a swelling on her neck. She said the physician examined it and advised admission to hospital for the two-fold purpose of treating her renal complaint and of discovering the cause of the swelling, which she said he thought to be inflamed glandular tissue. She was admitted to hospital A in July 1976 and radiological examinations were carried out. The complainer said she was told by the physician that urgent consideration would be given to carrying out a biopsy to discover the cause of the swelling. She said he also told her that pituitary gland abnormalities had been detected.

5. The complainer said she was re-admitted to hospital A on 13 September 1976 and two days later underwent an operation for the removal of the swelling. On 16 September she was visited by the consultant surgeon (the surgeon) who had performed the operation and who, she said, told her he had removed about half of the tissue. She said he also told her that when the pathology report was available he and the physician would decide which of them would provide any further treatment which might be necessary.

6. The complainer was discharged from hospital A on 18 September and after a few days the swelling and pain returned. She said that about two weeks after her discharge she telephoned the physician who told her that her condition was due to a 'mysterious glandular tissue' and that further surgery would be necessary. On 5 October the complainer went to the hospital, in response to his invitation to see him, so that she could find out more about the condition. She alleged that the physician was reluctant to explain the description he had given her a few days earlier but at her insistence revealed that the cause of the problem had been diagnosed as a 'hibernoma'. The complainer said he confided to her that he was not getting the cooperation of his colleagues, but explained that about two-thirds of the tissue had been removed by the surgeon and that further treatment would be a matter for discussion between himself and the surgeon, and suggested she should undertake a course of short wave diathermy (deep heat treatment) for cervical spondylosis.

7. The complainer said that, having been told by the physician that a hibernoma was a rare condition, reference to which would not be found in any medical dictionary, she suggested she might find out more about it through contacts which she had at a university. She said the physician agreed to this, and in telling her that he would be grateful for any information on the subject, referred her to the 'American Journal of Pathology'.

8. The complainer consequently sought advice by telephone from a doctor who worked for the pathology department in a university; he told her that a

hibernoma was a benign tumour. The complainer had told him there was a swelling in her neck, arms and fingers and he agreed this could be the result of the hibernoma and that she should see the surgeon again as soon as possible. The complainer also obtained some papers about this condition from the university library and sent a copy to the physician at hospital A. The complainer said that after her discussion with the university pathologist she telephoned the physician to suggest that he might learn more about the condition from the pathologist but he appeared reluctant to do so.

9. The complainer said that when the physician telephoned her on 9 October about sending a report to the family practitioner he told her there would have to be further surgery on her neck. After visits to hospital B and hospital C (referred to later in my report) the complainer was seen on 16 December 1976 by the surgeon at hospital A. She told my officer that the surgeon saw the swelling on her neck and arm and he mentioned arthritis and cervical spondylosis. She said he told her that no further surgery was necessary and that he had taken most of the tissue away from the neck area. The complainer told my officer that she was at a loss to understand how different assessments could be made of the amount of tissue removed.

10. The complainer said that on 3 February 1977 she again saw the surgeon, who told her that a consultant surgeon at hospital D whom the complainer had recently seen had confirmed that no further surgery was necessary. She also said that the hospital A surgeon had told her that the condition had never looked like a hibernoma tumour. Subsequently the physician arranged for her to be x-rayed on 13 April 1977. She understood this was to see if the remainder of the tumour could be located, but nothing could be found.

11. The physician confirmed that when the complainer was admitted to hospital A in July 1976 he had intended that an assessment of the swelling should be made. He said the appearance and behaviour of the swelling caused him to suspect a hibernoma tumour. X-ray examinations revealed cervical spondylosis of the 5th, 6th and 7th cervical vertebrae. He arranged for the complainer to be seen by the surgeon, who had planned to carry out a biopsy of the neck swelling, but on 18 July she took her own discharge, refusing to sign the irregular discharge form, and the biopsy was therefore not carried out.

12. The complainer attended the physician's out-patient clinic on 26 July and arrangements were made for her re-admission to hospital, which she entered on 13 September; an operation to discover and remove the cause of the swelling was carried out on 15 September. Following the operation, pathology tests confirmed the presence of a hibernoma tumour. The physician saw the complainer at an out-patient clinic on 5 October; he told my officer that she complained of increasing pain and discomfort from her neck; he said he explained her condition to her and that as much as possible of the tumour had been removed. He said he told her that he thought her pain was caused by cervical spondylosis but the complainer did not appear to accept this. He said he also told her that, because of an error in a laboratory test, information previously given to her about a pituitary gland abnormality was incorrect. He denied referring to the condition as 'a mysterious glandular tissue' and that he had told the complainer that further surgery would be necessary; he said he had told her that such a decision could be reviewed in the light of further developments. He said,

however, that he might have described the tissue as unusual and that the description 'glandular tissue' and 'hibernoma' were not conflicting terms. The physician said that he had been reluctant to tell the complainer that a tumour, albeit benign, was the cause of the swelling. He recalled that she had suggested she might find out more about the condition through contacts at a university. He said he had not objected to this but assured my officer that he did not refer the complainer to any source of reference such as the American Journal of Pathology. The physician also emphatically denied making any comment to the complainer about a lack of cooperation by his hospital colleagues, with whom he had a good relationship. The complainer had requested a second opinion on the pathology findings so he had arranged this with the head of the pathology department, and they were in fact confirmed.

13. I have seen the clinical notes for 5 October which record the physician's impressions at that time; they include reference to cervical spondylosis and show that he also considered the possible effect of the residue of the hibernoma which the surgeon had not been able to excise. The documentary evidence shows that he was well aware of the complainer's anxiety about her post-operative condition. The physician suggested a course of treatment involving diathermy and physiotherapy but the complainer failed to take the opportunities offered. I have seen the relevant records which contain evidence of this.

14. The physician told my officer that the complainer and members of her family had been in frequent contact with him, often without regular appointment, and that he had thoroughly explained the complainer's condition to them on several occasions. The complainer was convinced that the tumour was still the cause of her pain and, to find out if this was so, in April 1977 an x-ray examination of the blood supply to the neck was carried out but this revealed nothing abnormal.

