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Report of the Health Service Commissioner

Selected Investigations completed
April 1982 – September 1982

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HEALTH SERVICE COMMISSIONER

First Report for Session 1982/83

Selected Investigations Completed April—September 1982

Presented to Parliament pursuant to Section 119(4) of the National Health Service Act 1977 and Section 96(5) of the National Health Service (Scotland) Act 1978, as amended by The Health Services Act 1980.

Ordered by The House of Commons *to be printed*
6 December 1982

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HEALTH SERVICE COMMISSIONER

First Report for Session 1982–83
Selected Investigations completed April—September 1982

Section 119(4) of the National Health Service Act 1977 and Section 96(5) of the National Health Service (Scotland) Act 1978, as amended by the Health Services Act 1980, empower me as Health Service Commissioner for England, for Scotland and for Wales to make such reports to the Secretaries of State with respect to my functions as I think fit.

The Appendix to this Report contains a selection of the individual reports issued during the months April to September 1982. Those for England have the prefix 'W', those for Scotland the prefix 'SW' and those for Wales the prefix 'WW'.

December 1982

C. M. CLOTHIER
Health Service Commissioner

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APPENDIX

This selection of 24 reports is taken from a total of 39 cases on which full investigations were completed during the period April to September 1982.

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Case No. W.241/79–80—Availability of mother's previous medical history to an anaesthetist prior to delivery of baby by caesarian section.

Complaint

1. The complainant was admitted to a hospital ("the hospital") on 29 August 1979 for the birth of her child. On the following day it was decided to perform a caesarean section and serious problems were encountered in introducing a tube through her mouth and via the airways into the lungs for the purpose of administering anaesthetic gas prior to operation. (This procedure is known as 'intubation' and will be so referred to with necessary variations hereafter in this report). After the operation the complainant was transferred to the high dependency unit while her baby daughter spent some time in the special care baby unit. The complainant contended that her life and that of her baby were put at unnecessary risk because conclusions which had been reached in 1973 about intubating her were not included in her medical history in her obstetric notes. She said that the 1973 medical notes were not called for at any time and complained that even though she gave information about the findings in 1973 to doctors two hours before the operation, it was ignored. The complainant also said that in subsequent correspondence the assistant general administrator unreasonably minimised the risk to her and her daughter.

Jurisdiction

2. Before I started my investigation it seemed to me that the complainant might have a remedy by way of proceedings in a court of law. In order that I might exercise the discretion given to me in Section 116 of the National Health Service Act 1977 I obtained the complainant's confirmation that she did not intend to take legal proceedings. I also explained to her that I am not empowered to investigate actions taken by doctors solely in consequence of the exercise of their clinical judgment. But the complainant made the point that because of the absence of her full relevant medical history, the anaesthetic registrar was unable to make a proper clinical judgment. The provision of recorded medical history to a doctor to help him in treating a patient in an administrative matter and I can investigate any alleged failure in that provision. But what one doctor enters in clinical notes and whether another doctor decides to read them are alike matters for the exercise of clinical judgment and therefore beyond my reach .

Investigation

3. In the course of the investigation I obtained the comments of the Area Health Authority concerned (the AHA) and examined the medical and nursing notes for the complainant and her daughter. My officers took evidence from the medical, nursing and administrative staff and one of them discussed the complaints with the complainant and two of her friends who were at the hospital on 30 August and subsequently.

Background

4. The complainant explained that in 1973 she attended the hospital for a gynaecological operation, when it was discovered that she could not be intubated. She said that she was referred to an ear nose and throat consultant at the hospital (the sister hospital), who examined her and confirmed that she had a malformation of the throat which made intubation impossible. She was told that the condition was unimportant unless she had to have an emergency operation when a tracheotomy would have to be employed. I have seen the medical notes made in 1973. The consultant gynaecologist said that the complainant had been 'impossible' to intubate; but the notes made by the ENT team when the complainant was examined neither confirm nor deny this, although they show that she failed to attend a follow-up ENT out-patient clinic the next month.

The failure to take account of the complainant's medical history as indicated (a) in earlier medical records and (b) by the patient herself on 30 August

(a) *In earlier medical records*

5. The complainant said that when she first attended the ante-natal clinic on 7 February 1979 a student midwife took her medical history in the course of which she established that the complainant had a laparoscopy in 1973. The complainant said she did not mention the problems with intubation. She explained to my officer that she 'knew' that medical notes were always kept together and that the possibility of an emergency operation was not foremost in her mind when she visited the clinic on that and subsequent occasions. She said that at none of these attendances was it suggested that a caesarean section might be expected. In subsequent correspondence, however, the assistant general administrator (the AGA) indicated that 20 per cent of women having a first child towards the end of their child bearing years are delivered by this means.

6. The complainant asked why the previous medical notes were 'missing'. The AHA told me that they were at the booking clinic when the complainant first attended the hospital in connection with the birth but admitted that they were not in the theatre when her daughter was born. The procedure followed by members of the staff when dealing with previous medical notes at the time the complainant requested her confinement was explained by the medical records officer. She said that the maternity booking clerk arranged for the patient to complete a specific form and an appointment was made for the patient to attend the booking clinic. It was the practice of the booking clerk to collect together, a couple of days before the appointment, the patient's earlier notes and records and to send them to the ante-natal clinic. Normally the previous notes were returned after the appointment but when the patient's previous medical history was specifically relevant to the pregnancy, the notes might be retained with the obstetric notes which were prepared in the course of the pregnancy. My officer discovered that it was not possible to be sure whether the complainant's 1973 medical notes were sent to the ante-natal clinic in February 1979 but the medical records officed made the point that the sister in charge of the booking clinic was at pains to ensure that previous

notes were available for that appointment. I have noted that the medical number allocated to the complainant was the one she had when she attended the hospital in 1973 and that a pre-addressed adhesive label from 1973 was used on the ante-natal record card. The complainant herself said in the course of my investigation that she thought that on the balance of probability the earlier notes were available in February 1979.

7. My officers traced eight of the eleven staff on duty in the clinic in February 1979. Two were on a short attachment to the clinic and could not recall the detailed procedural arrangements. But the remaining six broadly confirmed that when, as in this case, a patient had an appointment to attend, the maternity booking clerk obtained any previous hospital case notes and a midwife, or trainee under supervision, created a new set of obstetric case notes for the patient based on the information given by the patient. The midwife also read the previous notes and was expected to draw the doctor's attention to any relevant information by including it in the obstetric notes. All the notes were then passed to the obstetrician who would see the patient at the same appointment. The member of the nursing staff whose writing most closely resembled the initial details included in the obstetric notes could remember nothing of the complainant but she was clearly aware of the procedures I have described. I have seen that the complainant's obstetric notes included references to the gynaecological operation in 1973. The obstetric notes form provides a box for an entry relating to ' high risk factors ' but there is no reference to intubation there.

8. The senior house officer in the consultant obstetrician's team (" the SHO ") recalled the complainant's attendance at the booking clinic and her fears of bearing a malformed child. He confirmed that, normally, previous medical notes which had been prepared at the hospital were available when the doctor first met the patient at the clinic. He pointed out that he was concerned only with obstetrics and although he could not be sure whether or not the earlier gynaecological notes were available when he first saw the complainant, he did not think he would have concerned himself particularly with the laparoscopy. He did not think that her anaesthetic history was relevant at her first visit to the clinic and he said that he would not have asked for an anaesthetic history from a patient unless an operation was to be performed. He thought that the patient had a responsibility to volunteer such information. The consultant gynaecologist told my officer that his obstetricians did not take anaesthetic histories but he expressed himself surprised that the complainant's previous problems had not been included in her medical history on the obstetric form.

(*b*) *By the patient on 30 August*

9. The complainant said that she was told in the late afternoon or early evening of 30 August that she was to have a caesarean section. She informed the surgeon (the obstetric registrar) who had with him a medical student (the student) that there was something he should know, saying: ' I can't be intubated '. She recalled that the obstetric registrar made no response to this but busied himself in a corner of the labour room apparently either reading

or making notes. She continued her discussion with the student referring to the ENT examination in 1973 but neither he nor the registrar questioned her about the information she had given. When she arrived in theatre a doctor she had not seen previously—in fact the anaesthetic registrar—spoke to her while she was on the trolley and said he understood that there had been some difficulty previously. The complainant thought he was being ironic and understating the problems but as she had already told the obstetric registrar that she was impossible to intubate she contented herself by replying that this was so and that the information was all in the notes from 1973. The anaesthetic registrar reassured her and promised to take great care and the complainant said she assumed that he would not intubate her.

10. The obstetric registrar has since gone abroad but I have seen the written statement he made when the complainant first put the complaint to the AHA and I obtained further written evidence from him. In the first statement he said that the complainant told him of the difficulty the anaesthetist had had while intubating her for a minor operation ; in his evidence to me he recalled that she told him that ' during the time she was anaesthetised for that operation she proved extremely difficult to intubate and she had to be transferred to [sister hospital] where she was anaesthetised. She was questioned and she ascertained (sic) that she was intubated at [sister hospital] and it was recorded in her notes '. He said he told the anaesthetist on duty on 30 August exactly what the complainant had told him and expected him to convey the information to his senior colleagues. The obstetric registrar added that he would have expected the information to appear in the obstetric notes. He would not have expected the previous medical notes, which might be extremely bulky, to be kept with the obstetric notes and he had no reason to ask for them ; nor did he know whether or not the anaesthetic registrar did so.

11. The student remembered spending much of the afternoon of 30 August on the ward with the complainant as part of his obstetrics training but, as a student, his role was that of observer only. He could not remember exactly what was said but recalled the obstetric registrar deciding to perform the caesarean section and explaining to the complainant why it was necessary and what would happen. The complainant gave her agreement to the operation and the registrar left to make the necessary arrangements. After he left, the student went over what the registrar had said and at this point the complainant told him of the difficulty with the previous intubation and how an ENT examination had been undertaken subsequently. He did not ask her about the outcome of this and he knew nothing about ENT as he had not yet covered this in his course. In these circumstances he considered it most important to pass on the information to the obstetric and anaesthetic registrars who would be best able to evaluate it. He therefore told the obstetric registrar what was said. The latter said they should pass on the information to the anaesthetic registrar and they went to the theatre together and spoke to him ; the latter then talked to the patient. The student was quite certain that the complainant told him she was *difficult* to intubate and not *impossible*. The only notes he saw were the obstetric notes which he probably took on to the ward himself when he went to sit with the patient.

12. The anaesthetic registrar said that it was not unusual in the event of an emergency caesarean section for the anaesthetist not to see the patient before her arrival in theatre. When a surgeon telephoned to make arrangements for an anaesthetist the latter normally asked whether there were any known problems but he could not remember being told that there were any with the complainant. The anaesthetic registrar's recollection was that he first heard of her previous difficulty from the patient herself when he went to the theatre and had a routine talk with her about her anaesthetic history. He was quite certain that she told him merely that she was difficult to intubate on a previous occasion but made no mention of the ENT consultation and its outcome. He examined the complainant and there was no visible abnormalities. Only her obstetric notes were in the theatre and the anaesthetic registrar was subsequently surprised to learn of the existence of other notes.

13. The anaesthetic registrar said that although the detailed anaesthetic history was the province of the anaesthetist any serious pre-existing medical condition might have emerged at the ante-natal clinic. He made the point that the obstetrician had overall responsibility for the patient and all aspects of her well-being. He agreed that, from his point of view, it would have been better had all the information been available because although the same anaesthetic route might have been chosen he could have called in the assistance of a senior registrar from the outset. And he made the additional point that as there was no evidence of major problems it was reasonable to proceed with the intubation, and this was a matter for his clinical judgment. In the event it was only after he encountered difficulty in trying to intubate the patient that he summoned the help of a senior registrar in anaesthetics.

14. The senior registrar in anaesthetics said that he was summoned to the theatre when he was attending a meeting at the sister hospital. He said that when he arrived there was not time to read the medical notes and he decided to make a further attempt at intubation. He explained that his decision was not a hurried one and took into account the bleeding which had resulted from the previous unsuccessful attempt at intubating the complainant. He succeeded in intubating the patient and nothing untoward subsequently occurred as a result of his action. He said that with hindsight he would make the same decision to intubate again.

Findings

15. On the balance of probability I think that the previous medical notes were available in the ante-natal clinic in February 1979. The opportunity to transfer relevant information contained in them to the obstetric notes was missed by both the midwifery staff and the SHO on that occasion. The progress of the complainant's pregnancy did not prompt the medical or nursing staff to call for the earlier notes again while she attended the ante-natal clinic. Both the SHO and his consultant made the point that a patient's anaesthetic history would not be a matter of concern to the obstetricians. But if, as I have been informed, it is not unusual for the first meeting between an anaesthetic registrar and a patient requiring a caesarian section to be in the

theatre, it appears essential that all relevant anaesthetic history is available there. In the circumstances it seems to me that if in the exercise of clinical judgment the obstetricians did not think it necessary to transpose to their notes the earlier information about anaesthetic difficulties, then both sets of notes should have been available in the theatre, so that the anaesthetist could be fully informed.

16. I cannot be sure whether what the complainant told the medical staff was that it was ' difficult ' or that it was ' impossible ' to intubate her. I think it more likely that she said it was ' impossible ' but in fact events on 30 August showed that this was not the case. I have no doubt that she did mention the problem that day and I am satisfied that the anaesthetic registrar had some notice of it. I cannot be sure what details were conveyed by the obstetric registrar to the anaesthetic registrar but in any event the consequent action taken by the latter would have been in the exercise of his clinical judgment and, as such, outside my jurisdiction. But because recollections about information given orally can differ, it makes it all the more important for earlier notes to be available. In my view the absence of the 1973 gynaecology notes on 30 August was a contributory factor in the registrar's decision to attempt to intubate the complainant before he called in the assistance of a senior colleague. This in turn caused her additional distress and suffering. I uphold this aspect of the complaint.

The assistant general administrator unreasonably minimised the risk to her and her daughter

17. I deal first with the complainant's own position. She contrasted a letter signed by a senior house officer of the consultant gynaecologist's team with statements made in two letters from the AGA. The former is addressed ' to whom it may concern ' and reads:—

> ' The complainant has an anatomical abnormality of her neck, which makes intubation particularly difficult.
>
> In August 1979, she underwent an emergency operation. Initial attempts at intubation failed. During this induction, she suffered a cardiac arrest, which rapidly responded to emergency treatment.
>
> In view of this, great care should be taken if a general anaesthetic is required in the future.'

In the first of the two replies from the AGA he said ' It now seems clear that no cardiac arrest occurred ' and in the second ' It is not now considered that a cardiac arrest actually occurred '. Understandably the complainant expressed considerable concern to me about the conflicting statements she had been given, making the point that in the event of her having to undergo another emergency operation she needed to know what information she should give.

18. The anaesthetic registrar told my officer that in attempting to intubate the complainant, he grazed the back of her throat and decided that he would have to waken her. He did so and she started to breathe spontaneously. But at this stage she suffered a spasm of her throat (a laryngo-spasm) and he was

unable to ventilate her. He described the laryngo-spasm as a severe one and he estimated that for a period of 30 seconds he could not inflate her lungs. At the same time the nurse could not feel her pulse at the wrist and the registrar could not feel the carotid pulse momentarily. The registrar told my officer that these symptoms did not necessarily indicate a cardiac arrest as they could have been due to low blood pressure. He assured my officer that the evidence for a cardiac arrest having occurred was based entirely on the apparent loss of pulse. He said he called for the resuscitation trolley and during this time the complainant became mildly blue. The cardiac arrest routine was implemented and although the anaesthetist did not ask for it, a male nurse or the operating theatre assistant started to give external cardiac massage on his own initiative. After 30 seconds, the registrar managed to ventilate the complainant. He estimated that all the events from the start of the anaesthetic procedures to her being ventilated after the laryngo-spasm occurred within three minutes. The registrar said that after ventilation the complainant breathed spontaneously and her condition was stable.

19. The obstetric registrar who was to undertake the caesarean section was witness to these events. He said that a cardiac arrest occurred during the first attempted intubation. A senior house officer in paediatrics was also present in the theatre but because her services were not required at that stage, she was pre-occupied with the paediatric equipment in the theatre. She recalled however that the anaesthetist saying ' cardiac arrest ' and immediately left the theatre in order to call the senior registrar in paediatrics. The medical student who had been with the complainant earlier that day was also in the theatre and said that the anaesthetic registrar had asked him to call a senior anaesthetist when difficulty in intubation was encountered. He never saw the complainant when she had no pulse or when she was not breathing.

20. The senior registrar in anaesthetics told my officer that he was at the sister hospital when a call was received indicating that the anaesthetist was experiencing difficulty in the theatre. He estimated that it would have taken him about a quarter of an hour to reach the hospital and when he arrived he found the complainant was breathing spontaneously. He concluded that he had time to prepare himself properly for the theatre and the anaesthetic registrar explained to him the problems he had met and that the patient had ' arrested on the table '. In deciding to attempt another intubation he had to take into account the risk of blood getting into the patient's lungs if an alternative anaesthetic route (e.g., a mask) was used. He succeeded in intubating the patient and the caesarean section then went ahead normally.

21. I have examined the clinical and nursing notes relating to the period in the operating theatre and immediately thereafter. The obstetric registrar recorded in the clinical notes: ' Patient had a cardiac arrest before intubation ' and the midwife responsible for the complainant during the delivery made a note in the nursing notes to the same effect.

22. I turn now to the comments that were made by the medical staff before the AGA sent his two replies to the complaints. The anaesthetic registrar wrote when commenting on the initial complaint, ' In retrospect it was

felt that a cardiac arrest may not in fact have occurred, the only evidence being the lost pulse '. The complainant was not convinced that the difficulties and dangers were as slight as the AGA's reply indicated and the anaesthetic registrar was invited to comment on her letter of 14 January 1980. He said that ' we do not believe that a cardiac arrest occurred '. At the same time, the obstetric registrar maintained that the complainant ' actually became centrally cyanosed and asphyxiated ' and that with the combined help of the surgeon and the anaesthetist they successfully resuscitated the complainant. In evidence to my officer the obstetric registrar stated that ' the cardiac arrest occurred during the first attempt ' at intubation.

23. I deal now with the events as they affected the complainant's baby daughter. The senior registrar in paediatrics was called from another hospital. He said it would have taken him about 15 minutes to make the journey. He told my officer he did not know whether the baby was being monitored when he arrived but the records showed that the foetal heart was heard after the cardiac arrest and prior to the caesarean section. Knowing that the baby was alive, the senior registrar in paediatrics prepared to resuscitate her and the appropriate equipment was ready when the baby was born. He said that the baby made some efforts to breathe but these were inadequate and her heart rate was falling. Because of that, at one and a half minutes after birth a tube was passed and the baby was ventilated until seven minutes after birth. She was cold and remained rather pale and was transferred to the special care baby unit where a blood gas test showed some degree of acidosis which was consistent with a moderate previous episode of lack of oxygen. The senior registrar added that the baby was examined at birth and after three and a half hours and again the following day and no neurological abnormalities were observed. He thought it likely, but could not be absolutely certain, that the baby's poor condition at birth was due to a period of lack of oxygen at the time of induction of anaesthesia. The contemporary notes prepared at the time of the birth support the senior registrar's statement.

24. The complainant also said that information given to two friends on the night of 30 August was conflicting. I have not recorded in detail the conversations these friends had on that occasion with members of the nursing and medical staff. One of those friends told my officer that at the time she assumed the role of a doctor in order to get information and I regard that as indefensible. The other, whom the complainant had nominated as her next-of-kin, was entitled to an explanation but I do not believe that it was reasonable to expect the staff to express views at that time on the possibility of brain damage and the likely longstanding effects of the operation on the complainant and the baby. So far as the baby was concerned I am satisfied that the medical staff just did not know. As for the complainant, she was transferred to the high dependency unit and, happily, recovered quickly.

Findings

25. But I do believe that subsequently, the complainant was entitled to a full explanation. She herself recalled visits from the anaesthetist and a member of the paediatric team but when she complained to the AHA it

should have been apparent that she still needed further explanation. It may well be that the explanations in hospital were given to her too early before she had recovered sufficiently from the shock of the operation. The position as the complainant understood it when she complained to the AHA was incorrect in important respects. There was no cardiac arrest or any suggestion of it during the *second* attempted intubation; delivery did not occur in the course of the cardiac arrest as the complainant believed; and I have found no evidence which supports her concern that she stopped breathing for 'three' or 'several' minutes.

26. Nonetheless there *was* an emergency in the theatre on 30 August and the information given to the complainant's friends that night clearly indicated that. The contemporary evidence indicates a widely-held belief *at the time* that a cardiac arrest had occurred, although subsequently the anaesthetic registrar took a different view. It is not for me to decide whether the complainant suffered a cardiac arrest since the matter is one of clinical judgment. However when dealing in his first reply with the question about her cardiac arrest, the AGA referred to the anaesthetic registrar's later view and I think the AGA did not sufficiently reflect the range of medical and nursing comments made at the time of the episode (paragraphs 17, 21 and 22) and which were maintained by some members of the staff even when my officers took evidence from them. I can well understand that the AGA's second reply failed to satisfy the complainant when she was holding the letter signed by the SHO (paragraph 17). I think it was essential in order to allay her fears that the AGA's correspondence should have acknowledged rather better than it did that the contemporaneous evidence supported what that letter said.

27. In my investigation I was impressed by the readiness of the medical staff concerned to explain to my officer in lay terms the events of 30 August and I think it very likely that much of the complainant's concern would have disappeared had she been offered the opportunity to meet the staff concerned after the shock of the events on that day had receded. The consultant paediatrician who saw her when she attended his clinic three months after the birth of her daughter told my officer that an explanation from him might have allayed her fears but he had not been aware of her complaints at that stage; he added that he had never been asked about the risks to the baby during the birth.

Conclusions

28. It was unfortunate that the complainant did not specifically mention her previous experience about intubation when she first attended the ante-natal clinic. But that does not excuse the failure to provide the anaesthetist with all the information which he ought to have had. When the AHA first commented on the complaint they accepted that 'established practice' broke down in that relevant information from the patient's previous records was not entered in the obstetric notes in February 1979. They told me that they had been unable to establish the reason for this; but it seems to me that, in part at least, the reason stems from the views of the senior house officer

in obstetrics who met the complainant that day about responsibility for transferring information about intubation (paragraph 8). However I am pleased to record that the AHA also regarded the failure most seriously and told me that they had taken steps to remind medical and nursing staff of the importance of checking each patient's notes in detail at the booking clinic and that all obstetric notes were to be kept together from the time of admission. The authority have recognised that it was an administrative responsibility to make available on 30 August the complainant's previous gynaecology notes and the information they contained. They have asked me to convey their apologies for their failure in this respect. This I gladly do.

29. I turn now to the question of communication. I have not found the complaints about communication with the complainant's friends on 30 August made out. But I believe that a meeting with her after she had first complained might have helped to reduce the concern that she then felt. The AGA sent two replies and these were full in many respects ; indeed a number of issues which the complainant raised were dealt with to her satisfaction and were not included in my investigation ; but I do think that the AGA's replies as regards the events in the operating theatre fully reflected the feelings of the nursing and medical staff who were there that night. Accordingly, I have concluded that there were grounds for the complainant remaining unsure about how she should react in the event of a future emergency operation. I have suggested that a meeting with the medical staff some time after the event may have allayed her fears (paragraph 27). I think that such a meeting may be helpful even now and that the successor authority should get in touch with the complainant to invite her to such a meeting. The successor authority have told me that the Chairman of the Division of Anaesthesia in the District, herself a senior consultant anaesthesist, has agreed to offer to do so and will be getting in touch with the complainant in the near future. The successor authority have also asked me to convey their apologies in this report for failing fully to reflect in their replies the comments of the medical and nursing staff who were present in the theatre on 30 August and for failing to allay the complainant's fears.

30. When she complained to me, the complainant said that if her suspicions of the gravity of the risk involved in her receiving a general anaesthetic in future were unfounded it would be a great relief, but she considered it important that she should know the truth. It is not for me to assess the risk but I hope that I have been able to dismiss some of the fears she held. Furthermore if she takes up the offer to meet the senior consultant anaesthetist, I believe she should obtain all the information she requires to assess the risk that another emergency operation would entail.

Case No. W.275/80-81—Care of and communication with parents patient in psychiatric unit

Background and complaints

1. The complainant's daughter, (the daughter), aged 21, was an informal patient at the Adult Psychiatric Unit (the Unit) at a hospital for a few months in both 1978 and in 1979. She returned there again in 1980.

2. The complainant contends that:

(*a*) on 6 August 1980 her daughter visited a ward of the Unit (the ward) and was given a tranquilliser, but was later turned out at night; and the ward staff failed to keep her and her husband informed of their daughter's whereabouts;

(*b*) on 15 October, when her daughter was a patient on the ward, because of lack of care and supervision she was allowed to leave the Unit; and when she returned there the next morning the staff failed to notify her or her husband as they had promised to do; and as a result, they were not consulted about their daughter's subsequent transfer to another hospital (the special care unit); and

(*c*) she is not satisfied with the way the Area Health Authority (Teaching) (the AHA) handled her representations to them.

Investigation

3. During the investigation I obtained the written comments of the AHA and examined the relevant papers including the medical and nursing notes. My officers interviewed the staff concerned in the complaint and also met the complainant and her husband.

(a) *The complaint about the events of 6 August 1980*

4. In her correspondence with the AHA and in her interview with my officers the complainant said that her daughter had previously been a patient on the ward and had been told to go back there if she ever felt ill. During the afternoon she received a telephone call from the ward to say that her daughter had arrived there on her own and had seemed 'a bit high', and the staff had decided to get her a sedative. (My officer identified the member of staff who had made the telephone call as a nursing assistant (the NA.) The complainant said that during the call the NA had asked whether they could collect their daughter from the ward and she had replied that her husband was resting from a back injury but would probably be able to drive over in a short while. However, the complainant said, her husband was still unable to move later and she had been about to get in touch with the ward when the NA telephoned again to say that her daughter was still there and she recalled that the NA had agreed to her suggestion that a taxi should be called to take her daughter home if she was not well enough to return by bus. She thought that this was at about 7.50 pm. The complainant said that, when her daughter had not returned after a reasonable time, she went to the bus stop and walked around the area looking for her without success. She telephoned the ward at about 10.15 pm and was very worried to hear that her daughter had left the Unit on foot shortly after 9 pm because it should not have taken her more than an hour to walk home. The complainant said that she asked to speak to the night sister (the NS) but was told that she would not be available on the ward until 11.15 pm.

5. The complainant said that she had therefore telephoned an hour later, when she alleged the NS disclaimed all responsibility and simply told her that her daughter had refused to get into the taxi which had been called. She des-

cribed the NS's attitude variously as 'very abrupt', 'rude' and 'unhelpful'. She told my officers that she thought the ward should have got in touch with her earlier to say that her daughter was being difficult. The complainant also told my officers that her daughter had said later that she had been frightened to get into the taxi with the male driver and that afterwards (probably between 10.30 and 11 pm) when the NS found her sitting in a room on the ward, the NS told her that she was not supposed to be there and had unlocked the outside door for her to leave, although she claimed she had wanted to stay on the ward. The complainant said she considered that since her daughter had been given medication the ward staff should have maintained responsibility for monitoring her condition.

6. The complainant said that after speaking to the NS, she had informed the police that her daughter was missing. They had apparently telephoned the ward and had been told that she was at the home of a former patient (Miss A). The complainant told my officer that she had been advised of her daughter's whereabouts by Mr. A and the police but the ward 'never bothered' to telephone her. Mrs. A had telephoned the complainant the following day to explain that her daughter had said she had been accosted by a man in a park near the hospital and had run to the nearest house for help. The occupants had taken her to the address she gave, which was Mr. and Mrs. A's house, where she had arrived just after midnight, 'soaked to the skin'. The complainant said that she also learned that her daughter had been taken back to the Unit by Miss A and, later, that she had then been admitted to the ward as an in-patient.

7. The NA told my officer that the daughter had visited the ward on 6 August and that she (the NA) had telephoned her parents to tell them. She said that when the complainant said that she would send her husband to collect their daughter she had seemed quite definite. After some time, when nobody had arrived she telephoned again and this time the complainant had said that her husband had a bad back and could not collect his daughter. The NA said that she had ordered a taxi to take the daughter home, as the complainant had asked her to do, and when she went off duty at about 8.50 pm she saw the taxi outside the Unit.

8. She told my officer that she would not have been involved in any decision to give the daughter medication ; she said that she could not recall having said anything to the complainant that could have given her the impression that it was intended to give her daughter any medication and it was unlikely that she would do so.

9. The day sister (the DS) told my officer that the ward was an open ward and that it was not unusual for a former patient to visit them. She said that the daughter was in the habit of turning up just to sit and talk to the staff and other patients, but on this occasion she had said that she wanted to be admitted to the ward because she had had a row with her parents. (The complainant, on the other hand, told my officer that she had no recollection of a quarrel, nor was she aware that her daughter had made any preparations for staying away from home.) However, the DS said, it had been decided that although the daughter was 'silly and giggly' she was not suit-

able for admission. The DS said that she could not recall any medication being given to the daughter or, indeed, that any had been authorised by the medical staff. She also said that it had been obvious that the daughter had had alcoholic drink before she came to the ward and no medication would be prescribed in these circumstances. The DS said that the NA had told her about her telephone calls to the complainant and, when she handed over to the NS, she had advised her that the taxi was expected.

10. The NS said that when she took over the ward that evening, she could not recall either being told or reading that the daughter had had any medication. She told my officer that she met the DS at the door where the daughter was 'playing games' while the taxi was waiting. She had talked to the daughter on the stairs and taken her back to the door, where she had said that she was all right and did not want to be accompanied out to the taxi. However, the NS said, as she went back upstairs to the ward she saw her running round the back of the building; and the taxi driver told her that the daughter had run away from him. The NS said that the taxi then left and, as it was still light (shortly after 9 pm), she had returned to her work on the ward. At about 10.30 pm, she had checked all the rooms and found the daughter sitting in one in the dark. The NS said she had told her that she should be at home, not out on her own at night. She had replied that she was not going home, but to friends. When the NS tried to find out who the friends were, she had told her it was none of her business. She warned her that it was dangerous to go out alone and asked her whether she wanted to stay on the ward, but she had replied: 'let me out'. The NS said that she had had to let her leave the Unit because she could not legally be detained against her will. This was confirmed by the senior nursing officer (the SNO) in his report on the complainant's first letters of complaint to the AHA when he said that her daughter was '. . . over 21 and obviously not sectionable'. He said '. . . had we detained her after she had demanded to leave we would have left ourselves open to the serious charge of illegal detention'. A staff nurse who was doing a relief night duty on the ward (the first SN) told my officer that although the ward was very busy the NS had spent 'ages' talking to the daughter.

11. The NS told my officer that when the complainant first telephoned the ward she was downstairs in the nursing officer's room. She said that when she did speak to the complainant later, at about 11.15 pm, the complainant's main concern had been why she had allowed her daughter to leave and she had explained that the daughter's condition did not, in her judgment, warrant admission to the ward and she therefore could not detain her when she wanted to leave. The NS said that the complainant had been understandably unhappy at this, but she had assured her that there was nothing else she could have done in the circumstances; and she finally said 'I'm sorry but I just can't help you'. The complainant had then rung off. The NS knew that the complainant claimed she had been abrupt, but she told my officer that she did not think she was abrupt and certainly had not intended to be so. The next thing the NS recalled was that some time after 11.30 pm Miss A's father telephoned and was upset and concerned because the complainant's daughter had arrived at their house. The NS said that she had not thought to telephone the complainant when her

daughter left the Unit the second time because she would not have been able to tell her anything positive about her whereabouts and had thought it likely that she would go home anyway. She did not telephone the complainant following the call from Mr A as she had been led to believe that *he* was going to tell the complainant that her daughter was with them.

12. I have seen the nursing record for 7 August when the daughter was admitted to the ward and this notes simply that she 'spent the day on the ward yesterday but did not go home at 9 pm. Spent the night [with] ex-patient [Miss A]'. There is no reference to any medication being given to her on 6 August, either in the nursing or the medical notes, nor is there any drug sheet in her name relating to that date.

13. When the complainant first complained to the AHA on 8 August 1980 she received a reply from the Sector Administrator (the SA) which said *inter alia* that 'it would have been better if the NS had then telephoned you to let you know what had happened . . . I do realise, however, how worrying this event must have been for you and apologise that we perhaps did not keep you informed as we might have done'. The SA also assured the complainant that her daughter did not receive any medication and emphasised that she was not a minor and she was therefore 'deemed in the eyes of the law to be responsible for her own actions, and it was, therefore, impossible for us to act against her wishes and deprive her of her liberty'.