15. The surgeon who performed the operation on the complainer told my officer that a tentative diagnosis of hibernoma had been made pre-operatively. On 15 September he had explored the neck and found the fat at the back of it to be of an unusual consistency. As much fat as possible was excised, exposing the underlying nerves supplying the arm, forearm and hand. The surgeon saw the complainer the day after the operation and again as an out-patient about a week after her discharge when, although the operation scar had healed, she again complained of pain and swelling. He made no further arrangements to see her as an out-patient again and referred the matter back to the physician.

16. The surgeon told my officer that he had gone to considerable lengths to explain to the complainer about the operation and their findings but that she did not seem to understand what he was saying. At the time of the examination on 3 February 1977 he could find very little to confirm the complainer's allegation of swollen limbs and fingers and discoloration; however, he suggested that a course of diathermy and physiotherapy might be beneficial but she did not accept this. The surgeon wrote to the complainer's family practitioner on 7 February to tell her of his findings.

17. After her operation the complainer was seen by the physician and the surgeon on several occasions for examination and for explanation of her condition. Documentary evidence shows that both doctors were consistent in their assessment of her condition. I am satisfied that she was given all reasonable

information and that the reason for the physician's reluctance to give a technical explanation of her neck condition was that he did not want to cause her unnecessary worry. I cannot be sure why she was apparently given somewhat different accounts of the amount of tissue removed but I can understand how the doctors, in giving separate explanations after the operation, inadvertently left the complainer with a feeling of uncertainty on this point.

The complaint about a delay in sending a report of the operation and treatment to her family practitioner

18. The complainer alleges that before being discharged from hospital on 18 September she was told by the physician that the pathologist's report should be ready by 21 September and that he would then write to her family practitioner. During the following week the complainer telephoned her family practitioner's surgery about the physician's letter but was told this had not arrived so she telephoned the physician who asked her to give him 'a few more days'. The complainer's husband then rang the department of surgery about the report but could get no information. The complainer stated that on a further two occasions she or her husband rang the hospital and were promised the matter would be looked into but heard nothing.

19. On Sunday, 3 October the complainer again telephoned the physician who apologised for the delay and promised to look into the matter; he agreed to see her at the hospital on 5 October. The complainer said that on Saturday, 9 October the physician told her over the telephone that he would be sending off a report to the family practitioner that day but the latter did not receive it until 12 October.

20. I have seen a letter of 22 October from the physician to the District Medical Officer of the Health Board which explained that the report from the pathology department was not available until several days after the patient's discharge. Since the complainer's attendance at the renal clinic earlier in the year she had changed her family practitioner and had informed the hospital of this, but inadvertently the surgeon's report was sent on 30 September to a doctor who had been giving the complainer private treatment. The physician said that when he spoke to the complainer on 3 October he undertook to send the information to her new doctor but owing to pressure of work the report was not typed and despatched until the following Friday, when he had personally posted the report since the rest of the hospital's mail had already been posted. He telephoned the complainer on Saturday, 9 October to let her know this had been done.

21. I have seen a copy of the report sent to the family practitioner and have confirmed that it was dated 8 October. In their letter to the complainer's husband on 4 November the Health Board agreed that because the original report dated 30 September had been sent to the wrong doctor there had been a delay. It was unfortunate that the change of doctor was overlooked but the physician and the Health Board took the view that the delay did not affect the complainer's health and I have seen no evidence to suggest that it did. Nevertheless, I understand the Health Board are willing to apologise for this oversight and the consequential short delay.

The complaint about treatment at hospital B and hospital C

22. The complainer's husband wrote to my office on 10 June on behalf of his wife and said that she had come to the conclusion that perhaps the surgeon at hospital A did not wish 'to trouble with this type of surgery' so she obtained the permission of the physician, which he said was readily given, to seek help from some other hospital. The complainer told my officer that she had wished to attend hospital B as it was nearer her home.

23. At her request her family practitioner referred her to a consultant surgeon at hospital B, which she attended as an out-patient on 20 October. According to the complainer she was not examined by this consultant but was told by him that it was not ethical for him to treat her as she was already under the care of hospital A and that she should report back to the surgeon who had performed the operation.

24. The complainer related a similar incident when on 8 November she was referred by her new family practitioner to the professor of surgery at hospital C. At her appointment on 26 November she said she was not seen by the professor but by one of his junior colleagues who examined her neck only when she asked him to do so and seemed to know little about her condition, although claiming to have seen several hibernoma tumours in his relatively short career. This surprised the complainer because she had understood the condition to be a rare one. She said he also told her she could not be treated at hospital C as she was already under the care of hospital A. She later spoke on the telephone to the professor of surgery who had no personal knowledge of her case but promised to look into the matter. He replied to the complainer on 6 December.

25. In May 1977 the complainer again attended hospital C, having been referred by her family practitioner. After she was seen as an out-patient by a consultant surgeon arrangements were made for her to be admitted for further investigation. She went into hospital C in July but told me she was discharged after a few days without a thorough assessment being made; she said she had been seen by a professor of orthopaedics who told her that there was minute cervical spondylosis and that she was 'orthopaedically clear'. She said that a subsequent request by her hubsand that the professor of surgery should arrange for a body scan and a skin biopsy was refused.

26. My officer spoke to the consultant surgeon at hospital B who said that when the complainer attended on 20 October she told him that she had a tumour about which no one was concerned. He said the complainer seemed unhappy with the management of her case; she had told him she had come to hospital B because she was dissatisfied with her treatment at hospital A.

27. The consultant said he examined the complainer to assure himself that the operation wound was healed and concluded that she should be referred back to hospital A. He had explained to the complainer that he could do no more at which she left abruptly, and a few minutes later he spoke to her husband and told him exactly what he had told her. I have seen documentary evidence which shows that the complainer was examined by the consultant and that he wrote to her family practitioner the same day suggesting that she be referred back to the surgical clinic at hospital A. He also suggested that should her symptoms merit further investigation an orthopaedic or neurological opinion should be requested.

28. The lecturer in surgery who saw the complainer at hospital C in November 1976 explained that she was referred to the professor of surgery by her family practitioner. I understand it is normal procedure for patients to be seen by staff of the professorial unit and not by the professor himself. The clinical files were arranged in the order of the patients to be seen and the doctors saw whichever patient was next.

29. This doctor said that he saw the complainer for about 45 minutes at the clinic on 26 November; she had told him that the surgeon at hospital A had not completely removed a hibernoma tumour from her neck and he had concluded that in the circumstances she should be referred back to the surgeon. He denied telling the complainer that he had seen hibernoma tumours on various occasions and said that, whilst he knew of this condition, he had never seen one. He wrote to the family practitioner that day explaining that he could find no clinical evidence of swelling nor any reason for pain and that he had decided to refer her back to the surgeon at hospital A, to whom he wrote asking him to see the complainer again. The professor of surgery wrote to the complainer on 6 December saying that his colleague had been correct in deciding that she should be seen by the surgeon who had performed the operation.

30. The consultant surgeon who arranged for the complainer to be admitted to hospital C in July 1977 explained to my officer that, although she was known to have received advice from several medical sources over the preceding months, it was thought that she should be brought into hospital for full assessment, and a variety of tests and examinations were carried out, including a bone scan. The professor of surgery saw the complainer's husband on 8 July and I have seen from documentary evidence that it was his opinion that he had then made it clear that he would not advise further surgery.

31. It was planned that during this stay in hospital the complainer would also be seen by a professor of psychiatry who had a particular interest in pain as a symptom but she discharged herself on 6 July without seeing him. Following her discharge, arrangements were made for the complainer to see the professor of psychiatry as an out-patient but she failed to keep the appointment. I have been told that the complainer's husband asked the surgical department on several occasions to provide treatment for his wife of a kind which he had read about in newspapers, or heard mentioned on television or radio.

32. My enquiries show that soon after her operation the complainer was seen at hospital B and at hospital C. She was not satisfied that sufficient efforts had been made to help her but I have verified that on both occasions she was medically examined and that it was decided by the doctors concerned that she should go back to the surgeon at hospital A who was familiar with her case. On each occasion her family practitioner was notified and following her visit to hospital C in November the surgeon at hospital A was asked to see her. The evidence shows that during her period of in-patient treatment in July 1977 in hospital C a variety of tests failed to establish a firm diagnosis for the symptoms of which she complained. Arrangements were made for her to be seen both during her stay and after her discharge by a psychiatrist who had a special interest in pain but she did not avail herself of this opportunity. I do not think it unreasonable for her to have been referred back to hospital A by the

doctors at the two other hospitals she attended. The evidence I have seen suggests that when she returned to hospital C some months later considerable efforts were made to help her.

The complaint about the delay in sending clinical notes to hospital D

33. In January 1977 the complainer was admitted to hospital D under the care of a consultant surgeon. She said there was no surgeon's report with the papers sent to hospital D from hospital A and although such a report was requested by the hospital D consultant it did not arrive until after she was discharged. She told my officer that the consultant had commented to her that if the surgeon's report had been available he 'might have been able to do something'. She also said that the consultant thought that 'surgery might be advisable in the future'.

34. The physician at hospital A told my officer that the complainer informed him at the beginning of December 1976 that she hoped to see a consultant at hospital D and asked that he write to him giving a brief description of the diagnosis. He did so on 11 December 1976 and on 14 December the consultant wrote requesting more clinical information and some unstained slides of the specimen taken at the operation. On 23 December the physician complied with this request. On 5 January the consultant wrote to the physician saying that he was also writing to the surgeon at hospital A 'to obtain his precise findings at operation'. He said that the complainer seemed very keen for him to re-explore her neck, that he was reluctant to do so, and that he hoped the surgeon's report would help him in making his decision.

35. The surgeon at hospital A told my officer that, one evening around 6.30 pm early in January, he received a telephone call from his secretary saying that the complainer's husband had telephoned asking that he should send a report to hospital D. He said he was unwilling to do so in response to that request but on hearing from the hospital D consultant on 11 January he sent a report of the operation and of his findings. A week later the consultant wrote to him saying that he did not consider that the complainer would benefit from further exploration of the neck at that time although such a decision could be reversed should the physical signs warrant it in the future. A full clinical report from hospital D was sent to the hospital A surgeon on 31 January, in which it was stated that it had been fully explained to the complainer that the small fatty area of her neck was not in any way dangerous nor was it the cause of her symptoms.

36. I have seen that a comprehensive report which included references to the operation and the pathology findings was sent on 23 December by the physician at hospital A and that the complainer entered hospital D on 4 January. The complainer was discharged from hospital D on 11 January, the day the surgeon sent his report to the consultant at hospital D. I do not think there was undue delay in sending this report once it had been formally requested. It is apparent from the clinical report, which I have seen, that the consultant had already formed the opinion, before receiving the surgeon's report, that further surgical intervention was unnecessary at that time but that, if the condition of the neck changed, this decision could be reviewed. It is clear that the consultant did not change his opinion after he had received the surgeon's report, since he conveyed his views to the surgeon a few days later.

The complaint about the Health Board's arrangements for obtaining a family practitioner for the complainer

37. The complainer told my officer that when she moved to a different area she had difficulty in finding a general practitioner who would accept her as a permanent patient. The Health Board had told her that it would be better if she could herself find a doctor as the alternative was for the Health Board to allocate her to a doctor's list. The complainer eventually had to ask the Health Board to obtain a doctor for her and arrangements were made for her to be assigned to each of four doctors on a three-monthly rota. She complained that she was often not told until after the beginning of the quarterly assignment who her doctor was and that the incoming doctor was not always in possession of her medical file.

38. The Health Board's primary care administrator told my officer that where a patient was having difficulty in obtaining a permanent family practitioner a rota consisting of four doctors assigned to the patient for three months each was arranged. At the beginning of the year the doctors were notified when their quarterly assignment would begin and end. The administrator told my officer that it was Health Board policy not to inform a patient of the arrangements too far in advance, otherwise he might contact the incoming doctor before the date of assignment. It had been normal practice to issue notice to the patient the day before the quarterly assignment but this has now been extended to a minimum of three days before it took effect. The administrator could see no difficulty in the new doctor not having the medical notes as he could easily contact the outgoing doctor for any necessary information. Medical records were sent to the Health Board by the outgoing doctor and sent by them to the next one.

39. In the case of the complainer and her family a rota was arranged for the period 3 November 1976 until 31 October 1977 but this was cancelled soon after it began as the complainer had found a practitioner willing to accept her as a patient. Unfortunately, however, that doctor had the complainer removed from his list and a second rota for the period 30 December 1976 to 31 December 1977 was arranged. This was cancelled after about nine months as the complainer had been accepted by another family practitioner. The doctors involved in the second rota were given a week's notice of the proposed arrangement in a letter from the Health Board dated 21 December and the Board wrote to the complainer's husband on 30 December advising him of the first assignment dating from that day. The next quarterly assignment took effect from 1 April 1977 and the complainer and her family were notified by letter dated 31 March; the medical records were issued on 5 April. The complainer's husband was notified of the third assignment by a letter dated 1 July—the first day of the new period—and the medical records were issued on 20 July.