Findings

14. I have been unable to establish whether or not a sedative, tranquilliser or other medication was prescribed for the daughter on 6 August when she visited the Unit but, on the evidence, I think it unlikely. It is not disputed that she left the Unit on her own late at night; but whereas the complainant believes her daughter's subsequent claim that she had wanted to stay there, the NS maintains that she demanded to be let out; and, in the light of other information about her behaviour, I accept the evidence of the NS. I am satisfied that the staff did make every effort to persuade her to stay; and, as the SA explained, the daughter could not be detained against her will except under the provisions of the Mental Health Act. I cannot question the decisions taken by the DS and the NS in the exercise of their professional judgment that it was not appropriate to refer her to the medical staff for this purpose. As to the complaint that the complainant and her husband were not kept informed of their daughter's whereabouts, the NS has agreed that she probably should have telephoned the complainant again when her daughter left the Unit the second time (though, in fact, she would have had little of any consequence to add to what they had already been told since her whereabouts were still not known). In view of the obvious concern of the complainant, I think she should have been informed direct by the hospital as soon as they knew where she was. I think it wrong that, in circumstances such as these, the onus should have been left upon a third party to pass on a message of such importance to the parents.

(b) The complaint arising from the daughter's absence from the Unit on the night of 15/16 October 1980

15. The complainant said in her correspondence and in her discussion with my officers, that at about 10 pm on 15 October the NS had telephoned her home to say that at about 9.40 pm it had been discovered that her daughter was missing. Her daughter had since told her that she had been frightened by stories told by one of the nurses. (The complainant gave the first name and a description of this nurse and I have indentified her as the state enrolled nurse on night duty (the SEN). The NS had agreed to her husband's suggestion that she should get in touch with the police. The NS she said also told her husband that she would notify them when their daughter returned; they had therefore been anxiously awaiting a telephone call from the ward and it was because of the promise that had been made that she had not telephoned the ward the next day. The police had been in touch with them at mid-morning on 16 October to see if she had returned home. At 2 pm, when they had still had no news, the complainant's husband telephoned a social worker at the Unit (the SW), with whom they had an appointment at 3 pm that day, and said that there was no point going there to discuss 'a missing person', especially as he and his wife had suffered a sleepless night. The SW had replied that the daughter was probably back on the ward by then and that he would check this. The complainant said that they had not cancelled the appointment and that, if the SW had informed them that their daughter was back, they would have kept their appointment. However, they had still had no news of her by late that night. The complainant said that the next day (17 October), at about 1 pm, her husband called at a police station to enquire about his daughter. They had seemed surprised by his enquiry and had told him that his daughter was back at the Unit. He therefore visited her that afternoon and was told by the ward staff that she had been back since the morning of 16 October and they thought that he would have known this. The complainant said, too, that she and her husband were very unhappy that they had not been consulted about their daughter's subsequent transfer to the special care unit on 18 October and described it as 'a case of prime bungling'.

16. I have seen the nursing notes relating to the care of the daughter and for at least three weeks prior to 15 October these show that her moods were erratic and she was a difficult patient, being described *inter alia* as: 'Aggressive . . . her usual giggling, unco-operative self . . . disruptive . . . extremely childish . . . aggravating fellow patients . . . very naughty and childish'. The notes also record that she ran away from the ward on at least nine days during this period and that on 15 October she had left the ward and had had to be brought back by a nurse on several occasions.

17. The DS told my officer that, at the time in question, the daughter was not being 'specialled', but, she said, the ward staff were always aware of where she was and would not have deliberately allowed her to go out alone. A staff nurse on day duty (the second SN) said that, as the daughter was an informal patient, they used to allow her off the ward if they knew where she was going within the Unit. The DS recalled that the complainant

had not liked to see her daughter in her nightclothes and she herself 'liked to wear nice clothes' and the staff had at first used their discretion about clothes. But in October, according to a BSc/SRN student nurse assigned to the ward (the student nurse), the daughter 'became supervised' and her clothes were taken away, although she still managed to escape when staff were busy. The DS could not suggest any particular reason for her running away that night, other than that she was a bit upset at the possibility of being sent to the special care unit. (The day duty note in the nursing record states: 'Is worried about incontinence and going to [the special care unit]'). The SEN mentioned by the complainant was on maternity leave from 5 October and thus could not have spoken to the daughter for some time before she absconded from the Unit. And the SEN told my officer that because of her (the SEN's) pregnancy, she had been 'sheltered' from the daughter for several weeks before that.

18. Neither the DS nor any of the other nursing staff interviewed could recall exactly how or when the daughter had escaped from the Unit on this occasion. The night duty note (by the first SN) in the nursing record states: 'When we arrived on duty, patient was missing . . . it is believed patient is wearing clothes stolen from other patients'. The NS explained that she was 'acting up' for the nursing officer that night and so was not always on the ward. She recalled that she was told that the daughter had left and that she had advised the ward staff to follow the usual routine of searching the immediate area and then informing the parents. The first SN also recorded that the 'duty doctor was informed, and also the parents, who asked us to inform Police'.

19. The DS was on leave on Thursday 16 October when the daughter returned to the ward and neither the second SN nor the NA could remember anything about her return. It was the student nurse who recorded that she 'returned to ward at 11.30 hrs having allegedly stayed the night with —', but she could not remember what had happened when she returned and did not know whether the complainant and her husband and the police were informed because, she said, this would have been the responsibility of the senior regular ward staff. The NS was not on duty the following night, 16/17 October, but the first SN remembered that the daughter had talked about her night away from the Unit. She told my officer that when a missing patient is found, it is routine for the ward staff to inform first the nursing officer, then the patients' relatives and the police, if they had also been involved; and she had simply assumed that the usual procedures had been followed when the daughter returned to the ward. There is no reference in the nursing notes to a visit by the father on the Friday afternoon and none of the nursing staff interviewed could remember his visit.

20. The day shift charge nurse (the CN) told my officer that the staff had preferred the daughter to stay on the ward but he recalled that this and the question of her clothing had, subject to the judgment of the staff, varied according to the feelings of and pressure from her parents. He commented that it had been very difficult for the staff to work with the parents because they did not agree with the diagnosis of her illness and frequently either

complained to the ward about the care of their daughter or abdicated all responsibility towards her. The CN confirmed that brief disappearances from the Unit were part of the daughter's usual pattern of behaviour at the time and that she had been worried at the prospect of a possible transfer to the special care unit. He said he had been in charge of the ward for the 'early' shift on Thursday 16 October; but he was usually away from the ward and busy with group sessions for patients from 9 am until lunch-time and he could not recollect anything about the daughter's return to the ward at 11.30 am. He told my officer that he was still responsible for ensuring that the nursing staff did what was necessary in such a situation; and he thought that they had been told that the complainant would telephone the ward again to check whether her daughter had returned and, later, that the SW had telephoned the ward to say that the parents would not see him. The CN, in company with the other nursing staff, could not recall seeing the complainant's husband on the Friday afternoon and remarked that, if the complaint's husband had protested about not being told of his daughter's return the previous day, the staff would certainly have told him about it.

21. The SW explained to my officer that he had not been directly involved with the daughter previously (although he was aware of her reputation for bad behaviour) and that in October he was standing in for his colleague at the Unit, who was away. He said that at the beginning of October the consultant psychiatrist had asked him to arrange an appointment with the parents to discuss with them their daughter's current condition and the possibility of a transfer to the special care unit. (I have seen that the clinical notes for 3 October record that it was decided 'to discuss with parents for [the special care unit]'.) He did not remember when he had done this but he knew it was early in October. He thought that he had first spoken to the complainant's husband and told him that it was a very important matter and that he needed to see him and his wife together. He had replied that he and his wife worked on shifts and their free time only coincided on Thursdays; but the Thursday following their conversation was not possible for some reason, and the interview therefore was arranged for the Thursday week—16 October. The SW told my officer that he had suggested the complainant and her husband might take time off work or that he should visit them in order that they should meet earlier, but they had not co-operated. In the meantime, the consultant psychiatrist had got in touch with the medical staff at the special care unit and the SW had therefore decided to involve his counterpart there. He told my officer that the complainant's husband had telephoned him at 2 pm on Thursday 16 October to cancel their appointment and that the only reason he had given was that he and his wife were still too distressed to come to the Unit, and *not* that there was no point in them coming because their daughter was still missing. The SW said he recalled that he had earlier been told that the daughter had been missing, but had returned; he did not remember saying that he would check with the ward that she was there and indeed, thought it very unlikely that he had done so. If he had made such a promise to the parents he would certainly have fulfilled it. The SW wrote to the consultant psychiatrist that same day. I have seen a copy of his letter which states, *inter alia*, that 'at 2 pm [the complainant's husband] telephoned to cancel the appointment'.

22. I have also seen the clinical notes which, in addition to the failure of the attempt to discuss the daughter with her parents on 16 October, also record on 23 September that 'parents contacted representing [the daughter] a case conference—refused to attend'. The consultant psychiatrist discussed the case with my officer and told her that the medical and nursing staff had had difficulties with the parents for many years. He described the ward as 'the most liberal, humane and dedicated' in the Unit; he recognised that there could be an occasional lapse in communication, but he was sure that there would not have been any deliberate misrepresentation or unkindness from any of the staff.

23. In the SA's reply of 12 November to the complainant about these complaints, he explained that, although the nursing staff had 'spent a great deal of effort persuading [the daughter] to stay on the ward that day', she left when the staff changed over and the number available for observation of patients was lower than usual. The SA said that the night staff had notified the police at the parent's request and that the police were notified when their daughter returned to the ward the next morning. He also explained that Section 25 of the Mental Health Act 1959 had had to be invoked by the consultant psychiatrist and the daughter's general practitioner to transfer her to the special care unit for 28 days as she was considered to be urgently in need of such care; and because it had been impossible to arrange a meeting with the complainant and her husband to discuss their daughter and obtain their consent to her being transferred under Section 26 of the Mental Health Act for the longer treatment at the special care unit which was considered necessary. The SA informed the complainant and her husband that the front door of the Unit was locked at 8 pm and the side doors before 10 pm (although he emphasised that this was rather to keep intruders out and that they had to maintain fire exits); and these security arrangements were confirmed by my officer when she visited the Unit at night.

Findings

24. The AHA did not accept that they had failed to offer the daughter adequate care and supervision. I recognise the problems encountered by staff over the supervision of informal patients in an open ward and I have found no evidence that they were culpable. I believe, however, that they did fail to notify the parents of their daughter's return to the ward on the morning of 16 October. I criticise them for this.

25. On the oral evidence given to my officers and the contemporaneous written records, I am satisfied that the hospital made efforts to arrange a meeting with the complainant and her husband to discuss their daughter's condition. When these proved fruitless, and the doctors decided in their clinical judgment that she needed to be compulsorily detained, I consider they had no alternative to the course of action they took—to place her under a Section 25 Order. I do not uphold this aspect of the complaint.

(*c*) *The complaint about the AHA's handling of her representations*

26. The complainant told my officers that she was annoyed with the letters from the SA because they 'skated round the facts' and tried to turn the blame for what had happened back on to herself. In particular, she said, the reply made to her complaint about medication on 6 August was not true; and she described the comments on her complaints about the ward staff as 'just whitewash' and 'tongue in cheek'. She also thought that the replies had taken too long.

27. The SA explained to my officer that a principal administrative assistant (the PAA) had made enquiries and replied on his behalf to the complainant. He had seen the later letters to the complainant before they were sent and had been content with them. The PAA told my officer that he realised that the correspondence might have become less than sympathetic because he believed he should deny the complainant's comments and defend the hospital staff where this seemed to him to be justified. He said that the correspondence, which I have seen, went over the same ground and he did not consider that he had put the complainant 'in a bad light'. He sent a brief formal reply to her last letter to terminate the correspondence as he was by then aware that she had written to me; and it appeared to him that his detailed replies had only invited further hostility. In his written response to me the AA said that in his opinion 'every effort has been made to demonstrate sympathy for [the complainant's] concern for her daughter'.

28. I have examined the correspondence and seen that it contains, *inter alia*, references to clinical matters, and that the complainant's letters were at times acrimonious and that she varied between the extremes of expressing great concern for her daughter and saying that she had no legal responsibility for her. She wrote to the SA on 8 August, 23 September, 19 October and 19 November. The SA promptly acknowledged her letters and sent substantive replies on 18 September, 24 October, 12 November and had concluded the exchange in a reply of 31 December 1980.

Findings

29. I do not find any evidence to support the complainant's contention that there was undue delay in answering her complaints. I think, from the correspondence, that she was very difficult to deal with and did not invite sympathetic consideration of her grievances. I do not criticise the tone of the AHA's replies. However, there were, in my view, failures in communication between the hospital staff and the complainant on 16 October and on 6 August in addition to that which I have referred to in paragraph 13 (for which the AHA have already apologised); and I think the AHA should have admitted this in their replies. To that limited extent I uphold her complaint.

Conclusions

30. I have given my findings in paragraphs 14, 24–25 and 29 of my report. The health authority who, from 1 April 1982, became the relevant successors to the AHA, have asked me to express to the complainant their regret for the shortcomings to which I have drawn attention and this I gladly do.

Case No. W.292/80-81—Option for private treatment because of failure to provide information about NHS waiting time.

Background

1. The complainant's mother, aged 70, underwent an operation for the removal of a cataract in her right eye at a hospital (the hospital) in August 1980. The operation was performed privately by a consultant ophthalmic surgeon (the consultant).

Complaint

2. The complainant contends that his mother was misled into obtaining private treatment because the full facts about the waiting time for the operation under the National Health Service (the NHS) were withheld from him and his mother. He also complains that although he told administrators that his mother could not afford private treatment and was assured that the operation would be carried out under the NHS she was treated as a private patient.

Investigation

3. During the investigation the written comments of the Area Health Authority (the AHA) were obtained and I have examined these together with the relevant correspondence and the case notes. My officers interviewed the medical and nursing and administrative staff concerned and also met the complainant, his mother and her sister.

The complaint that the full facts about NHS waiting time were withheld from the complainant's mother

4. In the report he sent to me with his letter of complaint and in his interview with my officers, the complainant said that his mother had been seen by the consultant at an out-patient clinic at a cottage hospital (the cottage hospital) on 5 August 1980. After the consultation his mother had told him that the consultant had said she needed an operation to remove a cataract in her right eye and that it would cost £600. The complainant said he had asked her why she should have to be treated privately because he felt that she should not have to pay to remedy a condition which could soon amount to near-blindness. She told him that she had asked the consultant how long she would have to wait and whether there might be a five to seven year's waiting period for a NHS operation. The consultant had replied that the operation could be carried out more quickly and his mother had asked if he meant as a private patient ; and the consultant had agreed. The complainant said that his mother was 70 years old and her sister who accompanied her to the cottage hospital was 73 years old ; both ladies were naive as to their rights and timid in their dealings with those in authority. His mother had been very upset at her loss of sight and had agreed to private treatment because she believed it was the only way she could regain it within a reasonable time.

5. The complainant's mother told my officers that the sight in her left eye had always been poor and that, following a car accident, the sight of her other eye deteriorated to the extent that she was nearly blind. She was referred to the consultant and, after waiting for an appointment for about five months, she attended the cottage hospital on 5 August. The consultant told her that he would put her on a waiting list for an operation to remove a cataract; he said that the condition was satisfactory for the operation but he did not indicate whether or not it needed to be done urgently. She had asked him how long she would have to wait and if it would be 'three years or longer' to which he had replied 'not necessarily'. She then asked him if he was referring to private treatment and he had said 'yes'. She said that the consultant had not asked her if she wanted private treatment. It was she, herself, who had first referred directly to it; and she thought that he had then assumed that she wished to be a private patient. He had therefore made enquiries as to the costs involved and had booked her a private room. She said that she had been very worried about her eyesight and was anxious to have the operation as quickly as possible. She was in no doubt that she had agreed to private treatment and when she got home she telephoned her daughter in Canada and told her that she had decided to have the operation for which she would have to pay. Her daughter said that she must go ahead with it and that she and her husband would lend her the money to pay for it. They had sent her the money shortly afterwards. But, she said, if she had known (as it transpired) that the NHS waiting time for the operation was only six or seven months she was quite certain that, provided the condition of her eye was stable, she would not have chosen to have private treatment.

6. The consultant told my officers that the patient's cataract had been ready for surgery but he had not considered her case urgent and she could have waited quite safely for a NHS operation. The consultant said he had asked her if she wished to go on the waiting list for an operation. She had said she would like to do so and had asked if there would be a delay. He told her that there would be some delay and she had then asked if the operation could be performed privately. He told her that it could, although there was also a waiting list for private treatment; but, he said, she had then expressed the wish to be a private patient. It had not been his suggestion. The consultant told my officers that she had not said anything about having to wait for several years for a NHS operation; he would have remembered this and would have vehemently disputed 'such an outrageous statement'. Neither had she asked how long the waiting period was for a NHS operation; and he had not volunteered this information because he did not like to give patients approximate dates for operations as they tended to get upset if the date passed without the operation being performed. Although he knew the total number of patients on his waiting list he did not consider it possible to assess with any degree of accuracy when they would be called because of a number of unpredictable elements. But, he added, if the complainant's mother had asked him directly what the waiting time would be for her operation as a NHS patient he would have given her his estimate but would have emphasised that it was only approximate. The consultant told my officer that he had

been taking clinics at the cottage hospital for 15 years but during this period only three patients had opted for private treatment.

7. My officer interviewed two staff nurses who had been on duty in the consultant's clinic at the cottage hospital. One of them could not remember the complainant's mother at all and, although the other remembered her, she could not recollect any details of the conversation. The complainant's aunt told my officer that she had remained in the waiting area when her sister was being examined by the consultant and had therefore not heard their conversation.

Findings

8. On this evidence I am not satisfied that the complainant's mother referred to her belief that she would have to wait a number of years before receiving treatment as a NHS patient. On the other hand I am quite satisfied that she did ask if she would have to wait for an operation 'on the NHS', because the consultant confirmed that she did. It must therefore have been plain to the consultant that she was weighing up the pros and cons of paying as a private patient as against waiting as a NS patient. I think the consultant ought to have helped her make up her mind, anxious about her eyesight as she must have been, by giving her *some* idea of how long she might have to wait if she did not choose to pay. I believe that he could have given her what he himself described as 'only an approximate assessment', but that that might have helped her. How she would have then decided it is impossible to say. But to the limited extent that the consultant was rather less helpful than he ought to have been, I uphold this complaint.

The complaint that information about NHS waiting time for the operation was withheld from the complainant and that, despite his protestations that his mother could not afford private treatment, she was treated as a private patient

9. In correspondence, and when interviewed by my officers, the complainant said that on 6 August he had telephoned the hospital where his mother was to be admitted and he had spoken to the assistant unit administrator (the AUA). The complainant told him that because of her eye condition his mother needed treatment as soon as possible and that she had been booked in for private treatment, but that she could not afford the cost. He told my officer that he had asked the AUA how long his mother would have to wait for the operation under the NHS, adding that she was prepared to wait up to a year but, if the waiting time was five to seven years that was a different matter. He had also given the AUA his mother's account of her conversation with the consultant on the previous day. The AUA said that he would look into the matter and write to him by 9 August.

10. The complainant telephoned the hospital again on 11 August as he had not received the promised reply; but he could not recall which administrator he spoke to. He explained that as he understood the operation was to be carried out on 25 August he needed an urgent reply to his enquiries. On 13 August he received a letter from the AUA which advised him that the

matter he had raised 'that [the consultant] stated that admission for the operation would be achieved earlier as a private patient than as a NHS patient' was being treated as a formal complaint. He had immediately telephoned the hospital and had spoken to the unit administrator (the UA) whom he told that he was not interested in making a formal complaint—what he wanted to know was the NHS waiting time for a cataract operation. He also told the UA that if the waiting time was likely to be prolonged he would make enquiries of other hospitals to see if it could be carried out more quickly elsewhere. The UA had assured him that they would 'sort it out', that he was not to worry, and that his mother would have her operation. The complainant said that on this assurance he assumed that his mother would have an operation under the NHS on the date planned and he advised her accordingly. He thought that his mother's prompt admission as a NHS patient was to compensate for the way her case had been handled and he had not considered the possibility that she would be treated as a private patient after the forthright way he had expressed his views to the administrators.

11. On 14 August the complainant replied to the AUA's letter of 11 August (see paragraph 10). He confirmed that it had not been his intention to make a formal complaint and gave an account of his mother's conversation with the consultant. He said that he was most anxious that the operation should be carried out on the date planned despite the hospital's enquiry which was being pursued. Although he gave his views as to how his mother came to agree to have private treatment, the complainant did not refer to his belief that his mother was to have a NHS operation, nor did he say that she was not to have private treatment. He explained to my officers that he had not considered it necessary to explain to the administrators that he was not prepared for his mother to pay for the operation as he had said this to them repeatedly during his several telephone conversations with them.

12. On 19 August, the complainant received a telephone call from the consultant who asked him whether his mother 'was prepared for the operation,' as the relationship between surgeon and patient was most important and he was concerned that she might have been upset by 'the fuss'. He had added, according to the complainant, that he was also concerned about the way in which the matter had been handled by the hospital administration—which the complainant thought was an allusion to his enquiry being taken as a formal complaint. The complainant said that at no time was the question of whether the operation was to be private or NHS mentioned and he had assumed that the consultant had been reprimanded and therefore intended to carry out a NHS operation; in these circumstances, the complainant said, he had not wanted to embarrass him by asking for confirmation that NHS treatment was to be provided.

13. The complainant told my officers that his mother was admitted to the hospital on 25 August and that evening she told him that she had signed a form agreeing to pay for accommodation and services; she had been fully aware of what she was doing but had had confidence in the assurance he had given her that the operation would be carried out under the NHS. The complainant assumed that there had been a mistake and the next day he

telephoned the AUA, who had expressed surprise and said he would investigate. When he telephoned the complainant later he told him that the complainant's mother had signed an agreement to pay for her hospital treatment; that she had been aware of what she was signing; and that a relative had been present at the time. The complainant told the AUA that at no point had he said that his mother was to have her operation as a private patient; he had wanted his mother to have the operation as soon as possible but not necessarily on 26 August. Being dissatisfied with the AUA's reply, the complainant had then spoken to the district general administrator (the DGA) who, not being familiar with the matter, had asked the UA to telephone him. The UA told the complainant that it had not been his understanding that he wanted his mother to have only a NHS operation and pointed out to him that he had not mentioned this in his letter of 14 August. The complainant replied that the whole point of his actions prior to the operation had been to find out the alternative to private treatment—i.e. the length of time his mother would have had to wait for a similar operation under the NHS, so that he would know whether to try other hospitals to see if they had shorter waiting lists. Shortly afterwards the UA had telephoned him and told him that the waiting time for a cataract operation at the hospital under the NHS would normally be six to seven months.

14. The complainant wrote a letter dated 2 September to the Area Chairman reiterating the complaints and saying that they were not prepared to pay for the private treatment. This was received by the AHA on 12 September. On 24 October the Area Chairman replied saying that there had been ample opportunity for the complainant's mother to delay the operation pending the clarification which the complainant sought and that his mother had signed the agreement to receive and pay for private treatment. He had concluded therefore that they could not withdraw the request for fees. The complainant then put his complaint to me. I explained to him that I would not consider it unless his mother first paid her bills from the hospital. In February 1981 I received an assurance that this had been done and began my investigation.

15. When interviewed by my officers the AUA, who has since left the hospital, said that when he spoke to the complainant on 6 August, the complainant said that the consultant had told his mother that she could have her operation earlier if she was a private patient. Although he considered that this was a rather obvious statement he thought that the complainant was making a complaint and that there might be more to it than appeared on the face of it. He had therefore treated it as a formal complaint and, following the usual complaints procedure, had written to him on 11 August confirming the complaint as he understood it and asking him if there were any other additional points which he wanted investigating. On the same day he sent a memorandum to the UA advising him of the complaint. The AUA was quite certain that the complainant did not ask him about NHS waiting time; if he had done so he would probably have treated the matter as an enquiry rather than a complaint. (I have seen a copy of the AUA's memorandum to the UA; it contains no reference to NHS waiting time.) The AUA said he next spoke to the complainant on 14 August after which he noted on his

file 'At Mrs ———'s instigation that (sic) private treatment has started. Mr. ——— [the complainant] would like operation to go ahead a.s.a.p.'. His final conversation with the complainant was on the morning of 26th August. The complainant told him that his mother had been admitted the previous day as a private patient and had been given a bill for £441. He had made enquiries but had not been able to get in touch with the complainant until about 4.30 pm when he told him that the document his mother had been given was not a bill but the agreement to pay private patients' charges, which she had signed; and that a bill would be rendered later when the length of her stay was known. He had asked the complainant to clarify his complaint and he said he wanted to know how long his mother would have to wait locally for the operation under NHS. If the waiting period was longer than in London he would get his mother admitted to a hospital there. The AUA said that this was the only occasion on which the complainant had mentioned to him the waiting time for NHS operations.

16. In a report he prepared on the complaint for the health district and when interviewed by my officers, the UA said that following his receipt of the AUA's memorandum he had discussed the complaint with him and agreed that there might be an implication that undue pressure had been put on the complainant's mother to opt for private treatment. He first spoke to the complainant on 13 August who told him that he did not wish to make a formal complaint. The UA explained the complaints procedure and the complainant asked that the enquiries should be pursued on an informal basis; but he said that he particularly wanted to know how long it would take to have his mother admitted as a NHS patient. He had replied that he would try to see the consultant by the end of that week and would get in touch with the complainant soon afterwards.

17. The UA said that he had first asked the hospital admissions department, who held details of all patients waiting for admission, if they could answer the complainant's question but they told him that they were unwilling to commit themselves to a specific waiting time because of the consultant's arrangements for bringing in waiting-list patients. (The UA explained that they were referring to patients being called not necessarily in strict order; for example the consultant might decide not to take any cataract operations in a session but to have a full session for these operations on another occasion.) He had then arranged to see the consultant, but at the appointed time, 8.30 am on 15 August, the consultant was not in his office. Shortly afterwards he was told that the consultant was unable to see him and that he should write to request any information he required. However, he had returned to the consultant's office and the consultant told him that, as the matter has been 'elevated' to a formal complaint he was not willing to deal with it informally and the UA must write to him. The UA said he then explained to the consultant that the complainant told him he wanted the matter dealt with informally and that he had asked for information about the NHS waiting time for the operation. The consultant, however, was insistent that the complaint should be dealt with formally and therefore, after discussing the complaint with the district administrative manager who was responsible locally for dealing with complaints, he wrote to

the consultant on 15 August ; he said specifically that the complainant would appreciate information about the length of time his mother would have had to wait for the operation as a NHS patient.

18. The UA said that he had concluded from his conversation with the complainant on 14 August that the complainant was concerned that there should be no delay in carrying out his mother's operation but that he was also concerned that she should have to pay for it. He had assumed that the complainant wanted to know about NHS waiting time so that he could perhaps reassess the choice of private treatment. Because he had not had a reply from the consultant by 20 August he wrote to the complainant and explained that he could not give him the information he had asked for within the promised time, because he had had no reply from the consultant. (The consultant in fact replied on 21 August but did not refer to NHS waiting time for cataract operations).

19. On 27 August, after the operation had taken place, the consultant told him that he had telephoned the complainant during the previous week and the complainant had assured him that he did not wish to make a formal complaint and that he wanted his mother's admission to proceed ; and, on 2 September, the consultant told him also that during this telephone conversation he had asked the complainant whether there were any outstanding problems he wished to discuss with him. The UA said he pressed the consultant about the question of NHS waiting time for the mother's operation and was told that she had not been a medically urgent case and would probably have had to wait six or eight months. The same day the UA telephoned the complainant and passed on this information. The complainant had then told him that the family would take no responsibility for any charges because he had made it quite clear to the UA that his mother could not be admitted as a private patient. He had replied that this was not his understanding of their conversation and the complainant had not raised this issue either in his letter or in his telephone conversation with the consultant the previous week. The UA told my officers that he had recognised that the information about the NHS waiting time was important to the complainant ; it was a pity that, unusually, it had not been possible to supply it but he had been prevented from doing so by the attitude of the consultant. Although he realised that the complainant wanted the operation to be carried out under the NHS he had understood his main concern to be that the operation should be carried out without delay. He was quite sure that he himself had not given the complainant any assurance that the operation would be carried out under the NHS.

20. In the letter to me and when he met my officers the consultant said that he clearly recalled the occasion when the UA came to his office on 15 August to speak about the complaint. His children had been ill the previous night and he was discussing their condition with a colleague and he had been due to give a lecture to nurses 15 minutes later ; he had therefore asked the UA to put his questions in writing as he did not have the time to speak to him. The UA had written to him the same day enclosing a copy of the complainant's letter asking for information about NHS waiting time but he considered that the letter contained a serious implied allegation that he had

misled the complainant's mother which had caused her to opt for private treatment. Because a serious complaint had been made against him, he was unwilling to hazard a guess at the probable waiting time. He had therefore, had to assess his waiting list so that his forecast would be as accurate as possible. The consultant said that he could not understand why the administration or the admissions clerk could not have given the complainant an answer as they had access to the same information as he had about the number of patients on his waiting list.

21. The consultant said that the UA had asked him to telephone the complainant although he could not recall why he was asked to do so. (The UA recalled that he had been surprised to learn that the consultant had spoken to the complainant; he could not remember that he had asked for the call to be made). When he spoke to the complainant on 19 August neither he nor the complainant had mentioned either NHS waiting time or the question of private treatment. He had however been assured that the mother's early admission should proceed and that the complainant did not wish to press a formal complaint. It was, the consultant said, the AUA, for reasons which were not clear to him, who had wanted to convert this enquiry into a formal complaint and he could not understand why a request for information about NHS waiting times, which apparently was all the complainant wanted to know, was not referred to the admissions clerk or himself in the first instance.

22. I have seen a copy of the consultant's reply to the UA which he made on 21 August (paragraph 18). In it he said: 'It is not, and was not, either my wish nor as it turns out, Mr ——'s, that his query should be turned into a complaint. This was done by [the AUA], and needs explanation. What I asked you was that you put your questions in writing, as has always been your custom [for formal complaints]. . . . I must point out that I am concerned with the manner in which this Hospital's administration seems to think that the only way in which an enquiry can be handled is by converting it into a complaint. As I said to you on Friday, 15th August . . . I find it very curious that there has been a sudden rise in the incidence of complaints emanating from your office. I do not know whether this is merely a matter of coincidence . . . or a 'conspiracy', and if the latter whether it is directed against the medical corpus of this Hospital or only against me, and whether in either case it is motivated by a religious, racial, political or some other animus. . . .'

Findings

23. Although there is conflict between the evidence of the complainant and that of the AUA about their conversations, it is not disputed that the complainant asked the UA about NHS waiting time and that he was not given the information until after his mother's operation had taken place.

24. I can understand the administrators' feeling at the outset that there was an implication that the complainant's mother had been wrongly persuaded to seek private treatment (although I myself am not satisfied that this was so); but, once the complainant had specifically asked for informa-

tion about the NHS waiting time, he should have had a prompt answer, even if it could not have been a precise one. The failure of the AHA to provide him with an answer was clearly caused by friction between the administration and the consultant which I regard as very regrettable. I uphold this complaint to the extent that the complainant was not given information to which he was reasonably entitled.

25. It is surprising, however, that the complainant did not say in his letter of 14 August that his mother was not to be a privatae patient or confirm, when he spoke to the consultant on 19 August, his belief that his mother was to have a NHS operation. I am satisfied from the evidence that the UA did not understand from his conversation with the complainant on 14 August that the operation was not to go ahead except under the NHS; furthermore, I believe that if he told the complainant not to worry and that the matter would be 'sorted out' he was referring to the *complaint* rather than the enquiry about the probable date for a NHS operation. I do not doubt that the complainant is sincere in his interpretation of his conversation with the UA. But I think there was a genuine misunderstanding and I do not believe that the complainant's mother was treated as a private patient despite the complainant's express wishes to the contrary.

Conclusions

26. I have set out my findings in paragraphs 8 and 23–25 of my report. Although I am not satisfied that the complainant's mother was misled about the NHS waiting time for her operation, I have found that the AHA failed to provide the information requested by the complainant before his mother's operation and I have criticised the AHA for this.

27. On the other hand the complainant, following his conversation with the UA, had clear opportunities which he did not take, to say that private treatment for his mother was unacceptable and to confirm his understanding (for which I believe he had little or no ground), that the operation would be done under the NHS. Had he taken these opportunities he would, I am sure, have been told that his mother was booked into the hospital for private treatment; and he would then have had the opportunity to request the AHA, with his mother's agreement, to delay it pending the information about NHS waiting time. While I have not condoned the way the AHA dealt with this matter, I think there is considerable doubt whether the complainant made his views entirely clear and I have concluded that this is not a case in which I should recommend that the AHA make an *ex gratia* payment.

28. The AHA have asked me to convey in my report their apologies for the shortcomings to which I have drawn attention, and this I gladly do.

Case No. W.326/80–81—Radiator burn sustained whilst in hospital

Background and complaint

1. A woman complained that her husband, a patient in a ward (the ward) of a hospital (the hospital), sustained serious burns to his feet at some

time during the morning of 9 October 1980 because of inadequate supervision on the ward. She also complained that the injury was not discovered promptly and that she was not told about it until she telephoned the hospital during the evening of 10 October.

Jurisdiction and procedure

2. The complainant told me that she would not take legal action against anyone in respect of the complaints and I decided to investigate them. I obtained the comments of the Area Health Authority (the AHA) and examined relevant documents including the medical and nursing notes. One of my officers interviewed members of the medical, nursing, administrative and engineering staff concerned. She also met the complainant and the secretary of the Community Health Council (the CHC secretary) who had assisted the complainant in making her complaint. (The hospital became the responsibility of the Health Authority, as successor to the AHA, on 1 April 1982.)

Investigation

3. The complainant told my officer that she telephoned the hospital at about 3.45 pm on 10 October and was told that her husband had burned his feet by standing on a radiator. She visited him on 11 October and was shocked to find him in a wheelchair looking very ill with his feet bound and propped up. The ward sister (the sister) told her that her husband, who had been in a single room, had been found on the window sill on the morning of 9 October and that it was thought that he had stood on the radiator to climb out of the window. The complainant said that she had telephoned the hospital during the evening of 9 October but that the accident had not been mentioned then. She said that the sister could not say why she had not been told earlier, why the injury had not been noticed sooner, or what treatment had been given. The complainant said that from her conversations with other staff there was clearly some confusion about when the accident had happened.

4. The complainant said that on 21 October she attended a meeting at which the consultant psychiatrist (the consultant), the sister, three ward staff, and about six other people had been present and during which she had been asked what she thought had happened. She had suggested that her husband (the aggrieved) had been locked in his room, felt confined, and was therefore trying to climb out of the window. The sister had said that doors were not locked, but when the complainant pointed out that she had found the door of the aggrieved's room locked on 11 October the sister had agreed that it could have been. The complainant said that at the meeting the staff had given her no explanation of how the accident happened. They had said nothing about an investigation or about any steps having been taken to prevent a recurrence.

5. The CHC secretary wrote to the hospital administrator (the HA) on 13 October and in his reply of 23 October the HA said that the accident appeared to have occurred during the early morning of 9 October, because at

7.30 am on that day the aggrieved had been found standing on the window sill of his bedroom having, presumably, first climed on to the radiator. No injury was then apparent but at 8.15 am on the following day, 10 October, a nurse had reported that there were blisters on his feet and first aid had then been given. The HA said that some time later the ward doctor had been called to examine the aggrieved and had prescribed treatment, and that the complainant had been informed of the accident when she telephoned during the afternoon. The HA said that the aggrieved was physically active but, suffered from memory impairment and was confused, restless and at times aggressive. Accordingly he had been given a single unlocked room. The HA said that the staff were well aware of the need to protect patients from the effects of their own actions but that it was impossible for them to be observed constantly. They thought that the aggrieved might have been trying to unfasten the window while standing barefoot on the radiator and that because of his confused condition he may not have had the normal degree of sensitivity or response to the hot surface. The HA explained that the ward heating was maintained at what was normally considered to be a safe level and that to reduce the temperature to the point at which even prolonged contact with a radiator would not cause a burn would result in inadequate heating. He added that it had been known for radiator guards to cause injury when they were climbed upon. The HA apologised for the injury, expresed his regret that the hospital had been unable to prevent it, and said that further study would be given to the problem of providing protection from radiator injury.

6. The then senior nursing officer (the SNO) reported on 17 February to the divisional nursing officer (the Div NO) about his investigation of the complaint. He said that the aggrieved appeared to have no difficulty in walking on 9 October and that no injury had been suspected. At 8.15 a.m. on 10 October he had been found sitting on the bed in another patient's room while that patient was in the aggrieved's room. The SNO said that when being dressed by a nursing auxiliary (the day NA) the aggrieved found it difficult to stand and blisters were discovered on the sole of his right foot. The nurse in charge (the SEN) was informed and immediately called the duty doctor who examined the aggrieved at about 8.30 a.m., advised a dry dressing and referred him to the ward doctor who saw him at 2.15 p.m. and prescribed further treatment. The SNO said that the SEN had decided to discuss the injury, which had not seemed to her to be serious, with the sister before the complainant was informed. The day NA and the SEN confirmed to my officer this account of the events of 10 October.

7. The day NA told my officer that when she had entered the aggrieved's room on the morning of 9 October she had found him on the window sill, grasping at the frame. She had called a staff nurse who, with other staff, had helped him down. The day NA said that the staff nurse had not indicated to her that the agrieved had been injured and he had not given any special instructions for his supervision. The day NA recalled that the aggrieved appeared to walk normally that day. My officer could not interview the staff nurse as he had left this country in November 1980. The sister, who had not been on duty on 9 October, told my officer that when she came on duty

at 1.30 p.m. on 10 October the staff nurse had told her about the previous day's incident, and that he had not recorded it in writing because he had not considered it significant. The ward sister said that she had told the staff nurse that it should have been recorded and I have seen the following entry inserted under the date of 9 October:—' Pt was found standing on a window sill close to radiator at 7.30 a.m. Brought down by nurses '. The sister told my officer that when she examined the aggrieved on the afternoon of 10 October she saw that both his feet were blistered. She said that after she had called the ward doctor and spoken to the staff nurse she had completed an accident form in which she assumed that the injury had arisen from the incident of the previous morning. I have seen that the report does indicate the date of the accident as ' ?9 October 1980 '.

8. Another nursing auxiliary (the night NA) told my officer that she could recall no sign of an injury when she put the aggrieved to bed on the evening of 9 October and that she had seen the aggrieved in his own bed at about 6 a.m. on 10 October. The duty doctor told my officer that he did not remember seeing the aggrieved but I have seen an entry of his attendance in the nursing record. The ward doctor said that she had not been available during the morning of 10 October but that she was called by the sister in the early afternoon and had prescribed treatment for the burns, which she had understood to have been sustained that morning.

9. The sister told my officer that the decision to inform relatives about an accident depended on the severity of the injuries. She said that the complainant telephoned every day when she was unable to visit and the sister had told her about the accident when she telephoned on 10 October. The sister said that confused patients had an impaired sense of danger and needed to be watched especially vigilantly by the nurses. Although, in her opinion, staffing levels were low she thought that more staff could only minimise the risk of accidents. She said that although radiator guards would be helpful the radiators were fitted with temperature controls and the nurses did try to ensure that they were set at a comfortable level. The sister assured my officer that she did not lock patients in their rooms as it would be unsafe to do so but the aggrieved's room could have been locked when it was empty, for reasons of security, on 11 October.

10. The nursing officer (the NO) told my officer that because there was a lot of activity on the ward between 7 and 8 a.m. the patients, especially those in single rooms, could not be closely supervised at that time. The SNO told my officer that supervision was adequate but that even with more nurses such accidents would happen, particularly with restless patients like the aggrieved. The SNO considered that the radiator should not have been so hot as to cause a burn but said that it was difficult to maintain an adequate temperature without one or two of the radiators becoming too hot. The SNO confirmed that doors were not locked except in a patient's absence to safeguard his property. The senior nursing officer (night duty) (the night SNO) told my officer that after the patients had been settled for the night they were checked at half-hourly intervals. The night SNO said that there was no reason to lock the doors. The acting senior nursing officer told my officer that the nursing staff tried to remove all apparent dangers and would

like to see radiator guards fitted, but he added that these could constitute a danger if they were broken.

11. The Div NO told my officer that although there was no doubt that the aggrieved's burns were caused by an accident in the side room it was not possible with any certainty to say how or when. He felt that they could have been caused by the heating pipes rather than the radiator. He commented that although the accident might not have happened had the aggrieved been in a dormitory rather than a side room, nurses were constantly having to balance the risk of giving patients a reasonable degree of independence against the need to protect them. The Div NO said that although, fortunately, such accidents were infrequent the risk of them had been considered from time to time before the aggrieved's accident. During the investigation of the aggrieved's accident he had submitted recommendations to the HA and I have seen that he suggested that first the side rooms in those wards with the most vulnerable patients should have radiator guards fitted: the ward was among those given top priority for this. The Div NO endorsed the views of his colleagues about staffing levels and about the locking of rooms.

12. The consultant told my officer that it was standard practice for the ward medical and nursing staff to see relatives when a patient was seriously hurt to explain what had happened and discuss any complaints. This had been the purpose of meeting the complainant on 21 October. In his opinion it had not been satisfactory because 'basically he considered that they were responsible . . .' He told my officer that he had written subsequently to the HA on 17 June 1981 requesting radiator guards for the side rooms in the ward.

13. The senior hospital engineer (the engineer) told my officer that the temperatures on the wards are checked regularly to ensure economy and, since the aggrieved's accident, to monitor safety. He said that when he was first notified of the accident, in February 1981, he had taken the surface temperatures of the radiators at their maximum. At 48°C, they were a little higher than the temperature at which burns might be sustained (43°C) but they were lower than the safety limit suggested by DHSS:—

'. . . a safe maximum flow temperature in geriatric, mentally ill, . . . areas may be taken as 50°C (122°F) if prolonged direct contact with the surface is possible'.

The engineer said that the hospital heating had been turned on progressively between 7 and 12 October 1980 and although he was unable to say when the ward heating came on the radiators should have been cooler than in February. He considered that as the ward heating system had been designed to maintain warmth without risk of burning, radiator guards were unnecessary. The district works officer (the DWO) told my officer that they had installed in the ward more radiators operating at a low surface temperature to provide sufficient heating. He showed my officer a DHSS Building Note which recommended:—

'In single bedrooms any exposed heating surface at a height of less than 2 metres should be guarded if the temperature of the surface greatly exceeds 49°C'

The DWO said that if the radiators were at the correct temperature guards should not be needed but they could be provided.

14. To try to establish the likelihood of the burn occurring on 10 October rather than the previous day my officer met the district community physician (the DCP), the consultant, the registrar, the ward doctor and the HA together. All the doctors agreed that a burn would normally have been noticed earlier than 24 hours after an incident. They said that the nursing evidence (paragraph 6) that at 8.15 am on 10 October only one foot was blistered whereas the sister reported (paragraph 7) that by the early afternoon both feet were affected suggested that the accident had taken place that day and not on 9 October. The doctors could not decide from the ward doctor's description of the shape of the burns whether the injury had more probably been caused by contact with a radiator itself or a heating supply pipe but they agreed that one or other was the only likely cause of the injury. The consultant said that even the modest amount of medicine being taken by the aggrieved could have slowed his reactions to the heat.

Findings

15. It is not disputed that the aggrieved was burned while in the care of the hospital. I have to consider first, whether the aggrieved was properly supervised and second, if the AHA was guilty of any maladministration in respect of their decisions about the heating system which could have put him at unnecessary extra risk if he was unsupervised. The weight of the doctors' opinions is that it was more likely that the accident happened on 10 October rather than on 9 October as originally indicated to the complainant. In any case, I am satisfied that the nursing staff gave the aggrieved proper supervision and that they acted promptly to have him treated once they were aware of his burns. There is nothing to indicate that if the staffing levels had been higher the injury would have been prevented or discovered earlier. I am also satisfied that there was no maladministration in the way that the AHA made their decisions about the heating system, but I am pleased to have had the assurance of the Health Authority that action has been taken since this accident to improve safety standards. I do not therefore uphold the complaint about inadequate supervision.

16. The nurses considered that the aggrieved's injuries were not sufficiently serious to inform the complainant immediately they were noticed and I do not find unreasonable their decision not to tell her about the accident until she made her expected telephone call during the afternoon of 10 October. On the assumption, which I have accepted, that the accident occurred on 10 October, I do not uphold the complaint that there was undue delay in informing the complainant.

Conclusion

17. I have not upheld these complaints but I am pleased to record the action which has been taken since they were made. I hope that the complainant will gain some saisfaction from that.

Case No. W.348/80-81—Mishandling of complaint by Health Authority

Background and complaint

1. The complainant's husband was taken by ambulance to the Accident and Emergency Department (the A and E department) of a hospital (the hospital) on 5 January 1980 following a riding accident. He was later moved to a ward (the ward) ; early the following morning he underwent an operation, but he died shortly afterwards.

2. When the complainant first approached me her complaint concerned the care and treatment her husband had received in the A and E Department ; in particular the delay in providing pain-relief for him and the apparent lack of urgency in regard to his treatment which prompted her request that a consultant (the consultant) be called to treat her husband as a private patient. She was told that I would be unable to look into her complaint as the matters complained about related, in the main, to actions taken in the exercise of clinical judgment—which are outside my jurisdiction. It was explained that I was also debarred from examining the actions of the consultant as he had attended the complainant's husband, at her request, in a private capacity and not as part of his National Health Service duties.

3. Shortly after this the complainant brought to my attention a letter dated 11 December 1980 from the Area Health Authority (the AHA) which she had received after she had put her complaint to me. She said that she was dissatisfied with the way the AHA had handled her complaint and that, in particular, the letter contained a grossly inaccurate timetable of the events. I agreed to carry out an investigation limited to these aspects.

Investigation

4. During the investigation I obtained the written comments of the AHA and examined all the relevant documents including the medical and nursing notes and the correspondence on the complaint. My officers met the members of the medical, nursing and administrative staff concerned. They also met the complainant and her son and spoke with a number of people who she said might be able to help in my investigation.

5. In the letter to the complainant dated 11 December 1980, the AHA, in reply to specific questions she had put to them, said amongst other things that: 'Mr —— arrived in Casualty at 16.07 hrs on on 5 January 1980 . . . 100 mgms of Pethidine were given at 16.25 hrs . . . A further 50 mgms were given at 18.00 hrs, 10 mgms of Morphine were given at 18.30 hrs and a further 10 mgms of Morphine at 22.30 hrs . . . The person authorising the injection was [the consultant], except in the case of the final injection which was authorised by a member of [the consultant's] staff . . . The time of [the consultant's] arrival is not recorded but I understand that it was not later than 16.25 hrs. When the AHA sent me their comments on this complaint on 29 April 1981, they informed me that because of an error in completing the record cards for the complainant's husband, the time of his arrival at the A & E department had been given incorrectly as

16.07. It was likely, they said, that he arrived about 20 minutes earlier because he was taken to the department as soon as he reached the hospital which according to the ambulance service was 15.47. They said they had written to the complainant and apologised for their error.

6. The complainant's account of the events following her husband's arrival in the A & E department which she gave in correspondence to me, when interviewed by my officers and in subsequent telephone calls, is summarised in this and the following three paragraphs. The ambulance arrived at the hospital at 16.07—the time originally given to her by the AHA, which she accepted. Her husband was put in a cubicle in the A & E department; a young nurse had tried to remove his vest and she, herself, suggested that it should be cut off to save her husband pain; a sister (the sister) came into the cubicle and after enquiring who she was, asked her to leave. She had then gone to the waiting area where she remained for some time.

7. The staff, she said, took x-rays and she saw the films lit up on a screen. During this time she heard her husband asking for something to relieve his pain. She had been told that the consultant had been called but, as no senior medical staff came to see her husband she became concerned and telephoned the family practitioner who had attended the accident (the FP) and asked him if her husband would obtain better attention with private treatment. He told her: 'If it is serious enough they will get [the consultant] in'. (Later, the FP had told her that he thought this call was possibly between 18.00 and 19.00 but not later than 20.00.) She returned to sit in the waiting area but a little later she telephoned her son and asked him to get in touch with her husband's company doctor and operations manager. About half an hour later she telephoned him again to see if he had been successful. She said that her son had told her that he thought the time of the first call was about one and a half to two hours after the ambulance would have arrived at the hospital and the second call approximately 25 minutes later—i.e. 17.30—18.00 and 17.55—18.25 respectively.

8. She then went to see her husband who was attended by the sister and some doctors and she heard him ask again for something to relieve his pain. One of the doctors told her in a kindly manner to go and sit down and said that they could not do anything for the moment. It was at this stage that a member of staff, possibly the A & E receptionist (the receptionist), had suggested that if her husband had private medical insurance she should use it, as it would get the consultant there more quickly. She told the doctors and the sister that her husband had private medical insurance and asked if it would help if they opted for private treatment. The sister replied: 'You must make up your own mind about that'. She then agreed to private treatment and returned to her husband, where she remained until the consultant eventually arrived. She was quite certain that her husband was not given his first injection until after the consultant arrived and that it was given in the A and E department shortly before he was taken to the ward.

9. My officer asked the complainant whether she had noted the times of any of the events she had described and she said (not unnaturally) that

she had not. What she had been aware of, however, was the passage of long periods during which nothing seemed to be done to help her husband. It was, she said, clearly impossible that all the events in the A and E department that she recalled could have taken place in the 18 minutes between 16.07 when they arrived at the department and 16.25 when, the AHA said, the consultant had arrived to see her husband. She would not have made her complaint or have had cause for dissatisfaction with the standard of service if it had followed the timetable outlined in the AHA's letter of 11 December.

10. The FP recalled his conversation with the complainant when she telephoned him from the A and E department. He said that she had been very upset and she had told him that nothing seemed to be being done for her husband. She asked him if the consultant would come more quickly if she chose to have private treatment for him. He told her that the consultant would be called if he was required and explained that, in the circumstances, the only advantage of private treatment would be that she would be able to choose the consultant she wanted. He said that he would choose Mr. —— and the complainant told him that he was, in fact, the consultant on call. The FP told my officer that he found it very difficult to pinpoint the time of the complainant's call ; the accident occurred at about 14.30-15.00 and the call was about three hours later ; he estimated that is was possibly between 17.00 and 18.00 but not later than 19.00. My officer told the FP that this conflicted with the time span which the complainant had said he had given to her (see paragraph 7) and the FP said that this only illustrated how difficult it was for him to say with any accuracy when the complainant had telephoned him.

11. My officer met the complainant's son who told him that he had been taken to the scene of the accident and when he arrived his father and mother were already in the ambulance, which left shortly afterwards. After leading the horse home he had stabled it and had fed the family's horses. Allowing for the time taken for this he estimated that it was at about 16.40 that he had telephoned a friend (the friend) who came to the house about ten minutes later. After about an hour (i.e. about 17.50) he had received his mother's first telephone call in which, besides asking him to get in touch with his father's firm, she had told him she was concerned because there was little progress in his father's treatment at the hopital ; but as far as he could recall she had not mentioned either that the consultant had not arrived or that no pain relief had been given to his father. His mother had telephoned again about 25 minutes later to check if he had been able to get in touch with the firm ; she said that ' the position was desperate ' but did not give him any details.

12. The friend confirmed that following a telephone conversation with the complainant's son on 5 January, he had gone to see him. He could not remember the time that he arrived but he thought it was about 17.10. The complainant's son was watching television ; it was a programme in which he himself was not interested—he *thought* it was rugby football—and he had gone to another room to do some recording. Later he joined the complainant's son and watched a film which he *thought* was a ' Western ' He

remembered that during this time the complainant's son had been telephoned by his mother; there was a call about 20 to 30 minutes after his arrival and a further call about 30 minutes later. In a written statement, sent to me by the complainant, the friend said that in these telephone conversations the complainant told her son that no painkillers had been administered but when interviewed by my officer he said that the complainant's son had told him that his mother was very anxious because 'nothing seemed to be happening at the hospital' and he did not remember anything being said about the delay in the consultant's arrival or the failure to give relief for the complainant's husband's pain. My officer obtained details of television programmes for 5 January 1980; according to the programme schedule, rugby was to be shown from 15.20 to 16.05; and the only programme at about the material time which could be construed, albeit loosely, as a 'Western' film was to run from 15.30 to 17.10.

13. The AHA told me that at 15.34 the hospital was alerted by ambulance control that a patient would be brought in with multiple injuries and that when the patient arrived he was taken direct to the A and E department on a stretcher; a medical laboratory scientific officer was present and immediately began to prepare for a possible blood transfusion. The doctor who was on duty in the A and E department (the A & E doctor) remembered that the complainant's husband had received immediate attention. He himself had examined the patient; a drip had been set up; and he had ordered a number of tests, including x-rays. He explained that it was important not to dull a patient's responses with any form of analgesia before an initial diagnosis of a patient's injuries had been reached. But by 16.15 he had completed his examination and tests and had prescribed Pethidine, which was administered by the sister at 16.25. Meanwhile he had decided that the complainant's husband should be seen by the duty surgical team and he had called the senior house officer in general surgery (the SHO) who came to the A and E department immediately.

14. The casualty records show that the complainant's husband arrived in the A and E department at 16.07 (although this time had been altered—see paragraph 19.) The entry by the A and E doctor indicated the cause of the injuries, the physical condition of the patient on examination and a possible diagnosis. His entry confirms that he ordered 100 mg of Pethidine to be given to the patient and that he referred the patient to the SHO who added 'Admit' to the casualty card with his signature. Supplementary records show that a head injuries chart was started at 16.00; that girdle measurements commenced at 16.00; and that five measurements were recorded between 16.00 and 17.30. The time on the first request form for blood to the Pathological Laboratory is unfortunately unreadable.

15. The A and E doctor said that he stayed to help the SHO but he could not recall when the consultant arrived in the department. He said, however, that as it appeared from the records that the complainant's husband reached the ward at 18.00 he thought it likely that, allowing the usual time for the consultant to consider the results of tests and to examine the patient, it could not have been later than 17.00-17.15.

16. The SHO confirmed to my officer that he had been called by the A and E doctor to see the complainant's husband and that he arrived in the A and E department at 16.15, which he had recorded in the clinical notes. Prior to his arrival Pethidine had been prescribed and had been administered by the sister at 16.25—which he also recorded. He said that blood had already been taken for crossmatching but he ordered further tests to assess the patient's stability and also for x-rays to be taken with a mobile unit. He said that a consultant would always have been called to see a patient in this condition but generally not until investigations and tests had been carried out to assess the extent of injuries and the stability of a patient's condition. He recalled that prior to his call to the consultant he had been told, he thought by the sister, that the complainant wanted her husband to be treated as a private patient. He stressed that her decision had not expedited his call to the consultant which he had made after he had completed the procedures which were his responsibility.

17. The SHO could not remember when the consultant came to see the complainant's husband but he estimated that, after his own arrival at 16.15, it would have taken about 30 minutes to obtain the results of the investigations and tests he had ordered, after which he would have been in a position to call the consultant. The consultant lived close to the hospital and therefore it was possible that he could have reached there shortly after 16.45, but, the SHO said, he did not know the exact time of the consultant's arrival.

18. The sister told my officer that she had given the complainant's husband the 100 mg of Pethidine, ordered by the A and E doctor, at 16.25; and that the initials on the casualty card, confirming that she had done so were hers. My officer saw the A and E department drugs book; it showed that the sister had signed for the Pethidine at 16.25 and that another nurse also signed the book as witness. The other nurse told my officer that she was present when the drug was administered immediately afterwards. Neither of these nurses could remember when the consultant arrived.

19. The receptionist who had recorded the time of the patient's arrival on the casualty card (which the AHA advised me was incorrect—see paragraph 5), explained to my officer how this error might have occurred and also why the time on the card might have been altered. Patients normally came first to the administrative area of the A and E department, where she wrote their personal details on the casualty cards. The complainant's husband, however, accompanied by his wife, had been taken direct to the treatment area. Shortly after his arrival, another patient, whom she knew, came in suffering from alcoholic poisoning and she had helped the nursing staff with her for a few minutes before going into the treatment area; there might therefore have been a short delay before she obtained the husband's details. Also she might initially have entered the time from the clock in the treatment area and then corrected it when she returned to the administrative area because she had remembered that there had been a difference in time between the clocks. (There was a difference of ten minutes when my officer visited the hospital).

20. The receptionist said that the complainant had been in a highly emotional state and that she would not leave the cubicle area, where her

husband was being examined, for any length of time. The complainant had asked her if private treatment would 'speed up' her husband's treatment and said that he had private medical insurance cover. When she told the complainant that 'it was up to her' she said that she wanted to telephone the FP to ask his advice on which consultant she should choose if she decided on private treatment for her husband. On such occasions, the receptionist said, she usually offered the use of her telephone but she could not specifically remember doing so on this occasion; and the public telephone boxes nearby were not visible from her desk. When she left the department there was still activity around the husband's cubicle but she could not recall whether or not the consultant had arrived by that time. To try to establish when the complainant made her telephone calls my officer checked the relevant hospital records but no calls had been booked against the complainant.

21. The consultant said that he was first aware that the complainant's husband was in the hospital when he received a call requesting him to see a patient who had asked to be treated privately; he had not been asked to attend previously. When he arrived he saw the x-rays, and the results of the tests that had been carried out and noted that Pethidine had been given at 16.25. He had been quite satisfied with the actions of the junior doctors prior to his arrival. The consultant examined the complainant's husband and, after speaking briefly to the complainant, who was clearly very distressed, accompanied the patient to the ward. On the ward he wrote up the drug sheet and prescribed 50 mg Pethidine to be given at 18.00. He included on the sheet the 100 mg Pethidine ordered and administered in the A and E department earlier but he had not signed that entry as the prescriber because he had not been present at the time. The consultant confirmed that he had later prescribed 10 mg Morphine given at 18.35. The remaining entry on the drug sheet, a further 10 mg Morphine to be given at 22.30, was signed by the SHO. The consultant said that he could not remember when he arrived at the hospital and could only be guided as to the timing of events by the times noted in the casualty card and the Kardex (the ward nursing report).

22. The first entry in the ward nursing report for the complainant's husband reads:

> '5.1.80 DAY. Emergency admission via casualty at 18.00. Patient fell off horse . . . . . Pethidine 100 mg at 16.25 in casualty. Pethidine 50 mg I.M. given at 18.00 and I.M. Morphine 10 mgm given at 18.35 . . .'

The state enrolled nurse (the SEN) who signed this entry was in charge of the ward when the complainant's husband was admitted. She told my officer that she herself had given the drugs on the ward to the complainant's husband and that she had signed the ward controlled drugs record book to that effect. My officer confirmed these entries and that another nurse who was on duty in the ward also signed the book as witness that the drugs were administered at 18.00 and 18.35. The SEN said that she went off duty that day at 19.00.

Findings and conclusions

23. My investigation has revealed a number of errors in the AHA's reply of 11 December to the complainant. First, the time of her husband's arrival

at the A and E department was given as 16.07 which the AHA realised was incorrect in April when I had commenced my investigation. This should have been clear to them from the outset as recordings in supplementary medical records started at 16.00 (paragraph 14.) Secondly, the AHA told the complainant that the injection given at 16.25 was authorised by the consultant ; but the contemporaneous hospital records, and the evidence of the A and E doctor, the SHO and the consultant himself established that this was not so. Thirdly, on this incorrect assumption, the AHA said that they understood that the consultant's arrival was not later than 16.25 ; the evidence is clearly to the contrary. In these respects the AHA's letter of 11 December was inaccurate and I uphold this complaint. I criticise the AHA for their failure to enquire adequately into these matters before replying to the complainant.

24. The complainant complained to the AHA because she believed that there had been an unreasonable delay before pain relief was provided for her husband and before the consultant attended him. She knew that the consultant had not been present in the A and E department at 16.25 and, she was told that he had prescribed the first injection, she understandably did not believe that it was given at 16.25. I am satisfied, however, from the evidence, taken separately, of four members of staff and from contemporaneous records, that it was administered by the sister at that time.

25. As to the time of arrival of the consultant, the evidence is conflicting. The complainant said that he had not arrived when she made a number of telephone calls which, she believed, took place after 18.00 or even 19.00. The evidence I obtained about the times of the calls was, I am sure, based on the genuine recollections of those who gave them. It is not surprising that neither the complainant nor those to whom she spoke had noted the times when the calls were made. I have not been able to establish when the complainant made the telephone calls nor exactly what was said. But although I have not been able to establish the time of arrival of the consultant in the A and E department, the evidence of the other doctors and that of the contemporaneous hospital records (compiled long before the complainant complained) that the complainant's husband arrived on the ward at 18.00 leads me to believe that the consultant cannot have arrived much after 17.30. And I have had no evidence to suggest that the time of his arrival was influenced in any way by the complainant's decision that her husband should be treated privately.

26. I have the utmost sympathy for the complainant in the tragic death of her husband and I hope that she will derive some comfort from the results of my investigation which have shown that there were not the delays that she believed had occurred in providing relief and care for him.

27. I believe, however, that some of her natural distress would have been assuaged had the AHA not misled her, as I have pointed out in paragraph 23 of my report. The Health Authority, who are the relevant successors to the AHA, have told me that they will be writing to the complainant shortly to apologise for that failure.

Case No. W.378/80-81—Conflicting information given to husband about wife's hospital treatment

Complaint and background

1. On 15 April 1980 the complainant's wife, aged 69, was admitted to hospital (the hospital) where she died on 19 April. The complainant contends that:

(*a*) he was given conflicting information about why his wife had been admitted to hospital ;

(*b*) the account and timing of events leading up to his wife's death given by the Area Health Authority (the AHA) differs greatly from his own ; and

(*c*) the AHA refused to arrange a meeting for him to discuss his complaint with any of the medical staff at the hospital.

Investigation

2. During the investigation I obtained the written comments of the AHA and examined the relevant documents, including the medical and nursing notes. One of my officers interviewed members of staff concerned in the complaint and she also met the complainant and his daughter. I am not empowered to look into decisions taken solely in the exercise of clinical judgment and I refer to the medical management of the wife's condition only insofar as it is necessary to set the complaint in context.

(*a*) *The complaint about the conflicting reasons given for his wife's admission*

3. In his correspondence with the AHA and in his interview with my officer the complainant said that his wife, who had been an invalid for eight years with severe arthritis, developed shingles early in 1980. Her family practitioner prescribed pain killing drugs for this condition and she also was visited at home by a consultant physician from the hospital (the consultant). The family practitioner tried to arrange for her admission to the hospital on 7 April and she was eventually admitted on 15 April. The complainant visited his wife that evening and spoke to the ward sister (the sister) who told him that his wife was receiving treatment for the after-effects of shingles. His wife suffered a heart attack on 17 April and died on 19 April. He write to 'the Medical Administrator' of the hospital on 21 May complaining about the lack of treatment for his wife and received a reply from the consultant dated 23 May which included the statement that the admitting doctor on 15 April diagnosed that she had suffered a heart attack. The complainant wrote to the consultant on 8 June querying the conflicting information he had been given about the reasons for his wife's admission and he also brought this matter up at a meeting arranged for him to discuss his complaints with the sector administrator (the SA) and the sister on 25 June. He said that the sister had once again confirmed that his wife had been admitted for treatment for the after-effects of shingles. He

was not satisfied with the outcome of this meeting and approached the Community Health Council (the CHC) who put his complaints to the AHA, but he still did not receive any explanation of the conflicting information he had been given.

4. The consultant told my officer that he had been treating the complainant's wife for a number of ailments for several years. He made a domicilary visit to her on 2 April 1980 because she had been confined to bed with right-sided chest pain. He learnt that she had recently suffered an attack of shingles, diagnosed the pain as post herpetic neuralgia and decided that her admission to hospital was unnecessary. He then went on annual leave ; on his return, he learnt of her death and was given the complainant's letter of complaint. He replied to him on the information he obtained from the wife's medical notes and from the medical and nursing staff who had cared for her. He said that, on re-reading his reply, he realised that he had unintentionally misled the complainant into thinking that his wife had been admitted to hospital because she had suffered a heart attack and he apologised for this mistake. The medical notes clearly showed that the admitting doctor's diagnosis agreed with the diagnosis he had made on his domiciliary visit. He said that he had not, at any time, been asked by the SA about the conflicting reasons given for the wife's admission to hospital.

5. In an interview with my officer, the SA said that he had been satisfied with the replies he had given the complainant at the meeting on 25 June. He had seen no reason to try to resolve the conflicting information given to the complainant for his wife's admission to hospital as she could have had a heart attack before her admission and her admission would thus have been because of both a heart attack and post herpetic neuralgia.

6. The sister confirmed that she attended the meeting with the SA and the complainant on 25 June although she left before it ended. The SA, she said, had assured the complainant that his wife had been admitted because she had a heart attack. She had immediately corrected the SA and told him that the complainant's wife had been admitted because of the pain she was suffering following an attack of shingles.

Findings

7. The complainant was given conflicting information about the reason for his wife's admission to hospital and the AHA, despite his continued protestations and the clear evidence available as to why she was admitted, made no effort to resolve the conflict. I uphold this complaint.