40. I can understand the complainer's anxiety at not knowing in advance who her family practitioner was to be for the following three months and the concern of the Health Board to refrain from giving this information to patients much before the date the rota commences since any approach by a patient before that date may prove detrimental to the arrangements, in which the practitioners' co-operation is voluntary. The Health Board has now introduced a new procedure by informing patients three days before the beginning of the

rota period. I do not think that in this case notification was excessively delayed but I have noticed some delays in sending the medical records to the new practitioner, notably in the third quarter of 1977. I hope the Health Board will keep an eye on this.

The complaint that the Health Board's reply was inaccurate and unsatisfactory

41. In a letter to my office the complainer's husband, writing on behalf of his wife, stated that the reply from the Health Board contained various inaccuracies. I have examined the documentary evidence and note that the Health Board's reply dated 4 November 1976 was based on the information obtained in their enquiries and contained no significant inaccuracies. I have found no evidence of maladministration on their part.

Conclusions

42. The complainer was convinced she was not being given the treatment she felt she needed to alleviate the pain and swelling of her neck and other symptoms. It was, however, explained to her at the outset of my investigation that the treatment to be given is a matter for a doctor's clinical judgment and outside my jurisdiction. The complainer has sought help from various members of the medical profession and has undergone extensive investigation in several hospitals. The evidence shows that following her operation she was offered diathermy, physiotherapy and an assessment by a doctor with a special interest in pain. She declined these offers and according to documentary evidence she discharged herself from hospital on two occasions.

43. My investigation leads me to conclude that the complainer's medical advisers, acting solely in the exercise of clinical judgment, did their utmost to tell her as much as possible about her condition without giving cause for needless worry; but the complainer may have misunderstood some of the information she was given, or failed to appreciate its significance. There was a short delay in sending a report to her family practitioner because the report had at first been issued to the wrong doctor and the Health Board apologises for this. I have not found anything to criticise concerning the medical reports sent to hospital D. I do not uphold the complaint about the complainer's attendances as an out-patient at hospitals B and C; the doctors concerned decided, after they had examined her, that she should be referred back to hospital A and this was a course of action they were entitled to take in the exercise of their professional judgment. I find nothing to criticise about the arrangements made for the complainer's treatment at hospital C in July.

44. I have noted that the Health Board now give at least three days' notice to patients of a change of family practitioners who give service to certain patients by rota and I hope they will also consider how the movement of medical files can be speeded up. I have not found anything of substance in the complaint that the Health Board's reply to the complainer's husband was inaccurate.

Case No SW7/77–78—Hospital accommodation

Complaint

1. A man complained that when he and his wife took their four-month old son to be admitted to the plastic surgery unit of a children's hospital on 1 May 1977, for an operation, he was so concerned about the uncontrolled behaviour

of older children in the ward that he felt unable to leave his child there. He also complained about the lack of consideration shown by the staff.

2. The complainer wrote to the local Health Board (the board) but was not satisfied with the reply he received from the district administrator. The reply stated that he was offered the use of a side ward but the complainer denies this.

Investigation

Complaint about the behaviour of the children in the ward and the lack of consideration shown by the nursing staff

3. The complainer told my officer that on 1 May he took his son to the hospital thinking he would be admitted to a nursery ward but found that he was to be admitted to a ward where there were other, older, children. The complainer described the scene on the ward when they arrived at lunchtime that day as 'three or four children rampaging about the ward, one of whom was being swung round by the heels by another older boy. Not to put too fine a point upon it they weren't quite right in the head'. (When he wrote to the administrator he had explained that one child was being dragged up and down the ward by the heels.) The complainer said that when the children saw his son they came over and began touching him. The children had no immediate supervision, there being only one nurse on duty in the unit at that time, which was during the staff's lunch break. He drew the nurse's attention to the behaviour of the children only to be told that not everyone was perfect. He thought his son would be at risk from the other children so he asked the nurse if he could be placed in a nursery ward but was told that all that could be offered was a big room near the main ward and even then there was no guarantee that his son would remain the sole occupant. The complainer said this would not be acceptable. The nurse therefore sent for a sister from the adjacent ear, nose and throat (ENT) unit to speak to him.

4. The sister confirmed that the accommodation offered was all that was available and the complainer again stated he would not leave his child under such circumstances. He said that the sister then left to fetch a doctor to speak to him but he did not see any purpose in this as it was apparent that his son was not to be given a room to himself or nursery accommodation. After a short while he and his wife left, taking their child with them.

5. The staff nurse who met the complainer and his wife on their arrival at the hospital told my officer that, while she was taking down their son's particulars, the complainer interrupted and stated that he did not wish his child to be admitted to the ward while the other older children were there, indicating that he thought the children looked strange. The nurse asked him what he meant and he said there was not enough supervision in the ward and his child might be harmed by the other children. In her statement to the health board the staff nurse said that the children who occupied the main ward at that time were a boy of nearly 12 years who had been attending hospital for some time for the repair of a cleft lip; another boy aged three who had burnt his left hand and was wearing a splint; and a girl aged five who had a squint and who wore very thick glasses. The only other patient was a girl of about 18 months with scalds of both legs who was in a twin-bedded room nearby.

The staff nurse was alone on the ward at that time as the nursing auxiliary was at lunch and she had not seen any of the children being pulled along the floor. She doubted whether they would be involved in anything other than normal noisy children's play. The board in their comments said that the complainer and his wife arrived slightly early for their son's admission. When the nurse saw them arrive she left her post to bring them to the ward in order to avoid leaving them to wait in the hall, and the patients in the ward became boisterous in her absence. Had it not been for the nurse trying to avoid keeping them waiting the incident would probably not have occurred. The board told me that nursing staff have now been instructed not to leave their station while on duty.

6. The accommodation in the plastic surgery unit comprises the main ward which has seven beds or cots, immediately next to which is the duty room. Some 20 feet away are two other rooms with accommodation for five and two children respectively. Apart from the three children in the main ward, the only other patient in the ward unit that day was the girl of 18 months. The five-bedded room was empty.