(b) *The complaint about the differences in the account of events leading up to his wife's death*

8. The complainant told my officer that he received a telephone call from the hospital at about 11 am on Thursday 17 April and was told that his wife had suffered a heart attack. He went immediately to the hospital and found his wife semi-conscious ; she could not move but she appeared to understand what was said to her. A doctor came to examine her at about noon

but she was not examined again by the medical staff. The nurses turned her on alternate sides to relieve her pressure areas and took her pulse regularly on 17 April but not thereafter ; further, his wife was not given any drugs or anything to drink from the afternoon of 17 April until the evening of 18 April. He remained with her through the night of 17/18 April ; his daughter joined him in the morning and they took turns to stay by her bedside. He said that the curtains were drawn around the bed for much of the time but either he or his daughter remained inside them. At about 2 pm on 18 April he saw three doctors in the ward sister's office and one of them approached him and told him that his wife had only a few hours to live. But, the complainant said, none of the doctors examined his wife or came near her. His daughter remained by her mother's bedside throughout that night and he himself returned to the hospital at 5 am on the Saturday morning (19 April) and was told by his daughter that no one had been to see his wife. He asked to see a doctor ; and the doctor who came told him that his wife could not be given any treatment because they did not know whether she had an embolism or had suffered a heart attack. The doctor told him they would have to wait for the results of blood tests, which would take about a week, before they could confirm the diagnosis. He then told the doctor that he was concerned that his wife had not been given anything to drink for two days. The doctor left but returned shortly afterwards to set up a drip for the complainant's wife. He and his daughter left the hospital when the drip was being set up and he went home to have a meal and to change his clothes. And while he was there the hospital telephoned to tell him that his wife had died.

9. The complainant said that in his letter to the 'Medical Administrator' he complained that his wife had not been given any treatment from after her heart attack on 17 April until the morning of 19 April—and then only at his insistence ; and at his meeting with the SA and the sister on 25 June he had complained, too, that his wife had been given nothing to drink for two days. He did not accept the sister's reply that a drink could not have been given to his wife because she had difficulty in swallowing but her lips had been damped regularly ; or that he would have been unaware of this because the relatives had been asked to leave when nursing procedures were carried out and the curtains had been drawn round the patient's bed. When the CHC put his complaints to the AHA, the content of their reply, which was recounted to him in a letter from the CHC Secretary dated 1 August 1980, was contrary to his knowledge of what had taken place prior to his wife's death. The reply stated that he was informed by a doctor of possible diagnoses of his wife's condtion on 18 April ; that she went into cardiogenic shock and a drip was set up the same day ; that she was seen by members of the medical staff on 16, 17 and 18 April ; and that the complainant would not have been aware whether or not his wife was given anything to drink as the nursing procedures were carried out with curtains drawn round the patient's bed. The CHC wrote again to the AHA on 1 and 5 August asking for the discrepancies which he had pointed out to be resolved. But, in a reply dated 20 October, the senior administrative assistant (the SAA) said that the complaint had been discussed with the consultant and it was considered that the reply already given 'explained the situation quite cor-

rectly ' and that nothing further could be done except to assure him that it was ' felt by all persons concerned that everything possible was done for the wife whilst she was with us at [the hospital] '.

10. The complainant's daughter told my officer that when she visited her mother on the evening of Thursday 17 April, her father told her about her mother's heart attack. She left her mother's bedside for only about one hour during Thursday night and a further hour during Friday ; otherwise she remained constantly with her mother until shortly before she died on 19 April. Initially she and her father were asked to move away from the bedside when nursing procedures were taking place and the curtains were half drawn ; but she had been able to see through the gap in the curtains what the nurses were doing to her mother and no drugs or drinks had been given to her. However, as time went on the nursing staff accepted their presence and they were allowed to remain by her bed while the nursing staff were carrying out their duties—ie turning her mother at about three hourly intervals and washing her. She said they appeared to be much more concerned with keeping her mother clean than with giving her treatment to try to save her life. She added that her mother was not given anything to drink from Thursday evening until Friday evening when, with the help of one of the nurses, she had managed to give her mother a little to drink from a feeding cup.

11. A senior house officer (the first SHO) told my officer that he had examined the complainant's wife on 16 April and again on 17 April after she had suffered an attack which he had diagnosed as either a heart attack or pulmonary embolism and he had ordered cardiac enzyme tests to be carried out to establish her condition. The tests, he explained, were carried out at another hospital and it took three to four days to get the results but meanwhile the treatment for both conditions was the same—ie monitoring the patient closely, prescribing pain killers and giving oxygen if necessary. He said that he would have examined her again during his morning ward round on 18 April and that later he had discussed with the complainant the two possible diagnoses of his wife's condition He told him that her condition was critical and there was a possibility she might die. However he did not, he said, indicate that she had only a short time to live.

12. Another senior house officer (the second SHO) told my officer that he had admitted the complainant's wife to the hospital on 15 April and that he had been duty doctor on 19 April. He was asked by a nurse to speak to the complainant early on the morning of 19 April but, before speaking to him, he carried out a routine examination of the complainant's wife and learnt from the medical notes of the attack she had suffered on 17 April and of her rapidly deteriorating condition. He discussed with the complainant the treatment being given to his wife and her poor prognosis but he did not remember being told by him that his wife had not been given anything to drink for two days. He had then left the ward but had returned later to find that her condition had deteriorated further. He had therefore set up a drip which included a drug used in cases of heart failure. Shortly afterwards, however, she suffered a cardiac arrest and failed to respond to resuscitation.

13. The medical notes for 18 April refer to the complainant's wife going into cardiogenic shock and a drip being set up. But the handwriting and the nib recording the date are different from those recording the note itself. My officer showed the medical notes to both the SHOs. The first SHO said that he had entered in the notes the date of 18 April but had not written anything against it. The second SHO said that he had incorrectly recorded against the date of 18 April that the complainant's wife had gone into cardiogenic shock and that resuscitation procedures were started. These events in fact occurred on 19 April. He said that he had not been on duty on 18 April.

14. The sister told my officer that she was not on duty when the complainant's wife suffered her attack on 17 April. When she returned to duty on 18 April she found a marked deterioration in the wife's condition and the first SHO told her that the patient had had either a myocardial infarction or a pulmonary embolism. She could not remember whether the first SHO examined the complainant's wife that day but she thought it unlikely as he had carried out a thorough examination the previous day when the wife collapsed. The complainant's wife had been only semi-conscious and was unable to take drugs orally and the sister recalled that the first SHO and two other doctors had discussed her case in the ward office during the afternoon of 18 April. She had asked them what treatment should be given to her and also if they had any instructions about her nursing care. She was told that in view of the patient's condition due to her arthritis and the stroke, they did not feel that any more could be done for her until a positive diagnosis was made.

15. The sister said that the complainant and members of his family remained by the patient's bed for most of the day but as the curtains were drawn around the bed and the family were 'popping in and out' she could not say that someone had remained with her constantly. The relatives *would* however, have been asked to leave while nursing care was given. She said that, although she had not seen it done, she was sure that the nurses had conscientiously carried out the nursing care for the complainant's wife which would have included washing her mouth with glycerine and, as she was not taking fluids, dabbing her lips with water. Other members of the nursing staff interviewed by my officer confirmed that relatives would have been asked to leave while nursing care was given ; they also confirmed that the oral hygiene and other care described by the sister would have been carried out. The nursing and medical notes record that two hourly care was given to the complainant's wife and that, although no drugs were administered orally after 17 April, because she was having difficulty in swallowing, a drug to relieve pain was given to her intra-muscularly at 11.15 am and 5.30 pm on 17 April and at 11.30 am and 8.05 pm on 18 April. The nursing notes also show that a drip was set up on 19 April and that she died at 10.25 am on that day.

16. The SA told my officer that he had been unaware (until my officer pointed it out to him) that the account of events, which was based on information provided by him to the CHC Secretary, was incorrect and that the events he had described as taking place on 18 April had in fact occurred on

19 April. He had made no attempt to resolve the discrepancy between his own and the complainant's version of events because he was satisfied at the time that the information he had given was correct. The SAA told my officer that she had not seen the medical and nursing notes when she provided the information included in the CHC's letter to the complainant of 1 August (see paragraph 9). Later, however, before replying to further correspondence from the complainant she had looked at the notes but had failed to realise that the entry in the medical notes for 19 April bore an incorrect date.

Findings

17. The treatment given for the complainant's wife's condition is a matter of clinical assessment on which I cannot comment. But my investigation has shown that drugs originally given orally were discontinued after her 'heart attack' but that other drugs to ease her pain were administered by injection twice daily on 17 and 18 April; further, it seems that it was considered by the doctors that little more could be done except to observe her and keep her as comfortable as possible until the results of the tests carried out on 17 April were known. There is conflict between the complainant and the nursing staff about the adequacy of the care provided for her. But the contemporaneous records indicate that the only care considered appropriate for her—to keep her as comfortable as possible—was, in fact, given. I do not believe that her basic needs were disregarded.

18. I am not surprised, however, that the complainant was uneasy about his wife's treatment. He was given information by the AHA which was wrong and which he knew to be wrong; and I think he was right to bring his complaint to my attention. The AHA made no attempt to investigate thoroughly his representations, although even a cursory look at the clinical notes would have demonstrated that their response was inaccurate. But they obdurately held to their view. I think this is deserving of criticism. The complainant was subjected to unnecessary extra anxiety and worry because of the slipshod handling of his complaint by the AHA. I uphold this complaint.

(c) *The complaint about the refusal to arrange a meeting with any of the medical staff*

19. The complainant in a letter forwarded to the AHA by the CHC dated 10 August 1980, expressed his willingness to meet any of the medical staff involved in his wife's care to discuss his complaints. However the SAA replied on 20 October 1980 that the consultant did not think there would be any worthwhile reason to have a meeting as the situation in regard to his wife's care had been explained 'quite correctly'.

20. The consultant told my officer that he would normally consider himself responsible for investigating complaints involving members of his staff and, if necessary, for meeting the complainant to discuss the complaint. However, because the consultant was on leave at the material time, the complainant, in a letter dated 8 June 1980 had rejected his attempt to answer the complaints. He had therefore passed the correspondence to the hospital admini-

stration and refused to have anything further to do with it. He had later been asked by the SAA if he would meet the complainant but he refused to do so as the complainant had already made it clear that he would take no notice of what he said; he therefore saw no point in meeting him. (In fact what the complainant said in his letter of 8 June was: 'I did not ask for or expect a personal explanation from you, it being quite obvious to me that you were not at [the hospital] on the dates in question'.)

21. The SAA told my officer that she had tried to arrange for the complainant to meet the consultant to discuss his complaint but the consultant had refused to agree to this. She had also spoken to the SA but he also refused to arrange a meeting because, he said, there had already been one and in his opinion he had answered the complaints satisfactorily and a further meeting with the medical staff involved would be therefore 'a waste of time'. The SA confirmed this to my officer and said he thought nothing would have been gained by such a meeting.

Findings

22. I know that explanations given by medical staff often put at rest the minds of complainants, particularly the recently bereaved. It is not disputed that a meeting was refused in this case and this refusal, I find, amounted to a substantial failure of service to the complainant. I consider that it was most unfortunate that, unusually, a meeting was not arranged. For had it taken place, the true reason for the patient's admission and the error of date in the medical notes would probably have been revealed and the way would then have been open for an acceptable response to be made to the complainant. I uphold this complaint.

Conclusion

23. I have set out my findings in paragraphs 7, 17-18 and 22 and I uphold all the aspects of this complaint. I have every sympathy for the complainant who, in addition to the distress caused by his wife's death, suffered further avoidable distress because of the inept handling of his complaint by the AHA.

The health authority, who on 1 April 1982 became the relevant successor to the AHA, have told me that they will be writing to the complainant shortly to apologise for the shortcomings to which I have drawn attention in my report.

Case No. W.414/80-81—Fatal accident to patient following discharge from hospital

Complaint and Background

1. On 18 January 1980 the complainant's brother was discharged from hospital where he had been treated for depression. About four hours later, he was involved in a road traffic accident and received injuries from which he died.

2. The complainant contends that:—

(*a*) records concerning his brother's earlier suicide attempts were not made available to the consultant (' the consultant ') treating him ;

(*b*) reports made to hospital staff by him and by his cousins (Mr. and Mrs.——] about his brother's stated intention to commit suicide were not brought to the attention of medical staff responsible for his brother's discharge from hospital ;

(*c*) insufficient account was taken of the home circumstances into which his brother was to be discharged ; and

(*d*) he was not satisfied with the response to his complaints put by his solicitor (the solicitor) to the Area Health Authority (' the AHA ').

Investigation

3. During the investigation, I obtained the written comments of the AHA and examined the relevant documents. My officers interviewed members of the medical, nursing and administrative staff of the AHA concerned ; they also met the complainant and his cousin [Mr. —].

(*a*) *The complaint about the availability of the earlier medical records*

4. The complainant told my officer that at the coroner's inquest held on 19 February into his brother's death, the solicitor had asked the consultant why it had been thought appropriate to discharge a man with a record of suicide attempts to an empty house. The consultant had replied ' I have no knowledge of any previous suicide attempts '. His solicitor had then asked the consultant to read out the entries in his brother's medical records relating to a suicide attempt in 1977 and the consultant had said ' I haven't read through the file '.

5. I obtained a copy of the coroner's notes of evidence of the inquest ; this confirms that the consultant said that he had not seen any records of attempted suicide in the patient's medical notes but there is no reference to the consultant saying that he had not read the medical records.

6. The consultant told my officer that he *had* read through the medical records and, although he had not seen any reference to suicide attempts in them, there was reference to suicidal *tendencies*. There was, he said, a clinical difference between threats of suicide and actual attempts to commit suicide. In this case there was, so far as he was aware, no record of the latter ; the overdose taken by the patient in 1977 could not in his opinion be considered a suicide attempt but merely as an act to draw attention to himself. Unless the person concerned left a suicide note, it was difficult to determine whether any suicide attempt was more than a display of suicidal tendencies. The consultant agreed that the evidence he gave at the inquest about this might have been misleading and that perhaps he should have made clear the distinction between suicide attempts and suicidal tendencies.

Findings

7. In his evidence to me the consultant said that he saw the clinical notes and he explained why, in his clinical judgment, which I cannot question, he told the coroner that he had not seen any reference in them to an attempted suicide. I do not therefore uphold this complaint. But I am not surprised that the complainant made this complaint to me because not every layman could reasonably be expected to appreciate the clinical distinction drawn by the consultant without explanation.

(b) The complaint that his brother's suicide threats were not reported to the medical staff

8. The complainant told my officer that his brother had been given leave to spend the Christmas period of 1979 at home and during this time he continually threatened to commit suicide. The complainant went with his brother when he returned to the hospital on 27 December and reported these threats to the registrar ('the registrar') and an arrangement was made for him to see the registrar the next day. At this meeting, with his brother present, the complainant again told the registrar about the suicide threats; the registrar asked his brother why he wanted to kill himself and the brother had explained what was worrying him. The complainant said that he himself had then gone through the alleged causes of his brother's depression and had shown that they were groundless. He told the registrar that his brother's condition had deteriorated while in hospital and warned him not to allow his brother to go out into the grounds unaccompanied. The registrar told him that his brother had not made any suicide threats to the hospital staff. The complainant replied that this was a repetition of what had happened in 1977: his brother had threatened suicide to him, but to no one else and the hospital staff had disbelieved him. However on that occasion his brother had demonstrated that he was telling him the truth by taking an overdose of drugs. Going back to the 1979/80 episode he said that he visited his brother on 4 January: his brother once more threatened suicide and the complainant again reported this to the registrar and the nursing staff; but he was greeted with 'disbelieving smirks' and told that his brother had not made such threats to them. The nurses told him however that they would note his reports in the nursing record.

9. The complainant said that his cousins [Mr and Mrs ——] visited his brother on Saturday 12 January and went with him for a walk in the hospital grounds. His brother told them that he had been told the doctors had done everything they could for him; that he was to be turned out of his present ward and locked up behind bars in the old part of the hospital for the rest of his life; and that he would rather kill himself than suffer this. Mr and Mrs —— had been very disturbed by his behaviour and had reported to the nursing staff what he had told them. The following day the complainant had visited his brother who, during a walk around the grounds, had repeated to him the story about his transfer and also said that he wanted to throw himself under a train or lorry. The complainant had returned to the ward immediately with his brother and had spoken to the nurse in charge of the ward when it was confirmed that his brother was to be discharged from the

hospital on 18 January. He had protested and said that his brother was still making threats of suicide; he had demanded to see the duty doctor (the SHO) who told him that the decision to discharge his brother had been taken in the full knowledge of his previous medical history.

10. My officer was unable to interview Mrs —— as she had died, but she spoke to Mr ——. He said that he and his wife had visited the complainant's brother on 12 January and found him walking in the hospital grounds. He had seemed to be rational but had then told them that he felt like throwing himself under a car or lorry. He and his wife did not know whether they should take these threats seriously but his wife was worried that he was being discharged while still making such threats and she wanted to ensure that the hospital staff were aware of them. Accordingly, on their return to the ward, his wife had spoken to one of the nursing staff and afterwards had told him (Mr ——) that, although she was not convinced that their cousin was well enough for discharge, which they understood was to be on the following Friday, she was satisfied with the arrangements made for it.

11. The solicitor, in a letter to the Community Health Council (the CHC), which was passed to the AHA, asked whether the emphatic statements of intention to commit suicide by the patient made to his cousins on 12 January and to the complainant on 13 January were reported at the ward round on 17 January, and, if so, why the staff still persisted with the discharge.

12. The AHA, basing their reply to me on this complaint on information provided by the consultant, said that there were 'reports in the notes concerning comments made by [the complainant] about [his brother's] behaviour'. The consultant told my officers that the information he had provided related to earlier entries in the medical records and that he had not been aware of any reports made by the cousins or the complainant on 12 and 13 January. He further said that the decision to discharge the patient was taken at the weekly ward round meeting on 9 January, attended by the available doctors and ward staff. If reports of suicide threats had subsequently been received, he would expect them to have been recorded and they would have been considered at the next ward round meeting on 16 January when the discharge was confirmed for 18 January. The consultant said that he had taken the decision to discharge the complainant's brother and treat him as an out-patient.

13. The registrar told my officers that he had spoken to the complainant and his brother together on the patient's return from Christmas leave and the complainant had told him of his brother's threats to his life. He had asked the brother if he wanted to commit suicide and the brother had denied it. He said that other reports made by the complainant of his brother's threats to him and the nursing staff had been discussed at the weekly ward round meetings; it was 'ridiculous' to think that they would have been omitted and therefore the consultant would have been aware of them. The registrar said that he was on leave from 4-21 January and had not therefore been present at the ward round meetings of 9 January when the decision to discharge the patient was taken and 16 January when it was confirmed.

14. The SHO told my officer that she had not been concerned with treatment of the patient until the registrar went on leave on 4 January. She was on duty on 12 and 13 January but she received no reports from the staff about threats of suicide made by the patient to his cousins or the complainant. On 13 January the nurse in charge of the ward had asked her to come to speak to the complainant who was concerned about his brother's discharge but when she arrived the complainant had said that he had to leave immediately to catch a bus and she had therefore had very little discussion with him. The SHO said that until she re-read the clinical notes during my investigation she had been unaware of the suicide attempt in 1977. The patient had not made any threats of suicide to her and neither the registrar nor the complainant had mentioned them.

15. The charge nurse of the ward told my officer that the patient had never made any direct threats of suicide to him although he had said that he saw little reason to continue living as there was not much left in life for him and that he might as well stay in hospital. The charge nurse had spoken to the complainant on several occasions when he visited his brother but he had not reported to him any suicide threats by his brother. If such threats were reported to the nursing staff they were recorded in the nursing kardex.

16. My officer interviewed the nurse in charge of the ward on 13 January and to whom the complainant had spoken. He said that he remembered little of his conversation with the complainant and his brother on that day but he recalled that the complainant had told him that his brother had just said that 'he was going to go and throw himself under a car'. He had questioned the patient about this but he had denied it and said that he had just been talking generally about the cars on the road passing the hospital. He said that he would have reported the conversation to the medical staff at the shift handover.

17. My officer was unable to identify the nurse to whom the cousin [Mrs. ———] spoke on 12 January but a student nurse told her that the complainant had reported suicide threats to her on 16 December and she had recorded this in the nursing report. Another student nurse remembered that when the patient returned from Christmas leave, his brother had said that he had threatened to kill himself with a carving knife. Many of the nurses interviewed told my officer that if suicide threats had been reported to them they would have recorded the information in the nursing report.

18. Entries made on 7 and 16 December in the nursing report record the complainant's concern that his brother might attempt suicide. The admission notes of 7 December say: 'that for the last two days often expressed suicidal thoughts'; and the registrar recorded in the medical notes his discussions with the complainant of 27 and 28 December when threats were also mentioned. There is no reference in any record to the reports made by Mrs. ——— or the complainant on 12 and 13 January.

Findings

19. There were references in the medical records on 7, 16, 27 and 28 December to suicide threats and the information was thus available to the

medical staff when the decision to discharge the complainant's brother was taken on 9 January. But this complaint concerns threats which were alleged to have been reported to the staff on 12 and 13 January—and which I am satisfied were made. These reports *might* have been very relevant to the confirmation on 16 January of the discharge decision, yet the consultant and the SHO, the doctors concerned with the patient's care, were unaware of them. I uphold this complaint and recommend that the AHA should ensure that all such reports are recorded in future.

(c) *The complaint that insufficient account was taken of the home circumstances*

20. The complainant told my officer that when he spoke to the nurse in charge of the ward on 13 January and the SHO about the decision to discharge his brother on 18 January, he reminded them that he worked in London and that therefore his brother would be alone in their house for eleven hours each weekday. He was told that this had been taken into consideration and that his brother would be discharged at the same time as he had been at Christmas i.e. at about 4–4.30 pm. Accordingly he had arranged to leave his work early so that he would be home by 5.30 pm to meet his brother. But he learned later that his brother had been discharged at 11 am. His cousin [Mr. ——] told my officer that his wife had also been assured by one of the nursing staff that the patient would not be discharged until the late afternoon when the complainant was home from work.

21. The consultant, when he commented to the AHA, on this complaint, said 'a full and proper account was taken of the home circumstances into which he was discharged'. He told my officers that if he or his staff had thought that the patient should not go home until his brother had returned from work they could have taken steps to prevent it, but it was not considered necessary to delay his discharge. The nursing report for 27 December recorded the decisions taken at the ward round meeting that day: it included 'contact S/W department social report, what's happening at home'. The consultant could not remember whether any action was taken on this and I was told by the sector administrator (the SA) that there was no record of any social report concerning the patient in this connection either at the hospital or the local authority social services department.

22. When interviewed the nursing staff told my officer that it was well known that the complainant's brother would have been at home by himself when the complainant was at work but none of them remembered being asked by the complainant to keep his brother at the hospital until late afternoon. A social worker attached to the ward said that patients were usually discharged on Fridays after the ward community meeting held each morning. She did not know if the complainant had asked for his brother's discharge to be delayed but this would not have presented any difficulty; patients sometimes remained in the hospital until the evening when relatives collected them after they had finished work. The social worker said that she had been on leave

on 27 December when it was decided to obtain a social report; this was not mentioned to her on her return and as far as she knew a report was not prepared.

23. The SHO told my officer that the complainant did not discuss with her the timing of his brother's discharge and the nurse to whom the complainant also spoke on 13 January could not recall any mention of it.

Findings

24. Whether or not the complainant asked for his brother to be discharged late in the afternoon or whether he assumed that the arrangement which pertained when he went home for Christmas leave would do so again I do not know. But from the evidence I am satisfied that the decisions to discharge his brother, and that no special arrangements were required, were taken in the full knowledge of the home circumstances. I do not therefore uphold this complaint.

(d) *The complaint about the AHA's response to the complaints*

25. The solicitor wrote to the CHC on 10 April 1980 that his client was concerned that the consultant had told the coroner that he was not aware of the previous suicide attempt in 1977 and asked whether the reports of suicide threats made by the cousins and the complainant had been reported at the next ward round meeting. He enclosed a copy of the witness statement which his client had provided for the coroner. The CHC forwarded the correspondence to the health district. The district administrator (the DA) replied on 6 June reporting the consultant's view that, as the coroner had been in possession of all the facts at the inquest and when recording an open verdict had made no comment on the treatment provided for the complainant's brother at the hospital, he did not consider that he could respond in any further detail to the complaints made. The DA said that in the circumstances it would be difficult for the AHA to carry out any further investigation of the case. The complainant was not satisfied with this reply and his solicitor wrote to the CHC on 1 July expressing his dissatisfaction. The CHC in a letter dated 16 October told the solicitor that the DA had suggested that the complainant should meet the consultant to discuss his complaints. The solicitor replied on 24 October that the complainant was willing to meet the consultant but not until a detailed written reply to the complaints had been received. Nothing further was heard from the health district and on 9 December 1980 the complainant's Member of Parliament (the Member) wrote to the DA expressing the opinion that it was not unreasonable of the complainant to ask for 'at least preliminary replies' before meeting the consultant. The DA told the Member on 21 January 1981 'I really feel that this matter can only be progressed by reiterating the offer that [the consultant] has already made . . . to talk to [the complainant] and/or his solicitor at a venue of their choice'. The complainant's solicitor then wrote to me.

26. The SA told my officers that complaints sent to the health district involving hospitals with which he was concerned were normally forwarded to him for investigation although the reply would be sent by the DA. The consultant had told him that the complainant had been given the chance to make any complaints at the coroner's inquest and therefore, as the coroner had received all the facts relating to the case, nothing further need be said on the matter. Later, when the complainant had pressed for a written reply to his complaints, he had again spoken to the consultant who had remained adamant that he would not provide a written reply, although he had agreed to meet the complainant to discuss his complaints.

27. The assistant district administrator (the ADA) told my officers that he met the consultant with the SA after the letter from the CHC was received expressing the complainant's dissatisfaction with the DA's initial reply. He had tried to explain to the consultant the distinction between evidence given at an inquest to help the coroner determine the cause and circumstances of a death and enquiries made by a health authority into the care and treatment provided for the patient in hospital before the death. However the consultant insisted that the two were related and he would not make a written statement about anything which he considered to be within the coroner's jurisdiction. He was surprised when the consultant had agreed to meet the complainant to discuss his complaints as, in his opinion, there was little difference between answering the complaints orally and in a written reply. The ADA said that as the complaints related primarily to clinical matters he himself could not reply adequately to them.

28. The DA told my officers that although the coroner's duty was to determine the cause of death, he commented in some cases on factors contributing to a death or to measures which could be taken to prevent deaths in similar circumstances. In this case, the Coroner had chosen to make no comment even though he had the complainant's statement which included his complaints, and the complainant was present at the inquest to give evidence. He therefore considered that the consultant's reluctance to make any further comment was an appropriate response and that his (the DA's) reply to the CHC dated 6 June was adequate. Following the receipt of a further letter from the CHC, the consultant agreed to meet the complainant to discuss his complaints and, the DA said, he had been satisfied with this conciliatory move by the consultant as he believed that the complainant was more likely to be reassured by a discussion than by a written reply to his complaints. Following the Member's intervention in December the DA wrote to the consultant and told him that unless some response was made to the solicitor there was a possibility that legal action would be taken against the health authority. He said he hoped, therefore, that 'you will after consultation with your defence organisation if it seems appropriate, be able to let me have some brief reply to the solicitor's enquiries'.

29. When the CHC passed the complaint to the health district they sent a copy to the AHA. The area administrator ('the AA') told the DA that the area medical officer (the AMO) had asked to see the draft of the reply. The draft was sent to the AA who advised the DA that, with only a minor

alteration, it was agreed. The AA, who has since retired, told my officers that it appeared from a newspaper report on the inquest that the complaints had been brought to the attention of the coroner but that he had made no criticism of the AHA. As it seemed that the coroner had dealt with the complaints the AA had agreed with the DA's reply—that the AHA could not comment further. He also said there could have been difficulties if the AHA had carried out further enquiries into the complaints because, since the coroner had opened an inquest into the death, any new evidence which came to light would have had to be passed to him ; and the findings on the new evidence would be a matter for the coroner and not the AHA. The AMO said that the complaints, although not clearly set out, were in the statement the complainant provided for the coroner and he too had thought, at the time, that they had been dealt with by the coroner. The AA and the AMO stressed to my officers that they were not further involved ; they had not known that the complainant was not satisfied with the reply to which they had agreed and the AMO's assistance was not sought, as would have been the usual practice, to try to persuade the consultant to help provide a written reply.

30. The consultant said that although the coroner had not permitted the complainant's solicitor to ask questions about his brother's treatment and had said that he was only concerned in determining the cause and circumstances of his death, the coroner had the statement written by the complainant and appeared satisfied with the evidence he (the consultant) gave and recorded an open verdict. The consultant said that he had not seen a copy of the transcript of the inquest proceedings and was not therefore prepared to provide a written reply to the complaints as his reply could inadvertently have contradicted what he had said at the inquest. Nor was he prepared to become embroiled in what could have become a protracted correspondence, which was not a satisfactory way of dealing with the matter ; but he did *offer* to meet the complainant to discuss his complaints. He thought that a meeting would provide a better chance of resolving the questions which had been raised.

Findings

31. I am not persuaded that the consultant's principal reason for refusing to provide a written reply to the complaints was that he might contradict what he had said at the coroner's inquest. I think it more likely that he and indeed officers of the AHA were confused about the exact functions of a coroner and thought that the complaints had been sufficiently dealt with at the inquest. It is the duty of a coroner's jury, or of the coroner himself if he sits without a jury, to determine at an inquest who the deceased was and how, when and where the deceased came to his death. He also has a right, under the Coroners Rules 1953, to attach a rider to his verdict, or that of the jury, if he considers it may prevent the recurrence of fatalities similar to that in respect of which the inquest is held. But whether or not he attaches a rider this does not prevent a health authority carrying out their own enquiries and I consider that it is their duty to do so if there is any

doubt about the service they have provided. I am surprised that the consultant and senior officers of the AHA were not aware of the scope and function of the coroner. The investigation of this complaint should not have been affected by the involvement of the coroner and the complainant had the right to expect a full reply to his complaint which he did not receive. I therefore uphold this complaint and cirticise the AHA for this failure, which I find constitutes maladministration.

Conclusion

32. I have set out my findings in paragraphs 7, 19, 24 and 31 of this report and have upheld two aspects of the complaint. The health authority, which is the relevant successor to the AHA have told me that they are reviewing their instructions to staff on the importance of recording in the medical and nursing records threats and reported threats of suicide made by patients. They have also asked me to convey their apologies to the complainant for the failures to which I have drawn attention in this report and this I gladly do.

Case No. W.535/80-81—Communication with wife about husband's illness

Background and complaint

1. A man, aged 44, was admitted to hospital on 12 February 1981 suffering from severe vomiting and pain. Despite extensive tests it proved impossible to diagnose his illness and he died on 24 February following an intra-abdominal haemorrhage resulting from the rupture of a hepatic artery aneurysm. His wife complained that:

(*a*) she asked repeatedly to speak to a doctor but was told by nursing staff either that the doctors were busy or that the nurses did not make appointments ;

(*b*) when she did voice her fears to a house officer (the HO) that her husband might be dying, the HO failed to reassure her on any point but said that her husband was not a terminal case and that she should not be morbid ;

(*c*) the attitude of a consultant surgeon (the consultant) at a meeting on 3 March, the day after her husband's funeral, distressed her ;

(*d*) she was given conflicting information by the consultant and a staff nurse about how her husband died ; and

(*e*) the replies of the acting area medical officer (the acting AMO) and the consultant to her complaint were unsatisfactory and she wondered why a reply from the consultant dated 30 March was postmarked 9 April, the day preliminary enquiries were made by one of my officers.

Investigation

2. During the investigation I obtained the comments of the Area Health Authority (the AHA) and saw the correspondence and medical and nursing notes. One of my officers, sometimes in the company of another, discussed

the complaint with members of the medical and nursing staff and evidence was also taken from the family practitioner (the FP). An officer also met the complainant and her sister.

(a) *Difficulty in seeing a doctor*

3. In written evidence and in discussion with my officer the complainant said that after her husband's admission to hospital she experienced great difficulty in seeing a doctor to talk about his illness. On 14 February, she discovered when visiting her husband, that he had been transferred to another ward. She asked a staff nurse in that ward three times if she could see a doctor but each time was told that they were too busy to be seen. But she knew from talking to her husband that he was in great pain and, accordingly, she persisted with her request until eventually she saw a senior house office (the SHO) at about 4.30 pm when she was told that the diagnosis was gastritis. She said that on later visits she repeatedly asked the nursing staff if she could speak to a doctor. On 18 February she was able to talk to the HO and asked her if she could see the consultant but, according to the complainant, the HO said that the consultant was too busy and could not be seen just like that. She continued to be worried about his condition and after the ward sister's return from holiday she asked her what was wrong with her husband. The sister replied that she had no information to give her and when the complainant asked to see a doctor she was told that none was available. The complainant mentioned that she had an appointment to see the consultant on 26 February and this prompted the sister to say that she could put her questions to him then. The complainant left the hospital feeling that her desperate concern for her husband was of no consequence to the sister, who appeared to regard her as a nuisance.