7. The staff nurse said she told the complainer that his son could be put into the empty side ward by himself for the Sunday but she could not guarantee that he would be alone for the rest of his stay in hospital. She said the complainer did not find this acceptable and more or less demanded a room for his child. She therefore asked the sister in overall charge of the unit that day to come and speak to him. The sister repeated everything the staff nurse had said and offered to fetch a doctor to speak to the complainer. While the complainer was waiting for the doctor he said he did not know why he was waiting as he would not change his mind. The staff nurse suggested to the complainer that he go back to his family practitioner but said he did not appear to be listening. He asked which Board of Management was responsible for the hospital and was given this information, after which he and his wife left with their son.

8. The sister who spoke to the complainer confirmed to my officer that she tried to allay his fears by assuring him that his son would be closely supervised and come to no harm during his stay in hospital, but he did not seem to listen and there was no opportunity to explain about treatment. When she told him that his son could be placed in a side ward for the Sunday night as it was empty at that time but that she could not guarantee for how long he would be there, the complainer said he must have a guarantee that his son would remain on his own and if this was not possible he would take his child home and have the operation done privately, or wait until the hospital sent for him when they had a private room. The doctor who had been sent for was busy in the casualty department so the complainer was asked to wait until he was free but after about ten minutes he and his wife left before seeing him. The sister immediately instructed the staff nurse to prepare a report of what had happened and she did likewise. Instructions were given that the family practitioner be informed the next day, a Monday, and this was done. The sister told my officer that she had never heard of any child at the hospital being injured by a fellow patient.

9. The nursing officer who has oversight of the plastic surgery unit explained to my officer that after his operation the complainer's son would have had to be restrained in his cot and to be constantly supervised, for which purpose

it would be necessary for him to be in the main ward. There was no nursery accommodation in the surgical unit; there was a mother and baby room but this was at the opposite end of the hospital and had he been accommodated there it would not have been possible to give him the required degree of care and attention after the operation.

10. I have been informed that patients with scalds need to be isolated hence it would have been medically inappropriate for the complainer's son to have shared the two-bedded room with the 18-month old child. The room with five beds was offered as it was empty at the time but the nursing officer has explained the reason why no guarantee could be given that the complainer's son would remain there on his own was because other children with burns and scalds might be admitted as emergencies.

11. The nursing officer commented that the sister and staff nurse were trained paediatric nurses who were well aware of the feelings of parents bringing their children to hospital. To allay any fears which the parents might have the staff always tried to explain what treatment and care a child was to receive but on this occasion this had not proved possible because of the complainer's preoccupation about the accommodation.

12. I enquired into the nurse staffing arrangements for the plastic surgery unit and found that to some extent the unit was managed in conjunction with the ENT unit of 23 beds which shares the same floor. The plastic surgery unit is normally staffed during the day by a trained nurse (sister or staff nurse), a student nurse, and an auxiliary nurse. At night, two nurses are on duty. During meal breaks, the staff of the two units arrange their time away from the wards in such a way that there are at least three staff available to cover both units by day, and two are available during meal breaks at night. The board have told me that at the time in question there were two nurses on duty in the ENT unit (which was empty, being prepared for new admissions) and the staff nurse in the plastic surgery unit. In the board's opinion, this was adequate staffing for the four patients to be cared for at that time. However, the staff nurse was not relieved by a colleague from the other unit so her patients were not supervised whilst she saw the complainer and his wife.

13. I examined the leaflet which is given to parents of children who are to be admitted to the hospital. It states that children under 14 years of age are not normally allowed to visit and that children who do visit must be constantly supervised by an adult. From this I conclude that the Health Board is aware of the need to safeguard their child patients from the attention of other children.

14. Parents are naturally anxious when they bring their children to hospital and the complainer's anxiety was heightened when he learned that his son was to be admitted not to a nursery but to a general ward containing older, ambulant, lively children who apparently were acting in what he regarded as an uncontrolled and boisterous way. The curiosity which the children showed towards his son may also have contributed to his fears for the child's safety. The other children looked odd to him, but they were considered by the staff to be pleasant children of normal intellect. In the circumstances, it was not unreasonable for the complainer to seek to ensure that his son would be adequately protected from older children by admission to a nursery ward, or

failing that, a single room. However, all that the staff could offer was admission to the empty five-bedded room; I am satisfied they had no other facilities to offer within the plastic surgery unit of the kind requested by the complainer. I am also satisfied that they could offer no guarantee that his son would remain alone in that room because they had no way of knowing what type of emergency admissions to expect, for which the room might be required. I believe the staff did their best to allay the complainer's fears for his son and to do what they could to meet his wishes within the limitations of the available accommodation.

15. Had one of the ENT nurses relieved the staff nurse when the complainer and his wife arrived the children would probably not have had the opportunity to become boisterous. I think that staffing arrangements at meal times are such that there must inevitably be occasions when a young child who is accommodated in the main ward cannot be under constant supervision, since the available nurses will from time to time be attending patients elsewhere or otherwise occupied. The complaint about lack of consideration was founded on the complainer's view that the admission arrangements offered were inadequate; I do not consider that the nurses were themselves lacking in consideration for the child or his parents.

The complaint about the way in which the Health Board dealt with his complaint

16. The complainer wrote to the district administrator on 3 May 1977 complaining of the proposal to admit his son to a ward of older children, whose behaviour he described. He said that children under a certain age should be in a nursery with someone in attendance, thus preventing possible harm from older children. The administrator acknowledged the letter and replied more fully on 12 May, having investigated the complaint. He said it was usual policy to admit children irrespective of their age to a general ward and not to place them in side rooms unless there was a medical indication that this was essential. He also said there was no private accommodation at the children's hospital but that he understood that a side ward had been offered, although the staff could not guarantee that the complainer's son would remain in it for the whole of his stay as such wards were normally used for children requiring special nursing attention. He assured the complainer that if his son returned for treatment he would receive every attention and he would have no cause for concern. He said he felt sure their family practitioner would give the same kind of assurance. The complainer replied indicating that he was not satisfied with this and asked for and was given the address of the Health Service Commissioner.

17. It is evident that there was some misunderstanding between the complainer and the hospital staff about the description of a side ward. The staff customarily refer to the seven-bedded room as the main ward and the other rooms as the side wards but it is apparent that the complainer's conception of a side ward was that of a room with one bed or cot. When the administrator said he understood that a side ward had been offered he was referring to the five-bedded ward which had indeed been offered by the nurses but which was unacceptable to the complainer. I am satisfied that the administrator made proper enquiries and that his reply was reasonable. I do not uphold this complaint.

Conclusion

18. I consider that the complainer was reasonably worried about the safety of his infant son and that his request for him to be put in a separate ward was understandable. But I am satisfied that the hospital could not, at the time of the planned admission, offer the kind of accommodation he wished. I understand that a new district general hospital will open in 1979 and I hope the paediatric unit there will include separate accommodation for very young children. The Health Board have reviewed their staffing arrangements and nurses have now been told not to leave their duty station. Had these instructions been in force on 1 May 1977 this complaint would probably not have arisen. For the reason given in paragraph 16 I have not upheld that part of the complaint which concerns the administrator's reply.

Case No WW29/76–77—Complaints about geriatric care

1. On 13 January 1976 the complainant's father was admitted as a geriatric patient to hospital A, where he died on 13 April. The complainant claims that—

(*a*) the decision to send her father to hospital B for x-rays rather than to use the portable x-ray equipment in hospital A took insufficient account of his consequent probable exposure to the very cold wet weather;

(*b*) when her father arrived for the x-ray at hospital B on 2 April 1976 he was kept waiting for an hour in a cold and draughty corridor;

(*c*) her father was not seen by a doctor between 10 and 13 April 1976; and

(*d*) the Health Authority (the Authority) took eight months to produce a substantive reply to her complaint and she thought it unsatisfactory.

2. Although the complaints that the patient had not been seen by a doctor and that he was kept in a cold and draughty corridor had not previously been brought to the attention of the Authority they agreed that I should include these aspects in my investigation.

Investigation

(*a*) and (*b*) *The complaint about the x-ray examination*

3. In her correspondence with the Authority and at her interview with my officer the complainant said that on 28 March 1976 she had been told by a doctor that her father was to be sent to hospital B for routine x-ray examination on 30 March. She had felt uneasy about this as her father was suffering from a chest infection, and she had thought that, on a previous occasion when he had been sent for x-ray, he had not been adequately clothed for the journey. She therefore telephoned hospital A from her home to express her concern, and was told that the x-ray had been postponed until 2 April. On that day, she said, her aunt had visited the hospital and had seen her father sitting by his bed in his pyjamas, whilst other patients in the ward who were also awaiting transport to the x-ray department were sitting in wheelchairs wrapped in blankets. But her aunt did not see how he was dressed when he left the ward. The complainant said that she herself had been x-rayed at hospital B and she knew from personal experience that patients had to wait in a cold and draughty

corridor. Subsequently her father's condition had worsened, and she was told by a nurse on 9 April that he had pneumonia. She could not understand why, in view of his condition, it was necessary for the x-ray to be carried out at hospital B rather than by means of a portable machine on the ward at hospital A.

4. The doctor in charge of the patient's care told my officer that on 25 March he developed influenza and signs of pneumonia. He was treated with ampicillin and his chest remained clear, but his condition began to deteriorate. Between 31 March and 5 April his temperature was normal, but there were indications that he might have suffered a lung collapse or an effusion and it was considered that an x-ray was essential to confirm the diagnosis in order to prescribe the best treatment. She assured my officer that his condition had been taken into account when the x-ray examination at hospital B was decided on. In her opinion the patient had been fit to leave the ward and travel the short distance involved.

5. The consultant radiologist at hospital B told my officer that the portable x-ray machine available in hospital A was of limited use and required a much longer exposure than the equipment at hospital B. The x-ray examination had in fact shown some evidence of an unresolved pneumonia.

6. The ward sister told my officer that she and the nurses remembered the patient, but that no one could recall what happened on 2 April. She said that nurses always ensured that patients going for an x-ray were well wrapped up in blankets and she could not accept that this patient might have been inadequately dressed. The record of ambulance movements at the hospital shows that the patient was one of four who were sent for x-ray on 2 April, and that the ambulance left the hospital at 2.45 pm, arrived at the hospital B x-ray department at 2.50 pm and returned to hospital A at 4.25 pm.

7. The hospital B secretary explained to my officer that it was usual to convey patients for x-ray examinations in groups, except in emergencies, and he confirmed that, as a result, there might be a waiting period of about an hour. My officer visited the waiting area for the x-ray department, which is part of a corridor and situated about 30 feet from the swing doors at hospital B's main entrance which is in frequent use. The area was centrally heated and the doors closed automatically, but if they were propped open, it could be draughty. The hospital secretary told my officer that staff were instructed that the door should not be kept open. He accepted that the arrangements were not ideal, but said they could not be improved in view of the layout of hospital B.

8. The decision that the patient was fit enough to be taken by ambulance to another hospital for x-ray was taken solely in the exercise of the doctor's clinical judgment and I do not question it. I am unable to say how he was dressed but, since it is apparently routine to wrap up patients well for the journey, I think it unlikely that he was inadequately protected from the weather or that he suffered significant discomfort during his wait for examination. But to have a waiting area so close to external doors which are in frequent use is far from ideal and, whilst I appreciate the difficulties imposed by the present layout of the hospital, I invite the Authority to consider again whether there is any scope for improvement.

(*c*) *The complaint that the patient was not seen by a doctor between 10 and 13 April 1976*

9. In her letter to me, the complainant said that her father's condition suddenly deteriorated on 10 April but she did not think he was seen by a doctor between the evening of 10 April and his death on 13 April. She told my officer that she had visited her father for several hours on each day from 9 to 12 April and had stayed, but her father was not seen by a doctor while she was there.

10. The clinical and nursing records show that the patient was examined by a doctor each day between 9 April and 12 April. The doctor who was on call on 10 and 11 April told my officer that she remembered that the complainant had been particularly anxious about her father's condition on 10 April and that she had discussed it with her. The entry in the medical notes for 10 April reads: 'daughter present and very anxious, have explained the position to her'. The doctor said that she visited the ward on 11 April; she examined the patient at about 8.30 pm and said that his condition remained critical.

11. The doctor who was on call on 12 April told my officer that she had been told by the nursing staff by telephone of the patient's condition. When she examined him she found that his breathing had become very irregular. She had asked for an intravenous infusion to be given (and the nursing notes confirm that it was) and instructed that the complainant be informed of her father's critical condition. There was very little else that could be done and he died at 1.45 am on 13 April.