4. The consultant surgeon said that the complainant was seen by his registrar twice, once before he examined her husband on admission and once after his examination. The registrar telephoned the consultant at home because he was worried about the patient. They discussed the case but did not contemplate surgery. The nursing notes record that the patient was seen by the consultant on 13 February and the consultant told me that if he considered a patient's prognosis grave, he would make a point of seeing the relative himself. In his clinical judgment that was not the case here, although when he saw the patient on 24 February there had been a change in his condition and he had asked the nursing staff to invite the complainant to see him, because he was not sure of the diagnosis and was seeking a further opinion. But, the consultant said, in addition to the registrar the complainant was seen by the SHO and on two occasions by the HO while her husband was in hospital. The consultant said he found the nursing staff sympathetic towards relatives. Arrangements would normally be made for those relatives who were worried about a patient to see the consultant after his out-patients' clinic and shortly before her husband died the complainant was given such an appointment. If a relative urgently needed to see him his name was in the telephone book and he had in the past been telephoned at home by worried relatives. The standard procedure however was for a nurse

to arrange for the house surgeon to see the relative and if the case was complex the relative would then be referred to him. The consultant added that in an ideal world the doctor should be able to see a relative straight away but this was not always practical as junior doctors in his specialty might be busy in the operating theatre.

5. The SHO said he saw the complainant on 14 February after she spoke to the nursing staff about seeing a doctor. He spoke to her briefly and then examined her husband whom he had not seen before as he was off duty on 12 February. He intended to speak to the complainant again after the examination when he hoped he would be able to be rather more forthcoming. But the complainant was outside the curtains screening her husband's bed during the examination and she told him that because she had overheard his conversation with her husband she felt there was nothing more to learn. Nevertheless he tried to reassure her about her husband's gastritis which was, at that time, the provisional diagnosis. The HO confirmed that she saw the complainant twice, once when her husband was admitted and on another occasion when she saw her in the ward office. She also thought that an arrangement had been made for her to see the complainant on the day her husband died, after a request was passed on to her by the sister. She did not recall the complainant asking to speak to the consultant or saying that he was too busy.

6. The sister told my officer that she returned to work on 23 February after a holiday. On her return, and, as part of the nursing report on the patients, she was told of the complainant's constant approaches to nursing staff about her husband. The nurses had only been able to tell the complainant what she already knew, that there was no firm diagnosis ; and on a number of occasions they were awaiting the results of further tests. The sister formed the impression that her staff thought the complainant a difficult person because of her aggressive and persistent questioning. On 24 February the complainant came to see her on the ward and explained that she was not satisfied with the answers she had been given about her husband's condition. The sister thought she responded by saying she would make an appointment for the complainant to see the consultant and went herself to see the consultant's secretary (the secretary) and an appointment was made. She could not remember whether she let the complainant know of the appointment ; she certainly would not have said that a doctor was not available. She told my officer that she would have been particularly careful what she said being aware of the complainant's anxiety about her husband and her repeated and aggressive approaches. The sister added that all of the staff nurses on the ward had considerable experience and were regarded as skilled in their work. She could not envisage that they would try to put the complainant off ; and if it was junior staff whom she asked to let her see a doctor, they should have raised the matter with the staff nurse on duty.

7. The secretary could not recall the sister coming to see her although appointments were sometimes made in this way. But she remembered the complainant telephoning and making an appointment to see the consultant (for 26 February). She said that it came as no surprise when the complainant did not keep this appointment in view of her husband's death two days earlier.

8. My officers discussed the complaint with each of the three staff nurses who were on duty while the complainant's husband was a patient on the ward. The first staff nurse remembered speaking to the complainant several times when he tried to reassure her about the care her husband was receiving; he knew that she had asked to speak to a doctor but could not remember when these occasions were or whether she had put her request to him. The other two had only slight recollections of meeting the complainant but one of them remembered her anxiety about her husband's condition and wondered whether the complainant had spoken about seeing a doctor to junior nursing staff, who were perhaps less responsive than they should have been. All three were aware that the standard practice when a relative wished to speak to a doctor was that a house officer should be approached in the first instance.

Findings

9. The compainant's own contemporaneous notes show that she asked to see a doctor on numerous occasions between 12 February and her husband's death. She did in fact see junior doctors following his admission on 12 February and again on 14 and 18 February. But, by the latest of these dates, it should have been clear to the staff that she remained dissatisfied and I think that after that her requests should have been referred to the consultant. With hindsight it is a great pity that the HO did not suggest this (whether the complainant asked her or not) on 18 February. The sister believed that she contacted the consultant's secretary on 24 February to make an appointment; but in any event the complainant had by then done so herself. Although the consultant was never able to make a firm diagnosis of her husband's condition she would at least have had the satisfaction of being told the position by the surgeon responsible for his care. As it was, it seems likely that her approach, which the staff came to regard as persistent and sometimes aggressive, caused her to be regarded as a nuisance. I believe that there were occasions when she clearly expressed a wish to speak to a doctor but did not receive the co-operation that a relative is entitled to expect. I uphold this complaint.

(*b*) *Meeting with the HO*

10. The complainant said that when she saw the HO on 18 February she expressed her concern that her husband was seriously ill. The HO replied that they were investigating his gall bladder and were not thinking in terms of a terminal illness. The complainant alleged that the HO said her husband needed to 'smoke his pipe' and that she should not be morbid about his condition. She said that she felt very unhappy about the hospital's view of her husband's illness: if *she* could detect that he was seriously ill why was this not apparent to the medical staff at the hospital?

11. When she gave evidence to my officer the HO said she shared the complainant's concern, for the medical team were aware that they had no working diagnosis. She remembered the complainant telling her that she thought her husband was seriously ill and asking if he had cancer. The HO said she told the complainant that there was no evidence of cancer but

she did not say that her outlook was morbid, or that her husband should 'smoke his pipe'. She added that she was not jocular and was quite used to seeing relatives to discuss very serious illnesses as the surgical team frequently performed operations for cancer. She was not necessarily trying to reassure the complainant; her approach was simply to explain what they were doing for her husband. I have seen it recorded after his death that neither the medical nor the nursing staff had expected his condition to prove fatal. And the consultant frankly admitted that the medical staff had tried to be too re-assuring; this had stemmed directly from his failure to diagnose the patient's condition correctly.

Findings

12. I do not doubt that the HO was concerned about the complainant's husband even though neither she nor the other medical or the nursing staff shared the complainant's view that he was dying. Undoubtedly the staff offered more assurance than was justified. But in the face of conflicting evidence about whether the HO suggested to the complainant that she was being morbid I am not satisfied that this aspect of the complaint is made out.

(c) *Meeting with the consultant*

13. The complainant said that the consultant 'sent for' her after her husband's death. At their meeting on 3 March he appeared uncaring and seemed continually to be trying to justify himself. She felt there was a marked lack of sincerity. The interview lasted for more than half an hour during which time the consultant drew diagrams to explain her husband's illness, but she was uninterested as this had already been explained to her by the FP. The consultant told her he was shocked by the death but later remarked that 'we are all mortal, it can happen any time; your husband should have carried a heavy life insurance. I do myself'. The complainant said that nothing was said to prompt the consultant to comment about life insurance. It was tactless in the extreme and implied that she and her husband were at fault for not arranging their affairs better.

14. The complainant's sister was also present at the meeting with the consultant. She said the FP told her sister that the consultant wished to see her. It seemed to her unnecessary to go so soon after her brother-in-law's death and she wished she had cancelled the meeting. Her sister was very emotional on the day and might have upset the consultant by saying that should she become ill she would rather be treated by a vet. She could not recall the consultant expressing any sympathy for her sister's bereavement but he was not overbearing or blunt. Nevertheless, he appeared as an uncaring and remote person. It was, in her judgment, an appalling interview; they were clearly expected to listen to his comments and to ask no questions. When they did complain of the lack of communication he made excuses, pleading inadequate resources to provide an ideal service, and he insisted that he was always available, a comment she was unable to accept. The consultant's reference to life insurance came after her sister asked him what she was going to do without support and with a young

child to bring up. As she recalled it, he replied that young people died all the time and he had seen to it that there was adequate insurance cover for his family. The complainant's sister thought he was suggesting that her brother-in-law was lax in not having made similar arrangements.

15. The consultant remembered that he was due to see the complainant on 26 February and when she did not come he telephoned the FP and suggested that she might like to see him on a re-arranged date. The complainant then telephoned his secretary who made it quite clear that there was no need for her to see him if she preferred to leave it for a while. He certainly did not demand that the complainant should come to see him. The consultant said that when he met her he opened the conversation by expressing his sympathy for her loss: he said something to the effect that he was sorry they had to meet like this and that he was sorry to hear about her husband's death. He went on to explain the nature of her husband's illness and said that unfortunately there was nothing they could have done to save him. The complainant said that she was left with a young child and asked what his wife would do in these circumstances. The consultant told my officer that this happened to be a question to which he had given much thought in previous months because of the number of relatively young people admitted to the hospital who subsequently died of unpleasant diseases. He replied, in an attempt to be friendly, that he had no relatives to look after his wife and family and in the past week had arranged for life insurance. He then went on to explain how rare her husband's condition was but he was not allowed to finish. The consultant told my officer that the complainant's aggression during their meeting was not an unusual response from a bereaved person. He tried unsuccessfully to calm her but she terminated the meeting.

16. The outpatient clinic sister (the clinic sister) who was also present at the meeting said that the consultant had been upset over the patient's death, which occurred before the medical team were able to make a firm diagnosis. At the start of the meeting he said how very sorry he was about the death of her husband but his remarks were lost on the complainant and her sister who were both shouting at him. She remembered the meeting as an unpleasant episode where it appeared to her that the relatives had come for a fight; she did not know what could have been said that would have satisfied them. In her view the consultant was completely sympathetic and handled the meeting well. He had considerable experience in talking to relatives because of the number of serious operations he performed. He always got on very well with them and was known for making himself available to relatives. The consultant's comment on life insurance came about because the complainant kept asking how was she going to cope and bring up her son with no support. This led the consultant to remark, in an attempt to be soothing, that he had children of his own and had taken out life insurance. His comment brought forth no reaction from the complainant or her sister at the time.

17. The FP wrote to my Office to say that he did intend that the complainant should see the consultant as well as himself since the consultant would be in a much better position to explain the condition from which her

husband suffered. The consultant's secretary recalled that the complainant telephoned her and a meeting was arranged for 3 March. She remembered telling her that she should not come along if she did not feel well enough. The secretary told my officer that the consultant was to be away from 9–21 March. I have also noted that on 3 March the clinical notes were still with the pathologist who had undertaken the post-mortem examination and that by then the full report from him had not been received.

Findings

18. It was the FP's intention that the complainant should see the consultant and I am satisfied that the consultant and his secretary made it clear that the meeting was not compulsory. The recollections of the meeting held by the complainant and her sister differ considerably from those of the consultant and the clinic sister. I do not find this surprising: the complainant was still very upset and suffering from shock at her husband's death. She was not happy with his treatment and undoubtedly thought the consultant was at fault. In such a charged atmosphere, it is very easy for misunderstandings to occur. I believe that the consultant was sympathetic and strove hard to explain matters to the complainant at what was a difficult meeting. I am sure that this reference to life insurance was made out of a genuine feeling of concern for her misfortune and was unhappily misinterpreted by the complainant and her sister. However I think that perhaps the meeting was held too soon after her husband's death.

(d) *Alternative version of the patient's collapse*

19. The complainant said that she was caused considerable distress by being given two versions of how her husband died. A staff nurse told her that her husband was seen to be in difficulties in his bed and he was rushed to the intensive therapy unit where he died. A different explanation was given by the consultant at the meeting on 3 March when he said that her husband collapsed after walking to the ward desk, complaining of pain and died there.

20. The consultant said that because the clinical notes were still with the coroner's pathologist (paragraph 17) he had had to be briefed for the meeting. He admitted that he had mistakingly taken a reference to a male staff nurse 'being at the ward desk' to relate to the patient.

Findings

21. I accept that the different account given by the consultant arose from a misunderstanding on his part. But the mistake was the more regrettable since the thought of her husband collapsing at the ward desk caused the complainant additional anguish which could have been avoided had a clearer understanding of his collapse been obtained. The medical and nursing notes make it clear that he died in the circumstances described by the staff nurse. I uphold this complaint.

(e) *Replies to the complaint*

22. The complainant's sister wrote to the consultant on 9 March complaining of the way he conducted the meeting on 3 March and about her

brother-in-law's treatment; she copied the letter to the Area Medical Officer. The AMO replied on 11 March, acknowledging with sorrow her letter, and saying that he would leave it to the consultant to reply. The complainant meanwhile wrote to my Office on 16 March. The consultant replied direct to the complainant in a letter dated 30 March, but postmarked 9 April. On 9 April, too, following a second letter from the complainant to my Office, one of my officers telephoned the acting AMO (who had taken the place of the AMO in the interim) to make preliminary enquiries about the case. In his letter to the complainant, the consultant explained the findings of the post mortem report which indicated that her husband died of a very rare condition. He said he was sorry that she had had such a harrowing time during her husband's illness. And in a letter of 6 April to her sister the consultant acknowledged that the main point 'we fell down on' was his communication with the complainant and he pointed out that had he been able to make a diagnosis or thought that her husband was in any danger he would have seen her earlier.

23. The complainant was not satisfied with these replies; she felt that while they were apologetic they did not answer the complaints. She was also suspicious of the interval between the date on the consultant's letter and the postmark and wondered whether he was only prompted to write by my officer's enquiry.

24. The consultant could vaguely recall dealing with the correspondence and explained to my officer that he had delayed writing because he was on holiday and wished to see the post mortem report before responding. He wrote two or three drafts of his letter to the complainant and in his written comments to me explained that there was sometimes a delay between dictating a letter and signing it. The consultant also stated that he was never in touch with the acting AMO about the case and that the reply to the complainant had left his office before 9 April and certainly before he knew of my enquiries into the case. The acting AMO confirmed that he did not contact the consultant after my officer's enquiry, or at any other time.

25. The secretary remembered that the consultant was upset and hurt by the complaint, particularly when the complainant followed it up by sending him, through the area administrator, a copy of a newspaper article on medical ethics. She said that he gave much thought to his reply and after a couple of drafts decided he wanted to think about the letter she had typed for him before signing it. This explained the delay between the typing of the letter and its being sent; she said she would not normally alter the date on a letter having typed it. The secretary added that part of the delay in writing to the complainant was due to the consultant being away on leave between 9 and 21 March (paragraph 17).

Findings

26. The sister's complaint was addressed to the consultant and the AMO and the acting AMO were right to leave the reply to him. When the AMO received copies of the consultant's replies he wrote straight away to her and mentioned that she should not hesitate to write to him if she had any observa-

tions to make on the consultant's letters. The consultant's reply to the complainant is apologetic in tone although I find that it does not take up the point she raised about her brother-in-law's care or the alleged poor communication between junior medical staff and the complainant. To that limited extent this complaint is upheld. But I am entirely satisfied that the postmark was no more than a coincidence, albeit an unfortunate one ; and this misunderstanding would never have arisen had it been made clear, as it should have been, that the letter was signed several days after its dictation.

Conclusions

27. The complainant was unable to accept that her husband should have died in 'such awful agony'. She said she was told that by relieving the pain too much it would mask various tests but I have seen from the clinical notes that pain-relieving drugs were administered. The extent to which they were prescribed and the failure to diagnose her husband's condition are matters on which I cannot comment. But it may be of some small consolation for her to know that the consultant histopathologist stated in his post mortem report that '. . . the condition was so widespread with extensive dissections in at least twelve peripheral arteries, that even had the diagnosis been made before death I do not think a fatal outcome could have been averted'.

28. The complainant contended that as the patient's wife, she had the right to know what was wrong with him. The failure to tell her of course stemmed directly from the failure to diagnose. But even so I have concluded that communication between the doctors and the complainant was not as it should have been. In March 1980 the same AHA agreed to bring the circumstances of another case I investigated at the same hospital to the attention of staff in order to help them to improve communication with the relatives of patients. Different staff were involved here but I am pleased to report that the AHA's successor District Health Authority have agreed similarly to bring this case to the attention of staff. I sincerely hope that their efforts this time will mean that I do not have again to investigate a complaint about communications with relatives at this particular hospital. The District Health Authority have also asked me to convey their apologies to the complainant for the additional distress she suffered because of the failings I have identified ; this I gladly do adding at the same time my own sympathy with her at the tragic and unexpected death of her husband.

Case No. W.553/80–81—Nursing care given to elderly man admitted to a psychiatric hospital as a voluntary patient following a fire at home

Background and complaint

1. In April 1980 the complainant's father, aged 81, who was arthritic and lived with her, was admitted as a voluntary patient to ward 1 at hospital A following a fire which left their house unsuitable for him to stay in. Shortly afterwards he was transferred to ward 2 and on 12 July 1980 to ward 3. On 21 August he suffered a stroke and was moved to ward 4 the following day.

On 28 September and 2 October he was taken by ambulance to the accident and emergency department of hospital B (the A and E department) because of a deterioration in his condition but on each occasion he returned to hospital A. At 5 pm on 3 October he was again taken to hospital B and was admitted for tests, but he died there later that night.

2. The complainant contended that:

(*a*) hospital A was not an appropriate place for her father ; he spent some time in a locked ward and could not understand why he was not moved to another hospital more suitable for geriatric patients ;

(*b*) ward 3 was inadequately heated, uncarpeted and possessed no external telephone ;

(*c*) her father was inadequately fed in ward 3 ;

(*d*) although her father was often cold when she visited him he was not allowed to wear in bed a cardigan she took him for that purpose ;

(*e*) there was inadequate medical supervision on ward 3 and she was given conflicting information about the occasions when visiting family practitioners saw her father ;

(*f*) the furniture on ward 4 was dirty ;

(*g*) despite being taken by ambulance to the A and E department on two previous occasions her father was not admitted until 3 October ;

(*h*) on 3 October she was given conflicting information about her father's condition and treatment at hospital A and he was taken to the A and E department clad only in his pyjama jacket and wrapped in one blanket ;

(*i*) although she was told that her father was suffering from renal failure and infection the cause of his death was given as broncho-pneumonia ;

(*j*) clothes belonging to her father were lost during his stay in hospital and others were incinerated in error when he was transferred from ward 3 to ward 4, but it was not until May 1981 that the Area Health Authority (the AHA) offered to contribute towards their cost.

The complainant complained to the AHA but was dissatisfied with their replies. She said that the points she raised in her first letter were formally investigated when she hoped for immediate action to achieve an improvement in conditions for her father and she contested two statements included in the reply of 23 January 1981 from the area administrator (the AA).

Investigation

3. During the investigation I obtained the written comments of the AHA and examined the relevant correspondence and the clinical and nursing notes. One of my officers discussed the complaint with members of the medical, nursing and administrative staff involved. She also met the complainant.

(a) *The suitability of hospital A*

4. In discussion with my officer the complainant explained that in April 1980 her father had accidentally set fire to the kitchen while attempting to

light the gas cooker. Following the fire the kitchen was unusable, the gas and electricity had to be turned off and the house was blackened by smoke and flooded with water. Although her father was not physically injured he was disturbed and shocked by the fire and because the accommodation was no longer suitable he could not remain in the house. Local authority accommodation was not available at the time and the family practitioner (the FP) arranged his temporary admission to hospital A as a voluntary patient. Unfortunately, the repair work was delayed and he was not able to return home. The complainant described the ward to which her father was first admitted as a general ward but said he was transferred from there after about ten days to ward 2, where he was reasonably happy except that he did not like being in a locked ward. In correspondence with the AHA the complainant said her father did not understand why he was in a psychiatric hospital. She said that when his condition deteriorated further she was told by a family practitioner who visited him in hospital (the visiting FP) that hospital A could not cope with her father. She asked the AHA why, if hospital A lacked the staff and facilities to cope with a sick, handicapped old gentleman, he had not been admitted to hospital C which catered for geriatric patients.

5. In his reply to the complainant the AA pointed out that the nursing staff had not said that the ward at hospital A lacked the facilities to nurse her father and there was never any suggestion from them that they could not cope. In their comments to me the AHA said that when a consultant psychiatrist from the hospital (the first psychiatrist) made a domiciliary visit after the fire he found that the complainant's father was having episodes of quite severe disturbance and considered that the correct place in which to assess him was a psychiatric unit.

6. I have seen that the first physchiatrist wrote that in view of his disturbed behaviour the correct place for the complainant's father was a psychogeriatric unit. He said that in taking into account behaviour disturbances he was acting in accordance with nationally agreed guidelines. He said that the complainant's father was admitted initially to ward 1, which was not a geriatric ward, because he thought that he was better placed among people who were less confused than those on the geriatric wards. However, after a short stay there it was decided to transfer him to ward 2 because he was unable to manage the stairs in ward 1, a ward on two floors. Although the door to ward 2 was locked there was a garden attached to the ward to which patients had access. The first psychiatrist said that it had become apparent that because of the father's condition ward 2 was a more suitable ward for him ; but he added that it was possible that his bed in ward 2 was required for another patient. The first psychiatrist also explained that the complainant's father was transferred to ward 3 when it became clear that he would need longer term care than was normally provided at ward 2.

7. The visiting FP told my officer that when the complainant's father became unwell on ward 4 in September and October 1980 he referred him to hospital B. He said that although the nursing staff on ward 4 were trained to care for the mentally ill, they were not necessarily capable of giving the intensive care required by a person as sick as this. Moreover the resident

medical cover at hospital A consisted of doctors specialising in psychiatric rather than physical medicine. He said he did not specifically recall mentioning this to the complainant.

Findings

8. The first psychiatrist decided in the exercise of his clinical judgment that the complainant's father required care in a psychogeriatric unit because of his disturbed behaviour and that is a decision which I do not question. It was for this reason that he was admitted to and stayed at hospital A. Although the visiting FP does not recall telling the complainant that the staff on ward 4 could not cope wth her father I do not doubt that he did so, since that clearly was his view. By October, the visiting FP thought that the complainant's father required admission to another hospital for treatment of an acute physical illness. I do not uphold the complaint about his admission to hospital A but in my opinion the AHA's reply to the complainant would have been better had it recognised that the view held by the nursing staff about the ability to cope with her father on ward 4 was not shared by the visiting FP.

(*b*) *Conditions on Ward* 3

9. The complainant said in correspondence with the AHA and to my officer that she had been told ward 3 was a long stay geriatric ward but she was not convinced of this because it was poorly heated and there was no carpet on the floor. She thought that a floor with a carpet would be both safer and warmer for elderly patients than a polished floor. She said that on one chilly wet day when she visited her father he was shivering with the cold although the heating was on in other parts of the hospital. She added that it was difficult to obtain information about her father or to leave messages for him because there was no external telephone on the ward.

10. In reply to the complainant's letters the AA said that ward 3 was a long stay ward providing physical care for patients who were unable to manage their own feeding and personal cleanliness. He agreed that its facilities did not match those of a geriatric ward in a general hospital and explained that this was because hospital A was not originally designed to cope with patients who required a high degree of physical nursing. As funds became available efforts were being made to improve the wards. The AA accepted that there were difficulties with the heating system in some parts of hospital A but said that if patients were thought to be at risk the nursing staff would take remedial action. The AA made the point that when the complainant's father sat out of bed a blanket was wrapped around his legs and when necessary an extra convector heater was placed by his chair.

11. The nursing officer responsible for wards 3 and 4 (the first NO) told my officer that facilities on ward 3 were not ideal. At one time there had been a carpet on the floor but because there were incontinent patients the carpet had become soaked with urine and had to be destroyed. It was decided not to replace it. She said that there had been a problem with the heating in one of the dormitories of ward 3 but this was not in the part of the ward in which the complainant's father was nursed. The charge nurse

on ward 3 (the charge nurse) confirmed in discussion with my officer that one of the ward dormitories was cold but said that electric fires were available for use when the central heating was inadequate there. In general the central heating warmed the day room adequately. The acting divisional nursing officer (the Div NO) told my officer that the nursing staff were aware that, because the complainant's father suffered from arthritis, he felt the cold; they tried to ensure that he sat by a radiator and was kept warm. When the Div NO visited the ward he had often seen the complainant's father sitting by a radiator. He confirmed the reason given by the first NO for the removal of the carpet from ward 3.

12. My officer visited ward 3, which had been re-organised after the complainant's father's stay there, on a cold November day. She found that the central heating was not on and although the main room was comfortably warm, a smaller quiet day room, which was previously a dormitory, was unoccupied because it was so cold. The hospital engineer later told her that the central heating system was operated by thermostats in different parts of the hospital. However there was not one in every ward and ward 3 was heated by a drop system from the ward above where the thermostat was located. If the temperature on that ward rose above 70°F the heating was switched off both there and on ward 3 whatever the temperature on the latter. If the nursing staff complained that a ward was cold the engineering staff checked to see whether the temperature had fallen below about 68°F and if it had, adjustments were made.

13. In his comments to me the AA admitted that heating was a problem at hospital A. The system was as old as the hospital and one central boiler at another hospital served several hospitals in the locality. The AHA considered the installation of lifts in the hospital to be more urgent than the replacement of the heating system and, because of the shortage of funds, the AA thought it unlikely that the heating system would be renewed. Nor did he think there was any possibility of replacing the system for individual wards if they were found to be particularly unsatisfactory. He said that when a patient was feeling cold, heaters and additional blankets were used. The AA said that there were two separate telephone systems at hospital A: internal and external. All wards had either an internal or an external telephone but most did not have both. The AHA accepted that replacement of the telephone equipment was necessary but because of financial difficulties replacement had already been postponed for two years. With the re-organisation of the National Health Service it was for the successor District Health Authority ('the DHA') to decide whether and how soon the equipment would be replaced.

Findings

14. I accept the AHA's reasons for not replacing the carpet on ward 3, but I uphold the complaints that the heating on ward 3 was inadequate and that there was no external telephone. The AHA are aware of the defects but having considered all the needs of the hospital they have decided that other projects take priority over replacement of the heating system. The AHA accepts that the telephone system needs replacing but financial constraints

have so far prevented this. However, it is most important that elderly patients whose mobility is restricted are in a warm environment and while I do not doubt that nurses try to ensure that patients are not at risk, I am concerned that they may not always be comfortable. I hope that the DHA will consider with a sense of urgency whether improvements can be made in the near future.

(c) *The food on ward 3*

15. In a letter to the AHA the complainant mentioned that her father seemed to be hungry when she visited him and that she understood the last meal of the day was taken at 4.30 pm. She and her brother occasionally took him extra food. In reply the AA told her that the nursing staff always asked her father whether he had had enough to eat and that he was always able to respond and invariably requested more food which was given. In a further letter to the AA the complainant said that food was sometimes put out on the tables 10-15 minutes before patients were seated and those patients who were mobile made inroads on the food before patients like her father, who had to be helped, were seated at the table.

16. The charge nurse told my officer that on ward 3 the last meal of the day was served between 4.30 pm and 5 pm. It was served so early because after tea all patients who could not look after themselves had to be bathed and put to bed before the night staff came on duty. This could take two and a half or three hours to complete. Hot drinks were given to all patients at 7.30 pm. He said that lunch time meals were served on to plates in the kitchen and sent to the wards as individual portions. However the evening meal was delivered to the ward in bulk and served out there. He said that he thought the amount of food was adequate and he had no recollection of the complainant's father being hungry.

17. The first NO confirmed that on geriatric wards the last meal of the day was served at about 4.30 p.m. although a drink and biscuits were provided at about 7.30 pm. She said that the meal was served early because of difficulties with the portering and domestic services. The food was sent to the wards in heated trolleys which had to be returned to the kitchen before the staff went off duty so that they could be cleaned and connected to the electricity supply to heat up ready for breakfast the next morning. She said there had been a recent change and that on geriatric wards the last meal was served now at 5 pm; on other wards it was served at about 6.30 pm or 7 pm. She believed the quantity of food was adequate—geriatric patients were not very active and did not need a great deal of food. However, since the evening meal was sent to the ward in bulk a patient who was hungry could always be given extra. There was additional food on the ward such as biscuits, cheese, fruit and cake, and this was given to anyone who was hungry.

18. In discussion with my officer the Div NO said he thought that the evening meal was delivered to ward 3 at 4.30 pm and that the patients started to eat at about 5 pm. On most wards the meal was served at 6.30 or 7 pm but on geriatric wards it was necessary to start earlier because some

patients needed help with eating and meals could take a long time. In addition geriatric patients needed help preparing for bed after their meals. The Div NO found it difficult to accept that the complainant's father did not have enough to eat because he thought his requests for food were met by the staff. He confirmed that extra food was available on the ward.

Findings

19. The staff have given various reasons for serving the last meal of the day when they do. While I accept that it might take some time to feed patients who cannot manage for themselves and prepare them for bed, I am not convinced that it is necessary for them to eat so early. Indeed, I believe that, increasingly, opinion across the country favours providing the last hot meal of the day at a later hour, and I hope the successor DHA/AHA will consider whether arrangements can be made to do this. The AA said in a letter to the complainant that her father invariably asked for more food and this indicates to me that he was not given sufficient when he was first served. However the evidence also indicates that there was additional food available and I do not think he suffered hardship in this respect.

(d) *The cardigan*

20. In her letters to the AHA and in discussion with my officer the complainant said that her father was often cold when she visited him and she therefore took him a clean woollen cardigan to wear in bed. However she was told by a member of staff that it was unhygienic and her father was given an extra blanket instead. The complainant thought that a warm light cardigan was more suitable than an additional heavy blanket especially since the bedclothes were not long enough to enable her father to pull them over his shoulders at night because he was a very tall man.

21. The charge nurse told my officer that he had not permitted the complainant's father to wear a cardigan in bed because he thought that a blanket was more suitable for keeping him warm. He did not think a cardigan was hygienic, even if it were kept solely for wear in bed, because the patient was incontinent and the cardigan might have become soiled. In written comments and in discussion with my officer the Div NO said that he considered it wrong of the nursing staff not to allow the complainant's father to wear a cardigan in bed, particularly when it was provided solely for that purpose. He said that it was general practice in most hospitals to allow patients to wear bed-jackets or cardigans and he felt it was unimaginative of the ward staff not to allow it at hospital A. Since this incident he had instructed staff that patients should be allowed to wear cardigans in bed.

Findings

22. I uphold this complaint and I am pleased to note that the Div NO has taken action to prevent a recurrence.

(e) *Medical Supervision*

23. In a letter to the AHA on 25 July 1980, the complainant said that she understood that there was no hospital medical officer covering ward 3 but

that local family practitioners attended when necessary. After her father's transfer to that ward she had asked the duty nursing officer (the second NO) whether he had been attended by a doctor since the transfer and was told that he thought so. The second NO was unable to give the name of the doctor or the date of the visit. The complainant asked in her letter whether she had been correctly informed that the consultant responsible for ward 3 had recently left and had not been replaced. The AA replied that the complainant's father was seen by a visiting family practitioner on 15 July. He confirmed that the consultant previously responsible for the ward had left and that cover was being provided by the first psychiatrist until a locum consultant (the locum consultant) took up post. The AA said that he understood from nursing staff that the complainant was advised to get in touch with the first psychiatrist if she wanted further information about her father's condition. The complainant wrote again to the AHA saying that although the second NO had been unable to say which doctor had seen her father, the name of a local family practitioner had been mentioned but when he was approached he said that he had not attended her father. The complainant also pointed out that despite her enquiries she had not been told of the locum consultant's appointment in August.

24. The AA told me that medical supervision on most wards at hospital A including Ward 3 was in two parts. Psychiatric care was undertaken by teams of doctors under the leadership of a consultant psychiatrist and a duty doctor was on call at all times. General medical care was undertaken by local family practitioners who visited the wards on a regular basis and had a rota for emergency medical calls.

25. The charge nurse told my officer that soon after her father's transfer to Ward 3 the complainant asked whether he had been seen by a doctor since the transfer. There were four family practitioners who visited the ward regularly and the charge nurse knew that the complainant's father had been seen by one of them. However, because no entry had been made in the clinical notes he could not be sure which doctor had seen him. When pressed on the question he told the complainant the name of the doctor he thought most likely to have seen her father but it later transpired that he was wrong. Because he was unable to answer the complainant's questions the charge nurse called the second NO who suggested that the complainant should speak to the first psychiatrist about her father. The second NO did not remember discussing the medical cover for the ward with the complainant but confirmed that because he could not give detailed information about her father's condition he advised her to see the first psychiatrist.

26. The Div NO said that because a number of family practitioners visited the ward and no entry had been made in the notes it would have been difficult for the charge nurse to tell the complainant which doctor had seen her father. However he thought the charge nurse should have given more information to the complainant about the medical cover for the ward.