12. I am satisfied from the evidence that the complainant is mistaken in her belief that her father was not seen by doctors on each of the three days before his death. I am sure that he was seen on each of these days and that appropriate steps were taken to treat him and to inform his next-of-kin of his condition.

(*d*) *The complaint that the Authority did not deal satisfactorily with her complaint*

13. The complainant wrote to the Authority on 16 May 1976 and received an acknowledgment dated 26 May. She received several further letters assuring her that enquiries were continuing and promising a reply as soon as they were completed. A letter dated 1 November 1976 from the district administrator to the local community health council also gave an assurance that the matter was receiving urgent attention. A substantive reply was sent to the complainant on 18 January 1977.

14. My examination of the Authority's files shows that the complaint was referred by the area administrator of the Authority to the area medical officer (AMO) on 27 May. He sought comments from the district community physician who, in turn asked for a report from the consultant physician in charge of geriatric medicine (the geriatrician). There was a slight delay while the patient, whose name the complainant had not given in her letter of complaint, was identified, and a further delay while the medical staff concerned debated the propriety of releasing the clinical information for use by the administrative staff. On 14 June the geriatrician replied in detail to the district community physician explaining why the patient had been taken to hospital B for x-ray and he copied his letter to the AMO. On 15 July the area administrator approached the AMO to see what further action he intended to take. The AMO

said that everything possible had been done to investigate the complaint and the administrator to whom he talked noted this on the file. He told my officer that he recognised that the responsibility for replying to the complainant then rested with the administration.

15. I have been unable to find out why, when the investigation had been completed by June or July 1976, the Authority did not reply to the complainant until January 1977. I do not find fault with the content of the reply but I think the delay was regrettable. I understand that the complaints procedure now provides for a weekly review of outstanding cases and for a monthly report to be sent to the area administrator. This should prevent complaints being overlooked in future.

Conclusion

16. I have found no cause to criticise the attention given to the patient by the medical or nursing staffs and I hope that this will be of some comfort to the complainant. I think that the accommodation for patients awaiting x-ray at hospital B falls short of what is desirable, and I have invited the Authority to reconsider whether any improvements can be made. I have criticised the Authority for their long delay in replying to the complainant and I hope that the new arrangements now introduced will prevent any similar delays in future.

Case No WW3/77–78—Unsatisfactory nursing care and overdosage of a drug

Complaint and background

1. On 4 July 1976 the complainant's cousin, aged 61, was admitted to hospital A. On 31 July 1976 she was transferred to hospital B. On 6 August she was discharged from hospital and died a few days later.

2. The complainant claims that:—

(*a*) when her cousin arrived home she was suffering from a severe throat and mouth infection which had not been noticed at hospital B, her buttocks were inflamed, and she was in pain;

(*b*) at hospital B the dosage of a drug was doubled without explanation after the consultant treating her cousin had told her (the complainant) that she was already receiving the maximum permitted dose; and

(*c*) the reply she received from the Health Authority (the Authority) to her complaints was unsatisfactory.

Investigation

(*a*) *The complaint about the patient's condition on discharge from hospital B*

3. In a letter to the Area Medical Officer (AMO) the complainant said that when her cousin was discharged from hospital B she was suffering from a throat and mouth infection which had not been noticed at the hospital. Her buttocks were inflamed and she was obviously in pain. The complainant told my officer that on 7 August, when he examined her cousin's mouth, the family practitioner prescribed some medicine to clear up the infection and arranged for the district nurse to call.

4. When interviewed by my officer, the sister in charge of the ward at hospital B said that she noticed the patient's mouth was very dirty at the time she was transferred from hospital A and made a note of her findings in the nursing notes (which do, in fact, record that her mouth was dirty). The sister said that the patient was given routine oral care for the condition of her mouth, and she made the point that it had been difficult to clean her mouth and teeth as she used to bite on the toothbrush and prevent it being done thoroughly. She did not think the patient's buttocks could have been inflamed and sore because she was bathed regularly by the nursing staff and a condition such as that described by the complainant would certainly have been observed and recorded in the nursing notes.

5. Neither the family practitioner nor the district nurse, when they spoke to my officer, could remember the patient having a mouth or throat infection or sore buttocks. The district nurse did say that the insides of her thighs were sore. (This might have been caused by her incontinence of urine which is recorded in the nursing notes.)

6. I find that the nursing staff at both hospitals were concerned about the condition of the patient's mouth and although there is no record of any specific treatment having been prescribed for this, I have no reason to doubt that the nursing staff tried to keep her mouth as clean as possible. The nursing notes also record that the patient was bathed frequently and I believe that any signs of soreness on her buttocks should have been seen by the nursing staff and treated. Whether, in fact, she had sore buttocks or thighs at the time of her discharge I cannot now say.

(*b*) *The complaint about the increase in the dose of the drug Sinemet*

7. In her letter to the AMO the complainant said that, whilst at hospital A, her cousin had been given the drug Sinemet and she had been told by the consultant that she was receiving the maximum dose, which was one tablet of 'Sinemet 100' three times a day; but after her cousin was transferred to hospital B, the dose was doubled to two tablets three times a day, and this had had an adverse effect on her.

8. In her discussion with my officer the complainant said that the consultant had not been speaking to her direct about her cousin's dosage of Sinemet. She explained that on 25 July she had stayed at hospital A overnight and the following morning the consultant and another doctor had discussed her cousin's condition in her hearing. She said she heard the consultant tell his colleague that the dose of Sinemet had been increased gradually and the amount could not go any higher.

9. The complainant told my officer that on 1 and 2 August she had asked the nursing staff at hospital B about her cousin's medication and had been told that she was being given one tablet of Sinemet three times daily. On 4 August, on the instructions of the consultant, the dose was increased to two tablets three times daily. The complainant described the effect of the increased dose on her cousin as 'devastating'; her arms were moving uncontrollably and she seemed to be in pain. The complainant said that she had not made any enquiries of the medical staff about the increased dosage.

10. The consultant told my officer that the method of treating patients with Sinemet is to start with a very low dose and increase it gradually until the optimum response to the drug is obtained. This amount is then regarded as the standard dose, but the doctor adjusts the dose within the recommended guidelines if the patient's condition varies. The consultant said that most patients can be maintained on three to six tablets of 'Sinemet 100' per day. The maximum dose is eight tablets per day; any larger dose gives no advantage to the patient.

11. I have examined the patient's in-patient medication, prescriptions and administration record. This shows that on 8 July 1976 she was prescribed half a tablet of 'Sinemet 100' a day and on the instructions of the doctor the dose was gradually increased until 19 July when she was prescribed 'Sinemet 100' six times a day. This continued to be given until 2 August when the dose was reduced to two tablets a day.

12. In prescribing the quantity of the drug Sinemet for the complainant's cousin the doctor was acting in the exercise of his clinical judgment which is not for me to question. But the records show that it was on 19 July that the prescribed dose was increased to six tablets a day, and not on 4 August as the complainant believed. On 25 July when she overheard two doctors discussing her cousin's case she was being given six tablets a day of 'Sinemet 100' and it is clear that the dose was never increased above this level.

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

13. I have examined the papers about the complaint and I have seen that, before writing to the complainant, the AMO obtained the comments of the consultant in charge of her cousin's case. In his reply to the AMO the consultant did not explain when the dose of 'Sinemet 100' was increased and the AMO was thus not in a position to reply to the complainant on this point as fully as he might otherwise have done. He did explain that he could find no evidence about the patient's mouth infection and sore buttocks. This agrees with my own findings.

Conclusions

14. I have not been able to uphold the complaint about the lack of nursing care the complainant's cousin received because the evidence is inconclusive. I am satisfied that the complainant was mistaken in her belief that the dosage of Sinemet was doubled after her cousin was receiving the maximum dose. But I do not consider that the Authority dealt as fully as they should have done with this aspect of her complaint and they have asked me to express their regret to the complainant on their behalf for this.

Case No WW11/77–78—Loss of a patient's property

Complaint

1. The complainant was admitted to hospital on 1 December 1976 for an operation the following day. She complains that on the day of the operation her eternity ring was lost and that the Health Authority (the Authority) have refused to reimburse her.

Investigation

2. The complainant told my officer that when she arrived at the hospital she was seen by an admission clerk who asked her for her personal details. When she arrived on the ward a member of the nursing staff asked for details of her medical history, including any previous stays in hospital, serious illnesses, and any known allergies. Neither the clerk nor the nursing staff asked her if she had any money or valuables and whether she wished to hand them over for safe keeping.

3. On the day of her operation, the complainant said, she remembered from previous stays in hospital that she should remove her rings. She put her wedding ring and the eternity ring, now worth about £15, wrapped in tissues, in her watch-case, which contained a gold watch, and left the case on top of her bedside locker. She also left a handbag with about £42 in it on the bedside chair. After the operation she was a bit confused but she remembers a nurse putting her wedding ring on again and giving her a receipt for the cash which had then been taken into safe keeping. She told the nurse that there should be two rings, but she cannot remember whether a search was carried out immediately. When, later, her sister took up the matter with the ward sister, the ward sister said that a search made when the loss was reported had failed to bring the ring to light. Some days after the loss, it was reported to the security officer who instituted a search which, however, proved fruitless.

4. The ward sister told my officer that she realised that, as the complainant had been admitted at short notice, she would not have received the booklet, normally sent to patients in advance of admission, which explained the procedure for handing in cash and valuables. She could not be sure, she said, whether the procedure had been explained to her on arrival, but she herself remembered checking, at the pre-medication stage, that the complainant had not been wearing any rings and it had not occurred to her to ask whether she had any rings with her.

5. The staff nurse who had put the complainant's wedding ring back on her finger after the operation told my officer that a ring had been found outside the complainant's cubicle. None of the other patients had lost a ring and they had therefore assumed it belonged to the complainant. When she had returned the ring, the complainant had said there should be another one so she had made a search, and found the watch-case and the cash in the complainant's handbag, but no ring.

6. The staff nurse who had carried out the complainant's pre-medication said that she had used the bedside cabinet as a table when she recorded the complainant's temperature, pulse, etc and she was sure that there was no watch-case on it then. She also said that a housekeeper had found a ring outside the complainant's cubicle which had not been claimed by any of the other patients. She said she thought it likely that the complainant had put the rings wrapped in tissues on the top of her locker and that the housekeeper had picked up the tissues and thrown them away. Because of this, she and the other staff nurse (paragraph 5) had searched through the waste bins, but they had found nothing. They had then looked in the complainant's handbag and found the cash and the watch-case, but the watch-case had contained only a gold watch.

7. My officer saw two members of the treasurer's department of the Authority who had also been members of the panel of officers who had refused to meet the complainant's claim. They said that in reaching their decision they had taken account of three factors. First, there was a 'disclaimer' notice at the entrance to the ward; secondly, the complainant had been in hospital only one or two years previously and would therefore have known the procedure; and, thirdly, they did not consider the hospital staff to have been negligent. They said that, as a guideline, they used the former Ministry of Health's circular HM (56) 31 (although this related to loss of staff property, and not that of patients) which stated that Authorities could accept no responsibility for articles lost or damaged on hospital premises except for money or valuables which had been handed over to the Authority for safe keeping and a receipt given. My investigation showed that there was, in fact, a disclaimer notice in these terms (together with several other notices) beside the sister's desk on the ward. But I note that circular HM (56) 31 states that Authorities should warn their staff about loss of property, both by public notice and individually. Furthermore, a later circular from the Department of Health and Social Security and the Welsh Office (HM (71) 90) states that patients in all hospitals should be warned that the Authority cannot accept responsibility for cash or valuables not deposited for safe custody.

Conclusions

8. In view of the evidence given separately to my officer by members of the hospital staff about the discovery of the complainant's wedding ring and the search of her handbag, I think she may have been mistaken in her recollection that she put the two rings in her watch-case. Nevertheless, it seems clear that she was not sent the booklet which explains what patients should do with their cash and valuables; and I do not think the Authority should rely either on a patient or the relatives seeing a disclaimer notice, or on the fact that previous hospital experience would ensure a patient's awareness of the procedures. In my view there is no adequate substitute for telling each patient personally what the procedures are. I understand that the Authority have already taken steps to ensure this is done.

9. The Authority originally decided not to take any responsibility for the loss of the complainant's eternity ring. I invited them to reconsider this decision and to reimburse the cost, and they have recently told me that they have sent her a cheque for £15.

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