Findings

27. It is understandable that relatives will wish to have up to date information about the doctor responsible for the care of a loved one. When

many doctors are involved and changes of staff are taking place, as in this case, I consider it essential that full information is given. While I appreciate the difficulty the charge nurse had in identifying the doctor who saw the complainant's father I am not satisfied that she was given all available information. I therefore uphold this complaint. I hope the successor DHA will remind staff of the importance of making information in this respect fully available to relatives.

f) *Conditions on Ward 4*

28. In a letter to the AA on 11 December 1980 the complainant said that the tables and chairs on ward 4 were dirty as were the walls of the television room. The NO told my officer that following this complaint the tables on ward 4 were checked and it was found that they were indeed dirty. They were replaced by new style round tables which did not have any rims or grooves in which dirt could be trapped. The domestic services manager agreed that the walls of ward 4 needed washing and within a month of the complainant writing arrangements were made for contractors to do the work.

Findings

29. I believe that conditions on ward 4 were generally as the complainant described them but I have been pleased to record that the AHA took immediate action to improve the situation.

g) *Decision not to admit the complainant's father to hospital B*

30. The complainant said that when she visited ward 4 on 28 September she was told that her father was most unwell and that an ambulance would be taking him to hospital B because he had a haemorrhage following the removal of a catheter. The complainant accompanied her father to the A and E department there. He was examined by a doctor who said an intravenous pyelogram should be performed once his infection had cleared up He was sent back to hospital A. On 2 October the visiting FP telephoned the complainant to say he was trying to admit her father to hospital B because there was a kidney failure and infection. Her father was once more taken to the A and E department. Another catheter was fitted, an urgent appointment with a consultant was requested and he was again returned to hospital A. The complainant could not understand why her father was sent back to hospital A and said the staff there seemed surprised at his return.

31. In his reply to the complainant the AA agreed that it was unsatisfactory to transport ill patients to and from the acute units but said that the closure of beds earlier in the year had caused a shortage of beds at hospital B. The consultant surgeon at hospital B had made the point to the AA that a patient was not automatically admitted to hospital because he was taken to the A and E department by ambulance, even if it happened more than once. It was for the examining doctor to decide in the exercise of his clinical judgment whether admission was required.

32. The senior house officer who examined the complainant's father in the A and E department on 28 September (" the SHO ") told my officer that he was referred to hospital B for an opinion on the problem with his catheter,

not for admission. The SHO said he examined him and wrote a full opinion in the clinical notes. Since there was no emergency which necessitated the patient's admission to hospital B and admission had not been requested, he was returned to hospital A for continuing care. He added that surgery under general anaesthetic could not have been undertaken in view of his condition. The clinical notes show that the SHO suggested it was best to avoid re-catheterising the patient if possible because he had a urinary tract infection.

33. The visiting FP told my officer that he referred the complainant's father to hospital B on 2 October. He said that he had written a long referral note in which he had tried to make it as clear as he possibly could that the patient needed admission, particularly because his daughter was so anxious about him.

34. The house surgeon who saw the complainant's father in the A and E department on 2 October told my officer that as house surgeon he would not have taken the decision to send the patient back to hospital A; he would have sought the views of the senior house officer or registrar on duty. I have been unable to trace the doctor who was approached in this connection.

Findings

35. On 28 September the SHO was asked for an opinion on the complainant's father's condition and he gave this. He was not asked to admit him and did not consider his condition required admission. This was a decision taken in the exercise of his clinical judgment and I cannot question it. I have satisfied myself from my examination of the clinical notes that the decision that his condition on 2 October did not require admission to hospital B comes into the same category.

(h) *Events of 3 October*

36. The complainant said in a letter to the AHA that when she telephoned ward 4 at about 9 am on 3 October the ward sister told her that her father was 'not well' and that she could visit him at any time. But she was also told that he might be returning to hospital B. It was agreed that she would telephone again an hour later. In the meantime her niece telephoned hospital A and was told that the patient's condition had stabilised and a drip was being set up. When the complainant telephoned again she was told his condition had not improved and they were awaiting the results of tests from hospital B. The complainant telephoned again at 1 pm and then decided to visit the hospital. When she arrived with her niece she found that the drip had not been set up and her father seemed uncomfortable. At about 3 pm they were asked to leave his bedside while the drip was set up but when they returned half an hour later there was still no drip. She spoke to the doctor on duty (the registrar) who said that something unforeseen had occurred and he was waiting to speak on the telephone to a surgeon at hospital B when he came out of theatre. At about 5 pm the complainant's father was taken by ambulance to hospital B wearing only a pyjama jacket and wrapped in a hospital blanket. The complainant asked why she was given conflicting information about her father's condition and treatment.

37. The ward sister said that she spoke to the complainant on the telephone on three occasions on 3 October and her recollection of the conversations was very much as the complainant described them. But the ward sister said she did not describe the patient's condition specifically during any of the conversations. She said that the medical officer on duty in the morning had been in touch with hospital B about the patient and a drip was prescribed. The infusion was ordered from the pharmacy and when the ward sister returned from lunch she was able to prepare the drip. By then the registrar had taken over as duty medical officer and he decided that before setting up the drip he would re-examine him. The ward sister thought that the complainant could have been asked to leave her father's bedside while the drip was set up. When the registrar examined the patient he decided that he was not fit enough to have a drip and he got in touch with hospital B again and arranged for him to be taken back there.

38. The nurse who accompanied the complainant's father to hospital B told my officer that it was quite likely that he would not have worn pyjama trousers during the journey because of his condition. She said it was common on ward 4 for incontinent patients to wear long nightshirts rather than conventional pyjamas, particularly if they were catheterised. She did not recall what blankets the patient was wrapped in but said that the ambulance crew usually wrapped patients in one or two ambulance blankets depending on how warm it was.

39. The clinical notes confirm that the medical officer on duty on the morning of 3 October made some investigations and then consulted a member of the surgical team at hospital B who advised that a drip should be set up. They also show that later in the day the registrar was concerned about the patient's condition, contacted hospital B again and arranged for him to return there.

40. In reply the AA wrote that the apparent conflict in the reports given about the complainant's father's condition was because he was seen by two different doctors. The drip was not set up because of the risk of overloading his heart and causing it to fail. I have seen that this information was provided by the consultant psychiatrist (the second psychiatrist) who was then responsible for him.

Findings

41. The registrar concluded that the complainant's father's condition changed during 3 October and as a result he decided that a drip was unsuitable. He decided to refer him to hospital B again. These were decisions taken in the exercise of clinical judgment and I do not question them. The staff were trying to keep the complainant informed of what was happening, but because of her father's changing condition this information appeared to be conflicting. I do not criticise the staff for the reports they gave the complainant or for the clothing her father wore on his journey to the A and E department.

(i) *The cause of death*

42. The complainant said that the cause of her father's death was given as broncho-pneumonia whereas she had been told that her father was suffering

from renal failure. She asked why her father was in a surgical bed if he was suffering from broncho-pneumonia. In reply to this point the AA said that because of the pressure on beds at hospital B the medical and surgical beds were often mixed to make the best use of the available beds.

43. A consultant surgeon at hospital B said that the cause of death was a question of diagnosis. He made the point however that the two conditions the complainant mentioned could exist concurrently and added that broncho-pneumonia was commonly a cause of death of a patient suffering renal failure.

Findings

44. The diagnosis of broncho-pneumonia was made in the exercise of clinical judgment and I cannot question it. I accept the evidence that this can be the cause of death of patients who are suffering from other serious conditions.

(j) *The clothing*

45. In correspondence with hospital A and with the AHA the complainant said that trousers which her father was wearing on admission to hospital were lost while he was in ward 1 and she was told that they had been lost in the laundry. When her father was transferred from ward 2 to ward 3 further items of clothing were mislaid. Some turned up later but others apparently were never found. She complained that following her father's transfer to ward 4 in August 1980, a black plastic bag containing his personal effects and clothing was accidently incinerated. The nurse who told the complainant that the property had been burned (the staff nurse) appeared to consider it a joke because he laughed when he told her about it.

46. On 6 August 1980 the hospital administrator (the HA) wrote to the complainant offering a payment towards the cost of replacing the first pair of trousers. However when he received more correspondence from the complainant about further losses, the HA said that the matter would be investigated. On 2 September the AA expressed his sincere regret for the loss of the property which was incinerated. He said that most of the property would be replaced and asked the complainant to submit a claim for compensation in respect of the other items. He also said that some of the items which the complainant said had been lost when her father was transferred to ward 3 had never been recorded on hospital property lists and the AHA could not accept responsibility for them.

47. On 11 December 1980 the complainant replied to the AA that the garments offered to her as replacements for the lost clothing were not acceptable. The AA's next reply of 23 January 1981 did not refer to the missing property and she wrote to him again on 27 March saying that although she had completed a form with details of the value of the missing items more than three months previously she had heard nothing further and she therefore enclosed another list of lost property. On 5 May the AA offered the complainant an *ex-gratia* payment of £90 which was approximately two-thirds of the total she claimed and she refused this. The offer was increased to £115 and was accepted by the complainant.

48. The complainant told my officer that at first she had claimed only for those major items of clothing which were incinerated on Ward 4. But when she had received no communication on the subject three months later she took advice elsewhere and decided to pursue a claim for all the lost clothing. She then sent a revised list to the AA.

49. I have seen statements from the nursing staff on duty on Ward 4 on the day the complainant's father was transferred there. These show that while they were helping him into bed, another patient, who often helped remove black rubbish bags, took away similar bags containing his property thinking they also contained rubbish. When the nurses realised what had happened the bags had already been party incinerated; some items had been destroyed while others had been damaged. The staff nurse told my officer that he was present when the incident involving the patient's property occurred and when the complainant visited he had to explain to her what had happened. He denied laughing when he told her what had happened and said he did not consider that it was amusing.

50. The second NO told my officer that when he met the complainant they had discussed her father's property at some length. He said he had emphasised the need to hand clothing to a member of staff when it was brought on to the ward because there was no other way in which a proper check could be kept. As far as he could remember the complainant agreed that she had not always handed property to the staff. The AA thought it possible that the complainant had not attached to her letter the claim as it was first made and that this would account for the fact that no offer of compensation was made until after the second claim was received. However I have seen that the AHA's records include a copy of the original claim for compensation.

Findings

51. It was an unfortunate accident that this property was destroyed by fire and I do not believe the staff nurse intended to convey to the complainant the impression that he considered the matter a joke. It is clear that the AHA did receive a claim for compensation from the complainant and I have not been able to establish why it was not dealt with at once. I believe there was unnecessary delay in dealing with the claim but I am pleased to note that the AHA eventually offered to the complainant a sum in compensation which she considered acceptable.

(k) The handling of the complaint

52. In a letter to the AA the complainant said that when she wrote to the HA in July 1980 she was not asking for a formal investigation but for immediate help in improving conditions for her father on Ward 4. In the event she had received a reply which arrived two months later when her father was dying. The complainant told me that she found two statements in the AA's reply of 23 January 1981 perplexing. He had said that her father's catheter was only removed when it was considered that he was passing urine satisfactorily without it and that there was never any question of infection at that time. She said that her father was bleeding after the catheter was removed and a doctor who saw him at Hospital B said he could not insert

another catheter until the infection had cleared up. The AA had also said in his letter that he had been advised by the second psychiatrist that her father's admission to Hospital B was 'routine'. The complainant could not accept this both because she had been told that she could visit at any time—as her father was 'not well'—and because of the reasons she had been given for not setting up the drip (paragraph 40). She added that staff at the A and E department were expecting his arrival and he was seen immediately.

53. The AA told my officer that all written complaints were dealt with formally and that was why the complainant's letter was dealt with in that way. The complaint was investigated locally and the investigation did not indicate that there was anything seriously wrong at the hospital which was affecting her father's care or treatment. During the period when the complaint was being dealt with, the first NO spoke to the complainant on more than one occasion, the second psychiatrist met her and the HA spoke to her on the telephone.

54. As for the statement in the AA's letter which the complainant contested, the second psychiatrist said that the AA's statement that there was never any question of infection was an apparent misinterpretation of a comment that he (the second psychiatrist) had made that there was no evidence of obstruction or inadequate output after the catheter was removed. He pointed out that he had made no reference to infection. He said that the other statement by the AA which the complainant disputed was also a misinterpretation of his comment that as far as he could ascertain there has been 'no indication that a greater surgical/medical urgency existed than was apparent at the time', and pointed out that this was not the same as describing the transfer as 'routine'. The second psychiatrist subsequently suggested that in future, letters containing details of medical management should be agreed by the appropriate consultant; and that suggestion was accepted by the administration. The clinical notes confirm the complainant's account of the comments made by the doctor at Hospital B.

Findings

55. The AA's letter contained inaccuracies as a result of a misinterpretation of a consultant's comments. I am pleased to note that action to prevent a recurrence of this has been taken. Although the complainant received a formal reply to her letter of complaint I am satisfied that her comments were made known to those caring for her father on the ward.

Conclusions

56. I have investigated eleven aspects of this complaint. Four, (a), (c), (h) and (i) I have not upheld; complaint (g) I have concluded arose from the exercise of clinical judgment and I therefore make no comment upon it; five more, (d), (e), (f), (j) and (k) I have upheld and the successor DHA have asked me to convey through this report their apologies for the shortcomings to which I have drawn attention. This I gladly do. There remains complaint (b). I am satisfied that the AHA were aware of the difficulties in heating Hospital A and I am also satisfied that it is not because of mal-

administration that the whole system has not been replaced. In that respect the availability of resources has been the paramount consideration. Nonetheless, I conclude that some wards in Hospital A are not always as warm as they should be, and I strongly urge the successor DHA to consider whether some improvements might not be introduced. At the very least I think the temperature in one ward should not depend upon a thermostat in another. I am pleased to report that the successor DHA have agreed to consider this review. I regard this and the apologies as an appropriate outcome to my investigation.

Case No. W.15/81–82—Failure to provide a hospital bed

Complaint and background

1. The complainant stated that his wife was examined at home on 29 August 1980 by her family practitioner (the FP) who decided that she should be admitted to hospital for treatment. The FP made arrangements for her to be admitted during the next few days to a hospital (hospital A) and for her to be advised when she was to come in. As the complainant had heard nothing from hospital A about his wife's admission by 3 September he telephoned about it and was told that a bed would not be available for her for six or seven days. On 9 September, another family practitioner (the FP's partner) got in touch wth hospital A again and also with another hospital (hospital B) but was unsuccessful in obtaining a bed. The complainant's wife died at home on 10 September.

2. The complainant contends that the Area Health Authority (the AHA), by not admitting his wife when she urgently needed hospital treatment, failed to provide a service which it was their duty to provide.

Investigation

3. During the investigation I obtained the written comments of the AHA and examined these and the relevant correspondence. My officer discussed the complaint with the medical and administrative staff concerned and he also met the complainant.

4. In correspondence and when interviewed by my officer, the complainant said that his wife had received treatment for epilepsy and pernicious anaemia for about 18 years ; about the middle of August 1980 there was a change in her condition and the FP arranged for her to have a domiciliary visit by a consultant physician (the consultant). The consultant recommended that she should be admitted to hospital for further examination but she would not agree to this. However on 29 August her condition deteriorated and she told the FP, who visited her that day, that she would go into hospital. The FP, who was going away on holiday the next day, said that he would arrange the admission ; he telephoned the complainant later and told him that his wife would be admitted to hospital A on either 1 or 2 September and that he would be told when he was to take her to the hospital.

5. The complainant said that as he had received no instructions by 3 September he telephoned hospital A and was told that a bed would not be

available for six or seven days. He then telephoned the FP's surgery to express his concern; and the FP's partner called to see the complainant's wife. As the complainant was having great difficulty in looking after his wife, the FP's partner arranged for her to be attended daily by a community nurse. On 9 September the complainant spoke to the FP's partner again because his wife could not swallow the tablets she had to take. When the FP's partner saw her he told the complainant that his wife's condition was such that he could not administer her medication by injection. The complainant said that the FP's partner went to hospital A but he returned in the evening and told him that there was no bed available for his wife. He was told to try to get her to take as much fluid as possible but he was warned that her condition was very serious. The next morning the FP's partner was told that a bed was available for the patient, but by that time she had died.

6. In a report he made to the AHA and when interviewed by my officer the consultant said that when he made his domiciliary visit to the complainant's wife on 19 August, she had refused to go into hospital and he had asked the FP to have further discussions with her and her family in the hope that she would change her mind. On 29 August the FP told him that the patient's condition had worsened and that she was willing to go into hospital. The consultant had asked the FP to get in touch with his clinical assistant (the CA), to whom he sent a copy of his report on the domiciliary visit, and to request admission for her within a few days. He said that the situation at that time had not been considered to be 'desparately urgent' by either the FP or himself. The following day, 30 August, the consultant went on leave and a locum consultant was appointed to cover his absence.

7. The FP confirmed to my officer that he had spoken to the consultant about the complainant's wife on 29 August and that he had agreed to speak to the CA about her admission to hospital A. On 30 August the CA told him that as her case was not one of immediate urgency a bed could not be allocated to her but that he would let him know as soon as a bed could be provided.

8. The FP's partner, in an interview with my officer and in correspondence with the AHA, said that when the FP went on holiday after arranging for the complainant's wife's admission 'early next week' (the week commencing 1 September) for investigations he did not ask him or his colleagues to follow up the arrangements he (the FP) had made because he confidently expected the admission to proceed as planned. The FP's partner said that the complainant telephoned his surgery on 4 September and said that hospital A could not provide a bed for his wife for a further week. He, himself, saw the complainant's wife on 5 September and afterwards spoke to the CA about her admission but he was told that no bed was available for her. He visited the complainant's wife again on 9 September when he had found her condition critical. He spoke to the CA but was again told that there was no bed for her. He thought that he must have communicated the increasing degree of urgency in his conversation with the CA: it would have been medium priority on 5 September and top priority on 9 September since on his last visit to his patient (she had been gravely ill with pneumonia, in addition to her other condition. When he failed to obtain a bed at hospital A on

9 September he had telephoned hospital B to try to get her admitted there but, again, he was unsuccessful. He was later told by hospital B that a bed was available but by then his patient had died. In a letter to the area medical officer (the AMO), who had been looking into the complaint to the AHA, the FP's partner wrote: 'I appreciate that it is difficult if not impossible to make to materialize an empty bed when one requires it. I did however on the second occasion [9 September] tell [the CA] that [the complainant's wife] would die if not admitted very soon'.

9. In a statement he made to the AHA and when interviewed by my officer the CA said that he was informed about this case by the consultant and asked to admit her to hospital A; the request was for admission 'soon' but not as an urgent matter. The FP also made plain when he telephoned him that the case was not urgent and that the patient had been handicapped and ill for a long time; her illness was not acute and the prospects of being able to help her were small. He told the FP that he did not have a bed available for his patient but that he would let him know when the situation changed; he did not recall telling the FP that she would be admitted on 1 or 2 September. The FP's partner had telephoned him on two occasions and expressed his increasing concern about the patient. They had discussed her case fully but on these occasions and at times when beds became free he had considered that there were other patients of a higher priority than that of the complainant's wife. The CA said that the allocation of the consultant's medical beds at hospital A was his responsibility and that he had not raised the question of this patient's admission with the locum consultant.

10. The CA said that all the consultant's female medical beds at hospital A were in use throughout the period in question and he had also obtained additional beds for medical patients by 'borrowing' from other specialties; he had not however felt that he could borrow a further bed for this case. My officer asked if when the patient's condition deteriorated he had considered utilising beds used for private or amenity patients in hospital A. He said that he had not but that it was unlikely that a relatively unobserved side ward would be suitable for a gravely ill patient brought in specifically for observation.

11. The CA said that he had access only to beds in hospital A. If a bed was not available at a particular hospital, the onus was on the family practitioner to get in touch with other hospitals in the district to find a bed for a patient. Although this was not a written procedure it was the accepted practice, as he was well aware because he himself had been a family practitioner locally a few years previously.

12. My officer spoke to a senior house officer (the SHO) who had been identified as the doctor at hospital B who probably spoke to the FP's partner about the possibility of his patient's admission there. He recalled speaking to the FP's partner about an admission but could not be certain whether it was that of the complainant's wife. He explained that requests for admission to hospital B were dealt with in the first instance by the pre-registration house officer (the HO) on call who was aware of the current bed state.

He, himself, would not have been able to give an immediate answer to an admission request and would therefore have telephoned the FP's partner later after speaking to the HO. In these circumstances he thought it unlikely that he would have said that a bed was not available when he first received the request. My officer also spoke to house officers who had been at hospital B at the material time ; they confirmed the procedure outlined by the SHO.

13. The bed state records for hospital A confirmed that the medical beds were occupied during the period 1–9 September ; but in the same period there were, on each day, empty beds in other specialties. In addition, except for one private bed on 4 September, two private and two amenity beds remained unoccupied. According to the records for hospital B there were not less than three *medical* beds available throughout the period concerned except on one day when there was only one.

14. When the AHA replied to the complainant they told him that there had been no medical beds available at hospital A when the requests for his wife's admission were made and that it had been necessary at that time to admit acutely ill patients, who should have been in those beds, to the surgical ward. They said that there were not as many hospital beds in the district as were needed but they hoped that the new hospital that was being built would overcome this problem. They also told him that their enquiries had shown that there was a need to improve the arrangement for dealing with requests from family doctors for beds for their patients and that they were taking urgent steps to deal with this. They did not however tell him why the handling of his wife's admission had led them to take urgent steps to improve their arrangements.

15. In their written comments to me about this complaint the AHA said that their enquiries had shown that, although there had been no empty medical beds in hospital A at the material time, there were empty beds in the surgical specialties and there were empty medical beds in the district. They explained that the CA had not considered that he had the authority to admit the complainant's wife into these beds. They also said that although the acute services were organised on a district basis it had apparently been the procedure, and one which usually worked well, for family practitioners, unable to obtain a bed at one hospital, themselves to make enquiries at the other hospitals. However the AHA told me that, as a result of their investigation, they had asked the consultant staff in the district to consider changes in the existing arrangements, in particular, in regard to the use of beds in the same specialty at any hospital in the district notwithstanding where the patient lived ; the use of empty beds, irrespective of specialty, in cases of emergency ; and the responsibility of hospital medical staff, in cases where urgent admission on clinical grounds had been agreed, in finding a bed for the patient concerned. From the papers I obtained during my investigation I have seen that consultation on these matters, which was instigated by the AMO and which included the participation of the area chairman and the regional medical officer, began about two months before the complainant put his complaint to me.

16. During my investigation an addendum to "Notes for a Junior Medical Officer" (an instructional booklet for junior medical staff) was issued and was also circulated to local family doctors. It said that until the new district general hospital was opened the procedure outlined in the addendum was to be used for the admission of emergency patients. It said that information on vacant beds in the district would be available from the admissions office at hospital C between 0900 and 2000 and that during the night hours the nurse in charge of individual units would be able to advise doctors on vacant beds. Junior doctors were told that the consultant staff had agreed to two basic principles: —

(*a*) Within any one specialty, beds at hospitals A and B should be regarded as equally available for patients from any part of the district.

(*b*) Empty beds in one specialty would be available for use by another specialty in cases of emergency provided the senior house officer on-call for the specialty whose bed is being borrowed is consulted.

In regard to family doctors' requests for beds the addendum said that the following procedure must be adhered to: —

(*a*) Family practitioner contacts on-call doctor in the relevant specialty at hospital who accepts the case if beds are available.

(*b*) If these hospital beds are full in the relevant specialty then the hospital doctor ascertains where beds are available, either in another specialty or elsewhere within the district and informs the family practitioner accordingly.

(*c*) The family practitioner makes a telephone call to the appropriate admitting hospital doctor.

(*d*) If difficulties occur the family practitioner must be informed that the consultant on duty for that specialty is available.

Findings and conclusions

17. Three successive requests were made to the CA to admit the complainant's wife, the first being for tests only, the second being of medium priority, and the third being crucial. The decision of an admitting doctor about the priority of a patient in relation to the beds available is a matter for his clinical judgment, which is not for me to question. However it is clear that in this case the instructions to admitting doctors were inadequate and the CA did not regard it as his responsibility to try to 'borrow' a bed from another specialty or to arrange for the patient's admission to a medical bed at another hospital. I am in no doubt that there were hospital beds available within the district at the relevant times to which the complainant's wife could have been admitted and that the complainant suffered avoidable distress because of the failure to take advantage of them. I uphold this complaint. The Health Authority who are the relevant successors to the AHA have asked me to convey in my report their apologies to the complainant and this I gladly do.

18. I am glad to see that before my investigation began the AHA had already recognised that this case demonstrated the inadequacy of the emergency admissions procedure and had set in train consultations aimed at improving it. A new procedure was promulgated in order to obviate any repetition ; and I hope that the complainant', who told me that his motive for complaining to me was to make sure that no other resident in the district had to go through what he had to suffer, will derive some consolation from this.

Case No. W.32/81-82—Care of long-stay geriatric patient and management of her monies

Complaint and background

1. The complainant and her daughter were introduced to Mrs A, a long-stay patient at a hospital (the hospital) through a voluntary hospital visiting organisation. They both visited Mrs A regularly from July 1980 until her death, at the age of 95, on 30 March 1982.

2. The complainant contends that:

(*a*) Mrs A sustained a badly bruised ear as a result of being hit by a nurse and was subjected to taunts, some of which were of a sexual nature, from the nursing staff ;

(*b*) Mrs A's excursions from the hospital with the complainant and members of her family were discontinued without cause ;

(*c*) Mrs A was left in a wheelchair, without cushioning, for a considerable time until she became very sore ; on other occasions she was given an unsuitable wheelchair with detachable sides ;

(*d*) Mrs A's weekly pension was not spent on personal comforts for her and she was not allowed to purchase her own wheelchair ;

(*e*) Mrs A's financial affairs were mismanaged by the Area Health Authority (the AHA) who did not provide a statement of her financial position until they were required to do so by solicitors ;

(*f*) no arrangements were made for a social worker to visit Mrs A for over six years ; and

(*g*) she is dissatisfied with the way the AHA handled her representations to them.

Investigation

3. During the investigation, I obtained the written comments of the AHA and examined the relevant documents. One of my officers interviewed members of the medical, nursing and administrative staff of the AHA and met the complainant. She also saw Mrs A, who, at that time, was not in a condition to give evidence to her.

(*a*) *The assault and sexual taunts by the nursing staff*

4. The complainant said that she and her daughter volunteered to take part in a locally organised scheme under which volunteer visitors went to see long-stay patients in hospital who did not otherwise have any regular

visits. The complainant's daughter, who was allocated to ward Y, saw Mrs A sitting by herself and asked the ward sister (the first sister) if she received any visitors. The first sister had told her not to bother with Mrs A as she was very withdrawn but the complainant's daughter spent some time sitting with Mrs A and talking to her; Mrs A was at first very suspicious, but after a few weeks she began to respond to the visits. Some time later, the complainant herself began to visit Mrs A. On her first visit she noticed that Mrs A had a very black ear and Mrs A told her that she had been 'clomped on the ear' with a book by one of the nurses. The complainant said she did not complain about this at the time as she found it hard to believe that a nurse would hit a patient. Mrs A also told her that the nurses taunted her about sexual matters but she had not given any credence to this either until one afternoon when she was outside the ward and heard a nurse say 'I've had eight men, [Mrs A]; another: 'I've had six'; and a third: 'I had a bit last night, [Mrs A]; you should have some, it would do you good'. She said that she rushed into the ward and intervened telling the nurses 'to stop their filthy talk to the old ladies'. A nurse replied that she should mind her own business as she was not a relative and had nothing to do with Mrs A, another nurse said to her: 'you're not here at night when she's asking for a man', and a third nurse said that they were only having a bit of fun.

5. The complainant said that she was most perturbed about the nurses' behaviour and she telephoned the hospital the following day and made an appointment to see the senior administrative assistant (the SAA) the same afternoon. She explained what had happened the previous day and complained about the bruised ear. The SAA said that she would investigate the complaint and let her know the outcome. Two days later the SAA telephoned her to say that Mrs A had been transferred to another ward (ward Z) and at a further meeting the SAA said that four nurses involved in the 'taunting' incident had been questioned and that disciplinary action was being taken against them.

6. In an interview with my officer, the first sister said that when Mrs A was first admitted in 1974, her nephew visited his aunt regularly and warned the first sister that she was extremely difficult, caused trouble wherever she went, and might well make unfounded accusations about the behaviour of the nursing staff. The nephew died in 1975 and Mrs A did not receive any regular visitors until 1980. She was therefore pleased when she heard from the organiser of the hospital visiting service that two schoolgirls wanted to visit patients who did not receive regular visitors and she suggested they visit Mrs A. The complainants daughter was one of the schoolgirls. The first sister said that Mrs A had regularly made accusations that the nursing staff had thrown bedpans and chairs at her, but she had never found any evidence of bruising and had told Mrs A that such objects could not have hit her without there being some evidence of injury. She said, however, that bruises were often found on Mrs A but these were self-inflicted: for example, she sometimes caught the side of her face with her hand when she was throwing away something she did not want. Accident forms were completed whenever a large bruise was noticed on a patient—whether or

not the accident which caused it had been witnessed—and a doctor was called to examine the patient. Any small bruises were noted in the nursing record.

7. The first sister said that Mrs A generally asked any new nurse on the ward if she was married; if she was, Mrs A left her alone but otherwise she considered the nurse 'fair game for taunting'. The first sister had been on leave when the sexual taunting incident allegedly occurred but, she said, the nurse primarily involved in the incident (see paragraph 10) was married and was not therefore one of Mrs A's usual targets. She thought that Mrs A had probably introduced the topic of conversation herself.

8. My officer interviewed various members of the nursing staff, who said that Mrs A was aggressive and made allegations that she was being ill-treated by the nurses. A state enrolled nurse (the first SEN) said that she noticed when she was washing Mrs A on 28 June 1980 that she had a badly bruised ear and she recorded the fact in the nursing notes. She did not remember whether she questioned her about how she acquired the bruise and she had not considered it serious enough to warrant the completion of an accident report. She thought the bruise had been inflicted by Mrs A herself either by trying to stop a nurse washing her (which she frequently did) or by hitting herself trying to remove the tray from her wheelchair. The first SEN said that Mrs A constantly made allegations that she had been hit by a nurse: that the night nurses had thrown bedpans at her; and that sticking plaster had been put across her mouth. She had looked, but she had never found any evidence to support her allegations.

9. The nursing notes include only one entry relating to a bruised ear. This was on 28 June and was authenticated by the first SEN who wrote: 'patient has a very bad bruise on her ear . . . was noticed when nurse went to wash her this morning'.

10. Another nurse interviewed by my officer (the second SEN) said that she had been in charge of the ward at the time of the incident concerning the taunts. She said that Mrs A often introduced the subject of the men in the nurses's lives because, she thought, Mrs A had the impression that young people had loose morals. If Mrs A was in a cantankerous mood, the nurses ignored her but if, as on this occasion, she was in a joking mood, the nurses usually replied to her remarks in the same vein. The second SEN said that she was combing Mrs A's hair when Mrs A had asked her: 'How many men are you going home to tonight?'. She had replied: 'Ten, [Mrs A]'. At this point the complainant had burst through the screen which had been placed across the ward door while the patients were being put on their commodes and had angrily told her that 'she could have knocked her to the floor, talking to an old lady like that'. The second SEN said she had asked the complainant whether Mrs A seemed upset by their conversation but had left without waiting for a reply. She later learned that the complainant had complained of the incident. The divisional nursing officer (the Div NO) had questioned her about what had happened but had not criticised her. She herself had told the consultant geriatrician responsible for Mrs A's treatment (the consultant) of the incident and he had said that it would be best to move Mrs A to another ward.

11. My officer interviewed separately three other nurses who were on duty when this incident occurred. They all confirmed the second SEN's version of the events. She also questioned the Div NO who told her that he had carried out an immediate investigation on receipt of the complaint which he had considered as serious. He said he had interviewed the four nurses separately, without giving them prior warning of the allegations, so that they would have been unable to confer with each other before speaking to him. He said that each of the nurses' versions of events tallied with those of the others. He had been convinced that what they said was true; there had therefore been no question of disciplinary action being taken against them. The SAA said that she told the complainant that her complaint had been investigated but she did not think she said that disciplinary action had been taken against the nurses concerned.

Findings

12. Mrs A clearly sustained a badly bruised ear but I do not believe, on the evidence, that it was the result of her being hit by a nurse. As to the 'taunts', I believe that Mrs A herself introduced sex as a topic of conversation with the nursing staff and that they, sensibly, did not take offence but made light of it. I think the complainant's impression of the conversation was mistaken and there is no evidence that Mrs A herself was affronted. I do not uphold this complaint.

(b) the discontinuation of excursions from the hospital

13. The complainant said that one of the ward nurses had told her and her daughter that they could take Mrs A out of the hospital for tea at a local tea shop to celebrate Mrs A's 94th birthday. The nurse said that Mrs A was entitled to trips out of the hospital but that this was not possible because of a shortage of nursing staff. Mrs A so enjoyed this excursion that the complainant and her daughter started to take her out regularly to the local shops. However, one Saturday following Mrs A's transfer to ward Z, the complainant's daughter and a friend visited the hospital with the intention of taking Mrs A out but they were told that she could not be taken out of the hospital grounds. The complainant was asked to come to the hospital as the consultant wished to see her. At this meeting he told her that the hospital was Mrs A's legal guardian and that he could not allow her to be taken out of the hospital grounds. The complainant offered to accept responsibility for Mrs A but he would not hear of it.

14. The consultant told my officer that he met all the relatives of his patients as a matter of course. After Mrs A was transferred to ward Z, he learnt that the complainant had made a series of complaints about her nursing care and he was disturbed because Mrs A kept disappearing from the ward without the nurses being informed of her whereabouts. It became apparent that she was being taken out of the hospital grounds by the complainant and her daughter. He therefore offered to meet the complainant and at this meeting, he told her that she could no longer take Mrs A out of the hospital grounds until he had sought advice on the hospital's legal responsibility towards Mrs A (but this in fact he never did). He told my

officer that Mrs A was unpredictable, that her mental condition varied and that, in his opinion, she should not be taken out of the hospital. He believed the hospital had a legal responsibility towards its patients and said that he was not prepared to allow any stranger to come into the hospital and take out a patient. He had no objection to a patient's relatives taking out a patient or for patients to be taken on planned excursions by the officially recognised hospital voluntary workers. But as far as he was aware the complainant's hospital visits had been organised by a local church and no official approval had been given for them. If the complainant had wanted to become involved with the hospital's long-stay patients, she should have gone through the officially recognised channels and asked the hospital voluntary worker if she could assist on organised trips. She should not have attached herself to one patient in the way she had.

15. The first sister told my officer that she had thought the complainant and her daughter were taking Mrs A to the canteen in the hospital grounds and she had not been aware that Mrs A was being taken out of the hospital. if they had requested permission to take her to the local shops, she would have first needed to obtain confirmation from the duty doctor that Mrs A was fit to go out but she would not otherwise have objected to this. My officer identified the SEN (the third SEN) who dressed Mrs A for her 94th birthday outing with the complainant and her daughter. She told my officer that she had thought they were taking her to the canteen in the hospital grounds and she had not been aware that they were taking her out of the hospital. The other nurses interviewed also said they were not aware that Mrs A was being taken out of the hospital and that prior medical approval was required for such outings. The Div NO said that anyone, even a relative, was normally required to notify the staff if a patient was being taken out of the hospital.

Findings

16. A hospital clearly has a responsibility towards its patients, especially confused elderly patients who do not receive regular visits from their relatives. Whether or not the hospital was Mrs A's legal guardian, as the consultant evidently believes, is a question of law which I do not need to determine. As to his action in refusing to allow Mrs A to be taken out of the hospital grounds I am in no doubt that he considered, solely in consequence of the exercise of his clinical judgment, that Mrs A's condition was such that the risk of allowing it was unacceptable. This decision is not open to question by me, but I should say that I am satisfied that it was taken entirely in Mrs A's best interests. I dismiss this complaint.

(c) *The wheelchair*

17. The complainant told my officer that when Mrs A was transferred to ward Z she had her own wheelchair. However this was decrepit and was therefore discarded. She was given instead a hospital wheelchair without an air-ring to sit on and she consequently became very sore. The complainant therefore asked the ward sister to provide Mrs A with a foam ring. Later on, Mrs A had a serious fall from another hospital wheelchair she had been given which had detachable sides and no front tray. Despite the fall,

Mrs A was still made to use this chair until the complainant complained to the ward sister and another wheelchair with a fixed tray was found for her. The complainant also said that she complained to a doctor about the use of a wheelchair with loose sides but he told her that there were no other chairs available on the ward.

18. The sister of ward Z (the second sister) said that Mrs A was always given a cushion or air-ring to sit on as this helped prevent pressure sores. The complainant once complained to her that Mrs A had not been given an air-ring but when she went to look at Mrs A she found that she was sitting on one: the complainant had then said: 'Well she didn't have one to sit on yesterday'. The second sister said that she also had an argument with the complainant about the use of pillows at Mrs A's back. The complainant insisted on providing a pillow for Mrs A's comfort but, the second sister said, this pushed her forward and enabled her to slip out of her chair. She therefore removed the pillow and told the complainant that the nursing care of the patient was her responsibility. I have seen a record of this conversation which the sister made in the nursing notes.

19. The second sister said that Mrs A's own wheelchair was taken away from her because she could push out the table tray attached to it and fall: she also pushed the chair into other patients. She was given a hospital wheelchair with detachable sides but she could remove the table tray from this also. The sister said that as far as she was aware Mrs A had not detached the sides of the chair: these chairs were used on the ward because they enabled a patient to slide onto a commode. The second sister eventually found a suitable geriatric chair for Mrs A. This chair had small wheels and was manoeuverable, it tilted backwards slightly and had a table tray fixed to it. Mrs A had been unable to get out of this chair and from then on she had not had any falls.

Findings

20. Although there may have been occasions when Mrs A was inadvertently left without an air-ring, I think that generally she was provided with one. Mrs A was given a wheelchair with detachable sides at one time but the sister considered the chair unsuitable (for other reasons) for Mrs A and eventually found one which prevented her from falling. I do not uphold these complaints.

(d) *The failure to spend Mrs A's pension on personal comforts for her*

21. The complainant said that when she first began to visit Mrs A she had no personal clothing and very few possessions. As far as she was aware the nurses never bought anything for Mrs A from her weekly pension: her eyesight was too poor for her to read, she was teetotal, non-smoking and had never had her hair done by the hospital's hairdresser. The complainant said that Mrs A wanted to buy a new wheelchair from her accumulated weekly pension and the complainant had told the SAA and the Div NO of Mrs A's wish. However she was assured that there was no need for this and that a suitable hospital wheelchair would be provided for her. (I have found—paragraph 20—that this was done.)

22. The hospital records show that Mrs A was in receipt of a weekly pension and that this money was paid into a hospital savings account in her name. Until December 1979, Mrs A withdrew more money than she received in pension ; from January 1980 until September 1980, she withdrew only £2 fortnightly ; and from then until her death only irregular withdrawals of small sums of money (apart from one to meet a solicitor's bill to which I refer in paragraph 32). From January 1980 until her death Mrs A drew only £75·60 out of her total pension income of £634·05.

23. The patients' monies clerk at the hospital (the clerk) told my officer that patients' pensions were generally received fortnightly and paid direct into the patients' savings accounts. Her colleague visited the wards fortnightly to pay out money to those patients who regularly wanted money to spend. The patients, including Mrs A, signed for their money themselves and the transactions were witnessed by the nurse in charge of the ward. The clerk also telephoned the ward sisters each month to ask whether any other patients required money from their accounts and to seek instructions as to any money required by new patients. Payments to patients not capable of making their own wishes known were made at the request of the ward sister to meet their immediate needs. Generally the sisters asked for £1-2 for these patients and kept the money in safe custody on their behalf. The money was spent on hairdressing or on such items as cigarettes, soft drinks etc. obtained from the trolley service. Receipts were not given for purchases from the trolley.

24. The district finance officer (the DFO) told my officer that as far as he was aware, the ward sisters did not keep a record of the small amounts of money spent on behalf of the patients. No specific limit was set, but receipts were expected for sums over about £5. He said that he did not wish the nursing staff to draw more money from a patient's account than was needed immediately or for accumulating sums of money to be kept on the wards and the best method of control, in his opinion, was to limit the money available to the patients. He said that the requirements of most patients were small: there was a plentiful supply of hospital clothing. He did not think there was any necessity to issue guidance to the nursing staff encouraging them to spend the weekly pensions on the patients' behalf and he did not consider this to be a nursing duty ; the nurses, he said, were busy enough without this extra responsibility being given to them.

25. The first sister told my officer that when Mrs A was first a patient on her ward, she asked for her full fortnightly pension but she began to hoard the money and lose it from her handbag and the sister therefore cut the money to £2 per fortnight (much to Mrs A's annoyance) and she kept this money safe in her office. Mrs A purchased chocolates and tissues from the trolley service and the nurses bought fruit from a local stall for her and slippers at Christmas. She also received a copy of a daily newspaper. If receipts were obtained for purchases they were put in the patient's nursing file but she did not otherwise keep a record of purchases. The other nurses on ward Y interviewed confirmed that Mrs A had initially kept her pension in a purse in her handbag. However she began to stuff her bag full of used tissues and rolled her money up in them. The nursing staff frequently cleared her handbag of the soiled tissues but were concerned that they might inad-

vertently also throw away some of her money and Mrs A often made accusations that her money had been stolen. The first sister had therefore started to keep Mrs A's money in her office. They said that Mrs A was capable of saying how she wanted her money spent and they often bought fruit for her from a local street stall. She also occasionally purchased sweets from the trolley service, a daily newspaper and her own slippers: she generally wore hospital dresses as she was incontinent.

26. The second sister said that Mrs A had not been capable of spending money and generally she did not need to do so: both fruit and fruit juice were supplied by the hospital and the complainant brought in clothes for Mrs A to wear on special occasions. Normally Mrs A wore hospital clothing because it was sent to the hospital laundry. Therefore she had only withdrawn money, on Mrs A's behalf, when she wanted her hair done or when the complainant took her to hospital bazaars. On the latter occasions, the sister had withdrawn about £5 from Mrs A's account, Mrs A signing for the money with her own mark, and given the money to the complainant. She had not asked the complainant to account for the money spent by Mrs A. She said that she did not keep a ward record of the money spent on the patients' behalf. If an expensive item such as a pair of slippers was purchased for a patient not able to handle her own money, a receipt was obtained and kept with the patient's nursing record.

27. My officer has seen about a dozen receipts for soap, stockings and other articles of clothing, slippers and hairdresing in Mrs. A's nursing file. There is no record of any item of expenditure made on her behalf between November 1975 and May 1979.

28. The Div NO told my officer that he was aware of the Department of Health and Social Security's guidance on the handling of patients' pensions but he considered that the management of patients' monies was not a nursing responsibility. However the nurses were involved to some extent in making purchases on the patients' behalf and therefore needed to know how much each patient could afford to spend. This information was not at present available to the nursing staff. Although he had not seen any records himself, he 'guessed' that the ward sister kept some record in the form of a receipt book for substantial purchases made on behalf of patients. Receipts were not given for small items purchased from the trolley service and therefore no record was kept of them.

29. The Department of Health and Social Security (the Department) memorandum HM(71)90 issued in 1971, gives guidance to health authorities on the issue of personal allowances such as pensions to long-stay patients. In general, the Department say, patients should be encouraged to spend their full personal allowance apart from any amount they wish to set aside for purposeful saving. Arrangements for the payment of personal allowances and for patients' personal accounts, the hospital cash office and the hospital shop or trolley service should be the responsibility of the chief financial officer or secretary', as appropriate, and their staff. Where patients are so severely handicapped or confused that they are not able to decide on their own requirements, a nurse may need to *order* the goods which the patient

is most likely to appreciate and the nurse in charge of each ward should maintain for inspection by a senior nurse a simple record of all goods obtained for individual patients.

Findings

30. The system for handling patients' pensions in operation at the hospital contravenes the Department's guidance in several ways. From January 1980 onwards Mrs A was clearly not encouraged to make full use of the pension money provided specifically for her benefit and there is only very sparse evidence as to how her money was spent before that date. I have been unable to establish whether or not Mrs A's money was properly spent on her behalf. I do not doubt the integrity of the nursing staff, but the system is open to abuse. I strongly recommend that the health authority urgently review their procedures to ensure that in future adequate records are kept by the nursing staff of purchases made, or ordered, on behalf of patients; that these records are regularly checked by the senior nursing staff; and that patients' pensions are used to provide them with comforts and items to help preserve their dignity, unless the consultant concerned specifically says that he considers that the patient would not benefit. I am far from satisfied that this is so at present and to this extent I uphold this complaint.

(e) *The mismanagement of Mrs. A's financial affairs*

31. The complainant told my officer that Mrs A continually expressed concern about her financial affairs. She therefore reported this to the SAA, saying that she did not want to become personally involved but asking if someone could explain Mrs A's financial position to her: the SAA agreed to do this. However no information was given to Mrs A and, despite the complainant's repeated requests that this information be supplied and suggestions made to the AHA by the secretaries of two Community Health Councils (the CHCs) that a solicitor be engaged to deal with Mrs A's financial affairs, no action was taken. The complainant, therefore, herself engaged a solicitor on Mrs A's behalf. The solicitor, after carrying out some research, told Mrs A that she held £3,000 in trust bonds—the twice yearly income from which was paid into her hospital deposit account, the balance of which was £600; £200 in cash held in a hospital ordinary account; £1,000 held in a current account with Barclays Bank to which was added twice yearly the income from an annuity; and that she was then receiving £5·45 per week pension. The solicitor said that he had found all this information from the papers held by the hospital and that it had therefore been unnecessary to engage him. However, because of the extent of Mrs A's capital, she was ineligible for legal aid and would therefore have to pay his fee, which amounted to £189·17.

32. Following this the two CHC secretaries asked for a meeting with representatives from the hospital to find out why the information on Mrs A's financial position had not been given to her earlier, thus avoiding the unnecessary spending of her money on solicitor's fees. And they asked for an audit to be carried out on her finances because so little money had accrued in her hospital account during the nine years she had been a

patient in receipt of a weekly pension that was not being spent on her. The complainant said that an audit was promised but was not carried out.

33. The SAA told my officer that Mrs A had not been capable of managing her own financial affairs for several years. Until 1977, the then hospital secretary looked after her affairs on an informal basis but he then died and no other member of staff knew much about her financial background. The complainant repeatedly told her that Mrs A had asked for information about her financial affairs but when the ward staff questioned Mrs A about this she said that she did not want the information. The SAA said that she asked the consultant if Mrs A's affairs should be referred to the Court of Protection but he said that he did not think she had enough money to warrant this. Following the request she received from the CHC secretaries that a solicitor be engaged for Mrs A, she wrote to the unit administrator (the UA) on 5 December 1980 asking him to arrange for Mrs A's solicitor to visit her. She heard that a solicitor had visited Mrs. A, assumed that he must be her own solicitor, and the hospital secretary confirmed that he was. She later learnt, however, that he had not been engaged by Mrs A but by the complainant. As a result of her meeting with the two CHC secretaries, the SAA wrote to the district administrator (the DA), and passed on their request for an audit to be carried out on Mrs A's accounts.

34. The UA told my officer that he was responsible for the day to day management of patients' finances. No local guidance was given on the handling of patients' monies and he relied on the guidance received from the Department adapted to meet local conditions. He said that his predecessor, the hospital secretary, had visited Mrs A regularly and discussed her finances with her, advising her to claim back taxes etc. He said that he had also visited her once he was in post and Mrs A had told him that she held money in several accounts in various local banks. He had written to these banks on Mrs A's behalf but they had all replied that she did not have an account with them. In 1978 a former consultant geriatrician had suggested that Mrs A's affairs be referred to the Court of Protection. The UA said that it was his responsibility to refer such cases to the Court of Protection when asked to do so by a consultant who thought that a patient was no longer capable of managing his or her own financial affairs ; it was an error on his part that this was not done in this case.

35. The UA said that he had received the complainant's request that a solicitor be asked to come and visit Mrs A but, before he could make enquiries to determine whether or not Mrs A herself wanted a solicitor, the complainant had engaged one herself. He had not seen the ensuing correspondence with the solicitor and was unaware that Mrs A held a large sum of money in a current account which was not gaining interest. Even if he had known of this however, he would not have considered it part of his duty to advise a patient on the investment of money not held in a hospital account. As a result of this complaint he was trying to improve the feedback of information on patients' finances ; and the pension clerk was now sending him monthly returns of the account balances of all those patients whose pensions were received on their behalf by the hospital.

36. My officer spoke to the DA who said that he had passed to the DFO the SAA's request for an audit of Mrs A's finances. The DFO said that on receipt of this request, the clerk had confirmed that Mrs A was regularly receiving her pension and a check was made on how much income she received from trust funds and on how much money was withdrawn from the hospital account. He was satisfied that her finances were in order and therefore took no further action. No medical decision had been taken that Mrs A was incapable of handling her own financial affairs. If a medical decision had been taken that she was no longer capable of managing her own financial affairs, the Court of Protection would have been approached; and if, following his check on her finances, he had been dissatisfied with the management of her financial affairs, he would have recommended to the consultant that the UA be instructed to approach the Court of Protection.

37. The consultant said that the SAA had asked if Mrs A's financial affairs should be referred to the Court of Protection, but he did not think it was appropriate because Mrs A herself showed an interest in them.

38. The first sister said that Mrs A was very concerned about her financial position and was constantly asking how much money she had and where it was. The sister had told her that the money was safely deposited in her savings account. In her view, Mrs A was 'definitely not' capable of managing her own financial affairs. The second sister also said that Mrs A was not capable of looking after her own financial affairs. She said that Mrs A often spoke of the large amount of money she had but she had never questioned her about how much she had or where her money was kept. The other nursing staff interviewed agreed that Mrs A showed great interest in her financial position.

39. The Department's guidance to which I referred in paragraph 29 also deals with the custody, investment and disposal of money deposited by patients. A personal account should be maintained for each patient who has handed over money to the hospital and the patient should be told of the total amount held for him at appropriate intervals and in answer to reasonable requests. Patients who accumulate more cash than required for their immediate needs and are capable of understanding the transactions involved, should be encouraged and given every facility to invest the balance. Where a patient deposits or accumulates more than £100 from all sources in his account, and maintains such a balance for over three months, an appropriate amount should be reserved for the patient's immediate needs and the rest deposited in an interest earning account.

40. My examination of the hospital's records shows that Mrs A's pension income was properly accounted for as was her investment income (which was, in fact, credited to her savings account and not, as the complainant said, to her deposit account). And I have established that in accordance with the Department's guidance, periodic transfers of surplus monies in the complainant's savings account were made to her deposit account. But there was, and is, no system in operation to meet the Department's advice that each patient should be periodically advised of the total amount held by the hospital on his or her behalf.

Findings

41. The consultant's predecessor thought that Mrs A's financial affairs should be referred to the Court of Protection. I think it is a great pity that this was not done—but that is not the subject of the complaint. The consultant evidently thought that Mrs A was capable of managing her finances and this is a matter arising from his clinical judgment which I cannot question.

42. I criticise the AHA for not giving Mrs A any information about the balances in her hospital accounts. Not only did this offend against the Department's guidance; it ignored Mrs A's repeated requests to the first sister for such information and it effectively deprived her of the opportunity to look after her financial affairs which the consultant considered her competent to do. And since the AHA had knowledge of a substantial sum of money lying idle in Mrs A's private bank account, I think they should have reminded her of this too.

43. I find no substance in the complaint that little money had accrued in Mrs A's accounts when she was in receipt of a pension which was not being spent on her. With the reservation I have made in paragraph 30, I find that her money was propery accounted for. As to the 'audit', I find that a review was carried out. But I think that Mrs A should have been told so.

(f) *The lack of visits by a social worker*

44. The complainant said that she had spoken to a social worker at the hospital when she was trying to obtain information for Mrs A about her financial position. The social worker told her that Mrs A had not been seen by any social worker for six years.

45. The principal social worker (the PSW) responsible for the hospital told my officer that until the end of 1981, each long stay ward had a social worker attached to it and any patient requiring help with a problem not within the province of the medical and nursing staff was referred to the social worker by either the doctor responsible for the patient's treatment or by the ward sister. Social workers were last involved with Mrs A in 1975-76 when they arranged a holiday for her. Since that time the only notes in her file relate to requests for information from the complainant and Mrs A's solicitor which had been passed to the hospital administration. No request had been received from the medical or nursing staff for help with Mrs A.

46. The second sister said that the hospital social workers were not usually concerned with long-stay patients and only visited them when specifically asked to do so. Generally they were only involved where it was necessary to arrange accommodation for the patient in the community.

47. The SAA said that the Social Work Department would only have become involved with Mrs A if her condition had improved to the point where she could be returned to the community or to sheltered accommodation for the elderly.

Findings

48. The evidence is that social workers are generally only concerned with short stay patients requiring help when they return to live in the community and that as Mrs A was a long stay patient she did not need such help. I myself have seen no evidence to suggest that there was need for a social worker to visit Mrs A from 1975-76 onwards and I do not uphold this complaint.

(g) *The AHA's response to the complaint*

49. The complainant said that she was not satisfied with the investigation carried out into her complaints by the SAA and the Div NO and she therefore wrote to the AHA's area administrator (the AA) on 11 December 1980 asking for the matter to be dealt with at area level. However she received a reply from the area general administrator (the AGA) acting on behalf of the AA, dated 15 December that it would be inappropriate for the matter to be dealt with by the AA and that enquiries into her complaints were continuing at district level. The complainant wrote to the AA again on 27 March 1981 saying that she remained dissatisfied with the district's investigation and once more asked for the AHA to carry out their own investigation ; but the AGA replied on 31 March that ' no use would be served by any further investigation at local level ' and that if she wished to pursue the matter, she should take it up with me.

50. The AGA told my officer that at the time of this complaint, he was responsible for dealing with all complaints received by the AHA. The AHA's approach was for the district responsible for the care of a patient to handle all complaints relating to that patient. On receipt of a complaint, an acknowledgement was sent and the complainant informed that the complaint had been passed to the district for reply. If the complaint had already been investigated by the district, he reviewed the correspondence and spoke to the members of staff involved and the senior AHA officers but only in the few cases where the AHA were not satisfied with the way the district had handled the complaint would the AHA then investigate it themselves. In this case the AGA said that he had spoken to the SAA and the DA on receipt of both letters from the complainant. He was satisfied that the matter had been thoroughly investigated and thought that there would be no point in the AHA ' going over the same ground '. He had therefore suggested that if the complainant was not satisfied with the replies she had received, she should bring her complaint to me.

Findings

51. In dealing with the complaint which had been investigated by their officers at district level, the AHA had a duty to review the investigation already carried out and to satisfy themselves that it was thorough. In this case, the AHA reviewed the correspondence, spoke to the district officers involved and were satisfied. I consider that, during the course of their enquiries they should have recognised that the hospital's procedure for dealing with patients' monies was defective and should have admitted that Mrs A should have been told of the state of her finances. Apart from this, I consider that the complaint was handled satisfactorily.

Conclusions

52. I have set out my findings in paragraphs 12, 16, 20, 30, 41-43, 48 and 51 of this report. I have upheld the complaints about Mrs A's spending money and the management of her financial affairs. The Health Authority, who are the relevant successors to the AHA, have agreed to review their procedures on these matters and to bring them in line with the Department's guidance.

Case No. W.57/81-82—Lack of care given to patient following hip operation

Background and complaint

1. The complainant's mother aged 75, was admitted on 16 December 1980 to a ward (ward A) of a hospital (the hospital) for an operation on her hip, which was performed on 18 December. During the early hours of 25 December she was transferred to another ward (ward B) and on 26 December it was found that her hip had become dislocated. She had another operation that night. Her son complains that:—

(*a*) on 25 December his mother spent at least eight hours sitting in an unsuitable armchair, despite the protests of the family and contrary, he believes, to the intention of the consultant (the consultant) responsible for her care, and that as a consequence she suffered additional hardship;

(*b*) when on 26 December his mother's condition deteriorated there was an unreasonable delay before a doctor arrived to examine her; and that

(*c*) he is dissatisfied with the way the Area Health Authority (the AHA) dealt with his complaints.

Investigation

2. The complainant assured me that he had no intention of taking legal action against anyone arising out of his complaint and I agreed to investigate it. During the investigation I obtained the written comments of the AHA and I examined these and other relevant documents including the medical and nursing notes. My officers interviewed the medical, nursing and administrative staff concerned. One of them met the complainant and his sister. The evidence in paragraphs 3, 4, 17 and 26 to 29 is taken from this interview and from the complainant's letters to the AHA and to me.

(a) *The complaint about the time that the complainant's mother sat out and about the chair*

3. The complainant said that on 23 December his mother had been allowed to sit out of bed for short periods provided that her legs were supported. On Christmas day the family had gone to visit her but when they arrived on ward A, at about 2 pm, they were told that she had been moved during the night to ward B because a bed had been needed in ward A for a patient who had been admitted from the accident and emergency

department. They found her in ward B sitting in an ordinary armchair, her legs dangling on the floor and next to a bed which had no bedclothes on it. They said that they were shocked at the change in her condition. Although previously she had had no difficulty in communicating with people or feeding herself, now she was confused and disorientated and her dressing gown was covered with spilt food. The complainant said that there were no nurses about and eventually he found them in a restroom. He asked whether it was all right for his mother to be sitting out of bed, and a nurse told him that it was in order because it was in the consultant's notes. The family left the hospital at about 3.15 pm but the complainant and his sister returned later. The complainant estimated that this would not have been earlier than 4.15 pm. His mother was still sitting out of bed and they expressed their concern to another nurse who was in the nursing office. They said that that nurse reacted defensively and replied 'of course it's all right, it's in the notes'. The complainant said that his mother had still been disorientated and that she had barely known who they were and had not been able to talk to them. The following day the complainant and his sister were told that their mother had suffered a dislocation of the same hip that had been fractured.

4. The complainant told me that his mother must have been sitting out of bed with her legs unsupported for at least eight hours on Christmas Day. He did not think she could have been put to bed since her transfer during the night as the bed next to which she was sitting had not been made up. He said that nurses had told him that his mother would let them know when she wanted to return to bed. But he said that he doubted how she could, as she had been in a partitioned cubicle and could not be seen from the nursing office, her immediate neighbour was senile, and her own voice was affected by Parkinson's disease so that she would have been unable to make herself heard if she had called out.

5. The AHA told the complainant that his mother had been transferred from ward A to ward B because of the pressure on beds and that such transfers were regular occurrences. They said that the consultant had specifically instructed that the complainant's mother should spend time sitting out of bed and that his instructions had been carried out. They said that once the consultant had made his decision the nursing staff carried it out in the light of their professional expertise, but that there were regular opportunities for the medical and nursing staff to discuss the progress made by each patient. As to the dislocation of her hip, the AHA said that the incidence of such a dislocation was widely recognised to be especially high in patients who suffered from Parkinson's disease and that they were satisfied that there was no lack of care given to her which could have given rise to this further complication.

6. The AHA told me that the consultant had seen the complainant's mother on 24 December and had instructed that traction should be discontinued and mobilisation begun. They said that the complainant's mother had sat out of bed from approximately 9.30 am until 3.30 to 4 pm on Christmas day. They said that the sister in charge of ward B (the first sister) could not be sure what type of chair had been used but that it was the normal

practice to use a geriatric chair because they were fittted with a high supportive back. The AHA said that the relatives had visited during Christmas afternoon and that they were very angry that the complainant's mother had been transferred in the middle of the night. They had asked why she was sitting out of bed and the first sister had assured them that this was in accordance with consultant's instructions and was the first stage in her gradual mobilisation.

7. There is no reference to mobilisation in the medical notes for 23 or 24 December. The relevant part of the entry in the nursing record for 24 December says, 'Seen by [the consultant] discontinue traction sit out of bed & mobilise.'

8. The consultant told my officer that the complainant's mother had started her mobilisation on 24 December, which was a little later than most patients. Her Parkinson's disease made the decision a very finely balanced one. He said that he knew that she had her first walk that day when she had been accompanied by a physiotherapist. He said that he did not normally include information about a patient's mobilisation in the patient's medical notes. He said that he left the pace of a patient's mobilisation to the discretion of the physiotherapist or the nursing staff and he expected them to refer to him only if they were in doubt. He said that he would not have expected or approved of the complainant's mother sitting out of bed on Christmas Day for eight hours or more. He also said that a variety and combination of activities were the best means of mobilising a patient with Parkinson's disease, and he considered that spending a long time in one position could be conducive to dislocation and to bedsores. The consultant said that it was important that the seat of the patient's chair should be at the same level as the vertical height of the shin, and that the chair should have good high arms. He said that such chairs were not available on ward B.

9. An orthopaedic registrar (the registrar), who had been involved in the patient's care during this time, told my officer that a reasonable period for the complainant's mother to sit out on Christmas Day would have been 1½ to 2 hours. He did not think that support for her legs would have been essential.

10. A night nurse (the night SEN) told my officer that she had been on duty in ward B early on Christmas Day when the complainant's mother had been admitted from ward A, and the patient had been put straight to bed. She had also been on duty during the next night and said that when she came on duty at 8 pm the complainant's mother had been sitting out and that later on she had put her to bed.

11. The first sister told my officers that she had not been trained in orthopaedic nursing but that she had gained considerable experience in it by nursing orthopaedic patients transferred to her ward. She said that she had been on duty from 7.45 am until 2.30 pm on Christmas Day and that the complainant's mother had sat out of bed from about 9.30 am. She had seen the entry in the nursing report which said that the patient should be gently mobilised and, at about 11.30 am, she had asked her whether she wanted to go back to bed. The patient had declined and had said that she

was very comfortable. The first sister said that in her opinion it was too soon after her operation for the complainant's mother to sit out of bed for a long period. She added that if after lunch the patient had still wanted to sit out she would have insisted that she be put back to bed. The first sister told my officer that she had learned subsequentlly that the complainant's mother had been put back to bed by the night staff. She said that she had been told by the consultant, as well as by other consultants, that a chair with a sloping back was preferable to a chair with an upright back for post-operative patients. She said that although the chairs on her ward had good high seats, the seats were rather too long and, because of this, it had been necessary to prop the complainant's mother up with pillows. She said that she could not remember whether the patient's legs had been elevated. She said that she would have expected to have been given more detailed guidance on how to mobilise her.

12. A day nurse (the day SEN) told my officer that she had been on duty in ward B from 2 pm until between 8.30 and 9 pm on Christmas Day and that she had been in charge of the ward during this time. She said that she thought the complainant's mother had been sitting out when she came on duty. She said that the complainant's mother had been moved out of her own bay in order to get her away from a confused patient. She said that this confused patient tended to get into any bed that was made up and unoccupied and that the complainant's mother had been sat alongside a bed which had been stripped of bedclothes. The day SEN remembered speaking during the afternoon to the complainant's sister who had been annoyed that her mother had been transferred from ward A, and that she had read out to her the instructions in the nursing record about mobilising her mother. The day SEN said that all patients who were sitting out of bed had call-bells tied to the sides of their chairs and that they had been told to ring them if they wanted to go back to bed. She said that in addition the nursing staff regularly asked patients how they felt and if a patient did not want to go back to bed she would not be forced to do so.

13. The sister in charge of ward A (the second sister) told my officer that a doctor would not give detailed instructions but would leave the progress of mobilisation to the physiotherapist and the sister. She said that the first time a patient sat out of bed her leg would be elevated. On the first day of mobilisation a patient would only sit out while her bed was made, and a careful watch would be kept on her to ensure that she was not tiring. A patient like the complainant's mother would sit out of bed for an hour or so on the second day of her mobilisation. She would sit in a special orthopaedic chair to stop her slumping down because if she did there would be a greater likelihood of dislocation occurring. She said that it was better for the patient to be out of bed for several short periods than for one long one.

14. The consultant told my officer that sitting out of bed for as long as she did might have contributed to the dislocation of the complainant's mother's hip, but that it could not be regarded as a direct cause. He said that her hip had probably been progressing gradually towards dislocation and that this could have been precipitated by a spasm as a result of her Parkinson's disease and could possibly have occurred when she was in bed.

Findings

15. This complaint is amply made out. The complainant's mother was sat out of bed for at least eight hours and possibly for as long as twelve hours. This length of time was well beyond what the consultant had intended. The complainant's evidence has proved accurate on every other detail and I therefore see no reason to doubt his statement that his mother was in an ordinary chair and that her leg was not elevated. I uphold this complaint.

16. He did not complain to me about the circumstances of his mother's transfer from one ward to another as he accepted that it was a clinical decision and outside my jurisdiction. On the decision itself I may not comment, but I am surprised that no attempt was made to inform the relatives of this transfer.

(*b*) *The delay before a doctor arrived on 26 December*

17. The complainant's sister said that she had telephoned the hospital at about 8 am on 26 December 1981 when she was told that her mother was all right. But when she and her brother saw her at about 3 pm they found her lying in bed almost unconscious. The first sister told them that her condition had deteriorated shortly after breakfast and that staff had been trying to get a doctor since before mid-day. Eventually the first sister telephoned a doctor at home. He arrived at about 4.30 pm. As a result of his examination he found that the complainant's mother's hip had been dislocated. An operation was performed during the evening.

18. The AHA told me that the complainant's mother had sat out of bed at about 9.30 am on 26 December. Shortly afterwards she had vomited and this, combined with other symptoms, suggested that she may have had a minor stroke. She was immediately put back to bed. Efforts were made to contact a duty doctor (the first SHO), both by 'bleeping' him and ringing around other wards. When he could not be found another duty doctor (the second SHO) was traced to a nearby hospital. The first sister arrived on duty at 12.30 pm but a doctor still had not arrived. When her efforts also proved abortive she contacted another doctor (the third SHO) at home. Although he was off duty, the third SHO came to the hospital at about 4 pm and examined the complainant's mother. He found that she had dislocated her prosthesis and she was taken to the theatre at 7.30 pm. The AHA told the complainant that the demands on medical staff during the Christmas period were particularly heavy. They said that inevitably priority had to be given to patients such as those coming to the accident and emergency department. They said that the availability of medical staff was to a large extent dependent upon other emergency demands such as these together with duties in the operating theatre. They also told the complainant 'it is certainly quite clear that any delay did not result in any harm being caused to your mother'.

19. The consultant told my officer that he thought the delay had been caused by the duty doctors having to cover accident and emergency services as well as wards, and because staffing levels had been low over the Christ-

mass period. The delay had not, in his view, aggravated the patient's condition since from 10 am until early evening was not an unreasonably long time in which to make the necessary arrangements for an operation. He said there was some evidence that she had had a stroke.

20. The first SHO told my officer that he could not remember anything about what he had been doing on 26 December. He said that his 'bleep' had often gone wrong and that he had spoken to the hospital's administration about it. The unit administrator at the hospital (the UA) told my officer that he could not recall the first SHO complaining about his 'bleep'. He said that 'bleeps' were normally reliable but that occasionally a 'bleep' would consistently fail to work in a particular location. My officers were unable to trace the second SHO who is now living abroad.

21. The registrar told my officer that at the hospital the two senior house officers were first and second on call and a registrar third on call. He said the nurses were reluctant to summon a registrar directly. He considered that the orthopaedic medical staffing level needed to be increased if an adequate service was to be provided.

22. The day SEN told my officer that she had been on duty on 26 December from about 7.45 am until 2.30 pm. She said that the complainant's mother sat out of bed at about 9.30 am and that her condition then had been no different from what it had been on Christmas Day. At about 10 am the complainant's mother vomited twice; she was perspiring and 'clammy', leaning to the right and she would not answer the nurses' questions. The day SEN considered that she had had a stroke and immediately tried to contact a doctor but she did not receive replies to the 'bleep' calls that she put out to the first SHO and the second SHO. She said that the first sister had arrived at 12.30 pm and had taken over although she had not been due until 2 pm. The day SEN said that she would have contacted a nursing officer had the first sister not arrived when she did. Another nurse who had been on duty with the day SEN confirmed this account.

23. The first sister told my officer that she had thought that something was wrong with the patient's hip. She 'bleeped' the first SHO and the second SHO but received no reply and therefore she telephoned the third SHO at home at about 2.30 pm. She said that he arrived at about 4 pm.

24. The divisional nursing officer (the Div NO) told my officer that it was a pity that the nurses on ward B had not contacted the duty nursing officer when they had difficulty in contacting the first and second SHOs. She said that they were instructed to do this but were often reluctant to call senior nursing or medical staff.

Findings

25. What the AHA told the complainant about the demands placed upon medical staff during the Christmas period may well have been true, but there is no indication in this case that they tried to establish it one way or the other. It is in any case irrelevant to the complaint because the doctors failed to receive a message which would have enabled them to make a clinical decision about the priority they should give to the patient's

need. The consultant considers that the delay had no deleterious effect on treatment and it is not for me to comment on that. What does concern me is the failure in the implementation of the arrangements for the calling of medical help, which *might* well have been vital, and the apparent complete lack of action by the AHA to improve those arrangements when they considered this case. I uphold this complaint.

(*c*) *The AHA's handling of complainant*

26. The complainant said that on 7 January 1981 he complained to an administrator at the hospital about the care that his mother had received over the Christmas period and he enquired about hiring an airbed which the consultant had said would benefit his mother. The following day the complainant had telephoned the UA who had been told about his complaint. They discussed the airbed and the UA told him that a benefactor might be persuaded to make a donation to enable one to be purchased. The complainant had then asked the UA what would happen about his complaint. The UA told him that he could not discuss it as it was under investigation but that following an investigation the consultant would issue a medical report and the complainant would be sent a copy. The UA had also told him that if he wanted an explanation of any of the technical terms in the report a meeting could be arranged with the consultant or a senior nursing officer. On 13 and 19 January the complainant telephoned the UA about the airbed. He said that he had not asked about the progress of his complaint in view of what the UA had told him previously, but he did so on 24 February. The complainant said that the UA had seemed evasive about the consultant's report. He asked whether the complainant would like to see a senior nursing officer and to the complainant it appeared that the UA had changed his mind about how the complaint would be handled.

27. The complainant said that on 3 March the then acting District Administrator (the ADA) wrote to him saying that he would be happy to investigate his complaints and asking him to put them in writing. The complainant replied on 6 March. He reiterated the complaints that he had made orally. He also said that he felt the ADA should investigate the way in which his complaint had been handled, and that if it had been required in writing why had it taken until 3 March to ask for it? The ADA replied to the complainant on 18 March. His comments on the care given to the complainant's mother have been referred to earlier (see paragraphs 5 and 18). About the way the complaint had been handled, the ADA said that normally he undertook a full investigation into a complaint and then sent the complainant a written reply or invited him to discuss it. The ADA said that when it had become clear that it would be more appropriate for these complaints to be dealt with formally he decided to write to the complainant in order to establish that footing.

28. The complainant wrote to the ADA again on 31 March, and in respect of the handling of his complaint asked whether after an undertaking to begin an investigation and to provide a written report had been given, it was correct that nothing be done for a period of eight weeks. The ADA

replied on 7 April saying that he would arrange for the complainant's letter to be considered once again by the consultant and would write to the complainant again. He said he was surprised at the points that the complainant had made about the handling of his complaints: he understood that the UA had been in regular contact with the complainant during much of the period in question and that the complainant had had discussions with the consultant. He also said that the investigation of the written complaint had been completed within two weeks.

29. The complainant wrote again to the ADA on 21 April asking for a reply to all the points that he had raised and pointing out that his discussion with the consultant had taken place before he made a complaint. He said that when the UA had told him that he would receive a written medical report he had also said that he was unable to discuss the complaint until that report had been completed. The complainant told the ADA that this had led him to believe that he could not discuss his complaints further with the UA.

30. The AHA told me that at the meeting with the UA not only was the complainant's mother's transfer to ward B discussed but also her deteriorating condition. The complainant had told the UA about a conversation he had had with the consultant in which he had been told that it would be to his mother's advantage to be nursed on a 'low air-loss bed'. The AHA said that the UA's main concern was to deal with the 'positive aspects of the case' and that enquiries had been made about hiring or purchasing such a bed. The complainant had been kept informed of progress by telephone and, thanks to a donation, a bed had been purchased which had been of benefit to his mother. The AHA said that, up to this point the complainant appeared to have been satisfied with the way they had been dealing with his representations, and that he had also had discussions with the consultant and members of the nursing staff. However, at the end of February he had telephoned the UA and asked for a formal report to be sent and the ADA had assumed responsibility for the matter.

31. The UA told my officer that the major part of his conversation with the complainant on 8 January had been about the 'low air-loss' bed, but that he had also assured him that he would investigate his complaints and send him a written report. However, he had not intended to give him the impression that a medical report by the consultant would be sent to him. The UA said that he had asked the then senior nursing officer (the SNO) to initiate an investigation but he had met with 'a degree of equivocation'. He had then realised that the complaint was not straightforward and had decided that the best method of dealing with it was to arrange a meeting between the complainant, the SNO and the consultant. However, he had seen the acquisition of the 'low air-loss' bed as his first task. The UA said that on 19 January he had telephoned the complainant about the 'low air-loss' bed and he suggested a meeting to discuss the complaints. The complainant declined and reminded the UA that he had said that he would send him a report of his investigation. The UA said that on 27 February he had asked the Div NO orally for a formal report but that he had received the same reaction from her as he had received from the SNO.

He told my officer that he did not think that it would have made any difference if he had put his request in writing.

32. The Div NO told my officer that the UA had first mentioned to her in February 1981 that he had received an oral complaint from the complainant but that the UA had not spelt out the exact nature of the complaint. She had begun her preliminary investigations and had obtained statements from the first sister and the second sister but she told my officer that she now saw that they did not answer the complaints. The Div NO said that following a request from the UA in August 1981 she had provided a written response to the complaint. But she felt, in retrospect, that she should have gone into the complaint at an earlier stage.

33. The ADA told my officer that he was uncertain whether he had known that the UA had told the complainant that he would receive a written reply to his complaint. The ADA had been involved in obtaining the 'low air-loss' bed and he had known that the complainant had made an oral complaint and that the UA was dealing with it. But he had had the impression that the complaint was a minor issue compared with the need to obtain the 'low air-loss' bed and he had considered that the acquisition of the bed would probably satisfy the complainant. Later the UA had told him that the complainant was beginning to feel that his complaint was not being investigated properly and therefore he had written to the complainant.

Findings

34. The handling of the complaint may have been well-intentioned but it was very confused and disorganised. The replies were uninformative and often concentrated on matters irrelevant to the points at issue. For example, however statistically probable a dislocation might have been, the complaint was about the complainants mother's care on Christmas day. Similarly the answer to the complaint in respect of the failure of the staff of ward B to reach a doctor was based on supposition rather than a proper investigation. I uphold this complaint.

Conclusion

35. I have upheld each of these complaints. The Health Authority, who have succeeded the AHA, have told me that they have reviewed the instructions given to staff about the care of patients who are transferred within the hospital; the arrangements and mechanisms for the summoning of doctors; and the way that complaints are handled. They will also ensure that patients' relatives are told when patients are transferred between wards. The Health Authority have asked me, in this report, to convey their apologies to the complainant for the shortcomings I have found and I gladly do so. I hope that the complainant will gain some satisfaction from the fact that his complaint should lead to an improved service for other patients and their relatives.

Case No. W.101/81-82—Scald suffered by patient whilst in hospital

Background and complaint

1. The complainant's wife's aunt, aged 79, fractured her leg in a fall at home and was admitted to hospital (the first hospital) on 28 November 1980. On 10 January 1981, two days before she was expected to be discharged, she was scalded while taking a bath and was transferred to another hospital (the second hospital) where she died on 12 February 1981. An inquest into her death was opened on 20 February and completed on 25 February. I have seen that the verdict of the coroner was one of 'misadventure' and he expressed the view that she should have been supervised, but he attached no personal blame to any of the nurses involved.

2. The complainant says that:—

(*a*) he is not satisfied with the account of the accident given to him by the Area Health Authority (the AHA); and that

(*b*) he is not satisfied with the enquiry that the AHA made into the accident, or with the way they dealt with his complaint.

Jurisdiction and investigation

3. The complainant assured me that he would not take legal action against anyone arising out of his complaint and I agreed to investigate it. During the investigation I obtained written comments from the AHA (which was superseded on 1 April 1982 by the District Health Authority) and I have examined relevant papers, including the medical and nursing notes. The deputy coroner supplied me with 'notes of evidence' taken at the inquest. My officer interviewed the medical, nursing and administrative staff involved. He also met the complainant and his wife's aunt's brother. The evidence in paragraphs 4, 15, 16, 17 and 18 is taken from this interview and from the complainant's written statement to me.

(*a*) *The complaint about the AHA's account of the accident*

4. As I explain in greater detail when I consider complaint 2(b), on 15 January the complainant asked the AHA for a formal enquiry into the accident, but because of his wife's aunt's death a proposed meeting was postponed. The complainant told my officers that as a result of this postponement the first time he and the family heard a detailed account of the accident was at the inquest on 15 February. He said that evidence given by nurses at the inquest had been that his wife's aunt had been sitting in hot water when she was found, and the nurses' supposition was that she must have taken out the bath plug, allowed the bath to empty, replaced the plug and let in three to five inches of scalding water while sitting in the bath and without apparently calling out. The complainant and his wife's aunt's brother said that when they had visited the aunt at the first hospital before the accident they had seen that even with the aid of a walking frame she could walk only very slowly. They also said that for many years she had been unable to use her right arm properly although her fingers could grip. They could not understand how, if she had been sufficiently mobile to turn the tap on, she had not turned it off as soon as she had felt the discomfort.

The complainant said that he thought it was possible that she had been put into water that was too hot. He also said that a pathologist had said in evidence that 'a few seconds' exposure would have been sufficient to cause the scalding.

5. According to the notes of evidence, a nursing auxiliary (the NA) said that she had prepared the bath for the aunt and that it had contained approximately seven inches of hand-hot water. After she had helped the aunt into the bath, she left the bathroom to assist a student nurse (the SN) who had previously asked her to help with another patient. The NA said that when she returned to the bathroom, the aunt was sitting quite happily washing herself and she therefore went back to help the SN with her patient. This had only taken a few minutes and, when she and the SN had finished, they had both gone to the bathroom. They found the aunt sitting across the bath and after they got her out they noticed that her back was red and her skin was peeling. The NA said that the bath had contained a small amount of water and that the aunt had said that she had turned the hot water tap on.

6. The notes of evidence record that the SN said that she had taken the aunt into the bathroom for her bath. The NA was there and water which was not steaming, but which she presumed was hot, was already in the bath. She left the bathroom before the aunt had got into the bath. About five minutes later she saw the NA enter the ward and immediately return to the bathroom. About fifteen minutes after that, the NA had come to her in the ward and helped her to put a patient into a chair. The SN said that, at that time, she made an enquiry about the aunt and the NA told her that she had left the aunt in the bath. The SN said that she would go to see if the aunt was all right, but as she approached the bathroom, she heard the aunt calling out. She found her lying across the bath with her legs over the side and her buttocks in the water. The SN said that only about three minutes had elapsed since the NA had left the bathroom. The NA had followed her into the bathroom and together they lifted the aunt out of the bath. The SN saw that the lower part of her back was red and apparently scalded and that there was skin on the side of the bath. She heard the aunt say 'I have done a stupid thing. I have turned the hot water tap on instead of the cold.' The SN said that she did not test the water and she did not recall whether the plug was taken out whilst she was there. She said that prior to this incident the aunt had got about the ward quite well with a walking frame. She also said that the aunt had been mentally confused.

7. A state enrolled nurse (the SEN) said, according to the notes of evidence, that at about 11 am on 10 January 1981, the NA had asked her to come quickly and have a look at the complainant's wife's aunt. She went into the bathroom and found the SN with the aunt. The aunt was sitting in a chair, her buttocks and right leg mainly were scalded and there was also some scald mark on her left leg. The SEN said that the aunt was talking a lot and that she had said 'I shouldn't have done it. I have turned the hot water on.' The SEN said that there were about three inches of scalding hot water in the bath. She also said that the plug was quite effective. She did not know what time had elapsed between the aunt taking her bath and her being discovered in the position described by the SN and the NA, but she thought

that the aunt would have been nimble enough to turn the tap on and pull out the plug. The SEN said that the aunt had been able to walk with a walking frame but that she often walked without it. She also said that the aunt was mentally confused.

8. The SEN who had been in charge of the ward when the accident occurred and the SN confirmed to my officer their opinions given at the inquest about the aunt's mobility and her mental confusion. Most of the other nurses interviewed by my officer described her as very mobile or fully mobile and they all said that she was either confused or very confused. A number of them said that they had seen her walking without the aid of a walking frame, and that they had not noticed anything abnormal about her right arm. The duty medical officer (the DMO), who had examined the aunt after the accident, told my officer that although her mobility had been good when she was walking around, getting out of a bath would have been quite difficult for her. He also said that he had not noticed anything abnormal about her right arm.

9. The consultant pathologist (the pathologist), who had carried out the *post-mortem* examination of the aunt and had given evidence at the inquest, told my officer that in his opinion she could have been lucid at times and then suddenly become confused. The pathologist said that the scalding on the body, was consistent with the evidence given by the NA and the SN of the position in which they had found the aunt in the bath. The pathologist said that the aunt's operation would have reduced her mobility, although in his opinion she would have been capable of removing the bath plug, replacing it and operating the hot tap. He thought that she might not have realised what she was doing even when she felt the scalding water, and that because of her mental condition she might have had a reduced sensitivity to pain. He said that he had not noted anything abnormal about her right arm, although he said that the condition that the complainant had described (see paragraph 4) was typical in a person who had partially lost control of the limb, the cause of which could have been the large degree of deterioration in her brain. He said that if this had been the case it would have been almost impossible for her to have got out of the bath unaided.

10. The sister told my officer that she had nursed the aunt on two wards and knew her quite well. At the time of the accident she and a staff nurse (the staff nurse) had been attending a lecture and the SEN had been left in charge of the ward. She said that she had been called to the ward and had found the aunt sitting out of the bath ; the aunt had been shocked and had said 'I'm sorry' over and over again. The sister told my officer that there had been seven nurses on duty on the day of the accident. This had been a high number for a Saturday. I have also seen that a divisional nursing officer (the Div NO) said in a memorandum that, in the light of the staffing levels and the patients' conditions, the accident should not have occurred.

11. The NA told my officer that she knew that confused or elderly patients should be accompanied when bathing but that staff tended to use their own judgment particularly when other things had to be done. The senior nursing officer (the SNO) told my officer that except for the bathing of babies there

were no written instructions to staff about the bathing of patients at the time of the accident. The area nursing officer (the ANO) told my officer that bathing policy was being considered by the Area Nursing Procedures Committee and that a policy document had reached final draft stage. It was expected to state that 'dependent' patients must never be left alone when bathing, and that the decision about whether or not a patient was 'dependent' must be taken by the ward sister. He said that the complainant's wife's aunt would have been regarded as a 'dependent' patient.

12. The hospital administrator at the first hospital (the HA) told my officer that two different types of thermostatic control device for the hot water supply to the bath in which the aunt had her accident had since been tried experimentally. One had proved satisfactory and it was planned to fit it to all baths in the acute wards at the hospital. He said that baths in the geriatric wards were already fitted with thermostatic valves. The general administrator at the AHA (the GA) told my officer that the fitting of thermostatic control devices to baths in the acute wards of all hospitals in the area was under consideration.

Findings

13. The coroner's verdict was 'death by misadventure' and I see no reason to question that verdict or the evidence given on oath to the coroner. The evidence I have examined confirms that the aunt was quite capable of causing the injury she sustained. I find that the AHA were at fault in leaving her unattended but I find no reason to criticise the explanation they offered to the complainant.

14. I am pleased to say that the Health Authority have told me that a bathing policy has been implemented (see paragraph 11) and that thermostatic controls have been fitted to the taps of the bathroom of the ward in which the accident happened. They have also been fitted in some other wards in their hospitals. These steps should help to avoid a similar accident in the future.

(b) *The complaint about the AHA's enquiry and the way they dealt with the complaint*

15. The complainant told my officer that he had telephoned the first hospital on 11 January the day after the accident. He said that later that day he and his wife's aunt's brother met the DMO, who had been very sympathetic but knew nothing about how the accident had occurred and the duty nursing officer (the first NO). The complainant and his wife's aunt's brother were told that the aunt had been scalded during a mid-morning bath and that those concerned would be dealt with, but they were not given any details about the accident other than that water needed to be very hot for sterilising equipment, and a vague reference had been made to the depth of the bath water.

16. The complainant wrote to the area administrator (the AA) on 15 January 1981 informing him of his dissatisfaction with the discussion with the DMO and the first NO and saying that the accident was 'sufficiently

serious to merit a more official enquiry'. The AA replied to the complainant on 22 January saying that the request would be considered and that he would write to him again as soon as possible.

17. The complainant told my officer that he had concluded from this reply that the AHA were not going to enquire into the accident and he wrote to the AA again on 29 January. The AA had replied on 2 February saying that it was necessary to make a full enquiry into the circumstances surrounding the unfortunate incident. The AA wrote again to the complainant on 6 February stating that the chairman of the AHA (the Chairman) was satisfied that the facts about the incident were not in dispute and that he did not feel that any useful purpose would be served by setting up a 'committee of inquiry'. He said that the Chairman would be willing to discuss the matter with any of the relatives and suggested a meeting on 12 February. However the aunt died that day and the meeting was postponed until after the inquest.

18. The postponed meeting between the complainant, his wife's aunt's brother and the Chairman took place on 5 March, and the AA, the ANO and the secretary of the Community Health Council also attended. The complainant said that he had made it clear that he did not agree that the facts were not in dispute and he also expressed his concern at the way in which the AHA had handled the complaint. He had asked for a committee of enquiry. He said that the only real information to come out of the meeting was that disciplinary action had been taken against two of the nurses involved in the accident. However the AA wrote to him later to say that this information (which had also been given to the press) had been incorrect, and that it had not been possible to discipline one of the nurses because of her continued absence on sick leave. The complainant said that he had further correspondence with the AHA but the family remained dissatisfied. He had written to his Member of Parliament who referred the matter to the Minister for Health. The complainant remained dissatisfied with the reply he received and referred the matter to me.

19. The AHA told me that the day after the accident, the DMO and the first NO had seen the relatives to explain the circumstances of the unfortunate incident. The AHA said that in the course of their correspondence the complainant had requested an 'official investigation' into the accident but their legal adviser's opinion was that 'no useful purposes would be served by a committee of enquiry being established, as the facts were not apparently in dispute, appropriate action was being taken to avoid a recurrence and the matter was being dealt with under the [AHA's] disciplinary procedure'. At the meeting on 5 March (see paragraph 18), it had freely been admitted that the aunt should not have been left alone in the bath and that the nurses concerned had been dealt with in accordance with the AHA's disciplinary procedure. It had also been explained that some departments needed very hot water, but that the AHA were experimenting with mixer taps which would allow the temperature to be controlled at patients' bathroom taps.

20. The AHA told me that they did not consider an enquiry necessary as in their view there was no doubt about what had happened or that there was any dispute about the material facts. However, after the meeting the

complainant wrote to the AA again, asking for the decision not to set up a committee of enquiry to be reconsidered. The AA had replied that the Chairman did not feel that any useful purpose would be served by such an enquiry. The AA also gave some detailed information about the depth of bath water and the probable length of time that the aunt had been left unattended. In addition the AA apologised to the complainant because, since the meeting, it had been discovered that disciplinary action against one of the nurses had not been completed because of her continued absence on sick leave.

21. The AA told me that he had received another letter from the complainant but he had not attempted to deal with it because, by that time, the correspondence had been referred to the Minister for Health. Subsequently he had made a full report to the Department of Health and Social Security. The AHA said that they felt that they had done all they could to satisfy the complainant.

22. I have seen that on the day of the accident the NA and the SN each made a written statement about it. Two days later the SEN made a written statement and the sister completed an accident report and all these documents were sent by the first NO to the nursing officer normally responsible for the ward (the second NO) immediately. The second NO interviewed the SEN on 17 January and the SN on 26 January. On 19 January the second NO wrote to the SNO about the accident and, on 28 January, the SNO wrote to the Div NO. The Div NO made a detailed report to the ANO on 5 February. The Div NO told my officer that this had been the first occasion on which the SNO and the second NO had had to carry out such an investigation and that therefore there had been some delay in completing it, but that he was satisfied that they had got to the truth of the matter.

23. The first NO told my officer that, on the day that the accident occurred, she had told the sister that if the relatives wanted to speak to a doctor then they could speak to the DMO. She had telephoned the SNO and the duty administrator both of whom had decided that there was no need for them to come to the hospital. The first NO said that the complainant and his wife's aunt's brother were told about the aunt's condition by the DMO, and she herself had told them that an emergency had occurred and that the nurse who had been supervising the aunt had left her alone to go and help with it. She told my officer that the complainant and his wife's aunt's brother had seemed satisfied with the information she had given them but that they had asked some questions, in particular about whether it might be possible to control the temperature of the hot water supplied to the bath. The complainant had also asked if he could write to the AA and she had told him that he could. Following the meeting the first NO wrote to the SNO listing five questions which the complainant had asked.

24. The DMO told my officer that the complainant and his wife's aunt's brother had been told that the nurse who had been supervising the aunt had had to leave her, and that an accident had occurred which everyone regretted. In his opinion the complainant had not seemed to be satisfied by the explanations about the water temperature.

25. The SNO told my officer that she had reported the accident to the area nurse (general administration) (the AN(GA)). She said that the questions the complainant had asked could not be answered until after the investigation into the accident had been completed. She said that she knew the complainant had written to the AA and she thought that she had told either the AN(GA) or the ANO about his questions.

26. The AN(GA) told my officer that the SNO had told him on the morning of 12 January of the accident and that a detailed investigation into it was proceeding quickly.

27. The HA told my officer that the first NO had told him that the complainant and his wife's aunt's brother had appeared to accept the explanation that had been given to them. He said that he had not known about the points that the complainant had raised. I have seen that the HA wrote to the GA on 20 January 1981 and had said that the first NO and the DMO had interviewed the relatives and 'explained the incident to them'. The GA told my officer that he had assumed from this that the relatives had been given a full explanation about the accident.

28. The Div NO told my officer that he had taken up his post shortly before the accident. He said that he now felt that arrangements should have been made for him and an administrator to see the relatives. The ANO told my officer that there had appeared to be a misunderstanding in that it had been thought that the matter had to be referred to the AHA headquarters rather than be dealt with locally. He had assumed that the sector management team had been investigating the accident and that the relatives had been given a full explanation about it, and he said that he had since told the Div NO that he had expected him to see the relatives. The ANO also said that staff have been told to inform either him or the AN(GA) of any serious untoward occurrence so that developments can be monitored, and that divisional nursing officers have been told that they must discuss such an occurrence with an administrator at their level.

Findings

29. This accident was very serious. I think the DMO and the first NO acted responsibly and as helpfully as they could when they met the relatives on the day after the accident. Reports on the accident were made promptly and comprehensively. Thereafter until the complainant wrote to the AA there was confusion and misunderstanding about who was responsible for coordinating action about the complaint. I uphold the complaint about this aspect of the AHA's handling of his complaint. I am pleased to say that the Health Authority have assured me that the procedure to be followed at hospital level is now much clearer.

30. This confusion ceased after the complainant wrote to the AA. I recognise that the proposed meeting on 12 February could not proceed because the aunt had died and her death had been reported to the Coroner. I do not criticise the way the AHA acted thereafter nor do I find any maladministration in the way that they made their decision that a committee of enquiry would serve no useful purpose. I do not uphold the complaint about this aspect of the AHA's handling of the complaint.

Conclusion

31. I have given my findings in paragraphs 13, 29 and 30 and the Health Authority have asked me to convey, through this report, their apologies to the complainant for the shortcomings I have found, and I gladly do so. I hope that he and the other relatives will take some consolation from the improvements referred to in paragraphs 14 and 29 which have been made as a consequence of this tragic accident.

Case No. W.102/81-82—Unsatisfactory accommodation and lack of physiotherapy for private patient

Background and complaint

1. The complainant's mother, the aggrieved, (aged 76), was admitted on 14 August 1980 as a private patient to a hospital (the hospital) for an operation to replace the joint in her right knee (the operation). She was discharged on 3 September 1980. This period included the late summer bank holiday Monday 25 August and the hospital also had an 'extra statutory' holiday on 26 August.

2. The aggrieved's son complained that the accommodation and care provided for his mother were unsatisfactory in that:—

(*a*) although his mother had been accepted as a private patient who had requested a single room, she had been accommodated in three different beds in three weeks, including one week in a general ward and there had therefore been no forward planning for her stay ;

(*b*) no physiotherapy was available over the bank holiday and this was the principal cause for her stay being prolonged beyond the two weeks originally anticipated ; and

(*c*) the consultant had advised the complainant that his mother should have been regarded as a private patient for eight days only.

The complainant was also dissatisfied with the way the Area Health Authority (the AHA), which has since been superseded by a new health authority, handled his complaint.

Jurisdiction and Investigation

3. The complainant sought a reduction in the bill for his mother's stay, but he was advised by the area administrator (the AA) that it was not possible to waive any of the charges. The complainant asked me to investigate but I explained that in accordance with my normal practice I would not do so until he had settled the AHA's account, which he did.

4. During my investigation I examined the aggrieved's clinical notes and correspondence relating to the complaint. My officers interviewed the aggrieved, the complainant and members of the medical, physiotherapy, nursing and administrative staff involved.

(a) *The accommodation provided for the aggrieved*

5. The complainant told the AHA that in his experience a private patien expected to be allocated a single room and that as it was anticipated tha his mother would be in the hospital for two weeks and the hospital had fou beds available for private patients, it should have been possible to guarante her a single room. She was admitted to a single room (on ward 10), bu within a week was transferred to a general ward and later to a small sid ward.

6. The aggrieved told my officer that the consultant had arranged a singl room for her as that was what she had wanted. He had told her that h anticipated that her stay in the hospital would be between 8 and 10 days The aggrieved said that she thought the reason for her transfers was 'some thing to do with the theatres'.

7. I have seen that the aggrieved signed an agreement in which she under took to pay for the hospital accommodation services provided, although th aggrieved told my officer that she did not recall signing it. On the back of this form there are certain notes. One allows for the insertion of a daily charge for single rooms and the insertion, separately, of a charge for othe accommodation. In the aggrieved's case only the entry for a single room £72.40 a day, had been typed in, the other space being left blank. Another note reads 'the patient is being admitted to a single/other accommodation' but neither 'single' nor 'other' has been deleted. The assistant divisional administrator (the A Div A) told my officer that the agreement forms for private patients were sent out with a standard letter which included the following sentence 'Patients for whom it is intended single room accommoda tion be made available are advised to read the notes overleaf.' And the note overleaf reads 'We have a limited number of single rooms at the hospital and such accommodation is allocated subject to availability at the time of admission. Every effort will be made to keep such accommodation free for those requiring it, but no guarantee can be given. In circumstances where a single room is used for another patient alternative accommodation will be offered usually in a small side ward. The charge for accommodation will then be reduced accordingly . . .'.

8. The consultant told my officer that his private patients usually had a single room and he would have told the aggrieved, whose admission to hospital would have been arranged by his secretary, that she would have such accommodation. He said that medical staff were usually given advance warning of intended redecoration of accommodation but he had not been told in this case. He said that he did not know beforehand of the aggrieved's transfer to the general ward and that if he had he would have opposed it because the ward was normally used for gynaecological treatment and in his opinion there would have been an increased danger of infection. He would have suggested to the aggrieved several preferable alternatives.

9. The AA told the complainant that he conceded the probability that the facilities made available to the aggrieved did not meet her expectations and that there was a communication failure at the time of her transfer to the general ward. He apologised for this.

10. The AA told me that the aggrieved had been accepted as a private patient and that it was intended that she be accommodated in a single room during her stay. He said that at very short notice a decision was taken to transfer the services of her particular ward as part of a redecoration programme. He explained that the short notice was related to another decision to restrict operating because of the installation of new equipment in the operating theatre. He said that on the face of it this would appear to indicate a lack of planning but in practice it was a question of taking an opportunity that arose without much warning. He said that although the aggrieved was given an explanation it was quite clear that the hospital accommodation did not meet her and her son's expectations and therefore they had a legitimate complaint for which the AHA had apologised.

11. One of the two ward sisters responsible for the aggrieved's nursing care during her stay told my officer that redecoration of the ward had been long overdue. She said that the divisional administrator (the Div A) would not have been told that there was a private patient on the ward. The other sister told my officer that the aggrieved had not seemed too perturbed when she was told of the transfer to the general ward.

12. The Div A told my officer that he had not known that there was a private patient on the ward when he had made the transfer arrangements and he said that had he known he would have explained the reason to the aggrieved and to the consultant. He also said that had he known of the availability of the funds for the redecoration of the ward before the aggrieved's admission he would have advised her that single accommodation was not available. He thought that the nursing staff had told him about the aggrieved but before he had had a chance to visit her and to apologise, the complainant had rung. He went to see the aggrieved who expressed disappointment at having been moved out of her single room and said that she was not happy in the open ward but she had made it clear that she was leaving the matter to her son to sort out. The Div A said that he had apologised for the fact that she had not been informed about the move in advance and he had told her that there would be a small reduction in the charge to reflect her move into shared accommodation. He said that he had definitely not given her the impression that the reduction would be very great. He said that when the move was being arranged he would have told the nursing staff concerned and the three consultants who normally used the ward but not the aggrieved's consultant as he did not usually have patients on the ward.

Finding

13. Although the documents, which I am satisfied were supplied to the aggrieved, indicate that single room accommodation could not be guaranteed, both the consultant and the hospital felt the possibility of it not being available was remote. No one contemplated the possibility that the aggrieved would spend any of her time in a general ward. The reason for the transfers could not have been anticipated at the time the arrangements were made for the aggrieved's admission. But when the arrangements were put in hand no warning was given to the aggrieved and there was a failure in communication within the hospital. I uphold this complaint.

(b) *The lack of a physiotherapy service and its effect on the aggrieved's treatment*

14. The complainant told the AHA that his mother had expected to be in hospital for two weeks but she had stayed for three. He understood that the extra stay was due principally to the lack of physiotherapy during the whole of the bank holiday period. The complainant told me that it was the consultant who had advised him of this. I have seen that the consultant wrote to him: 'The further week at the hospital was due to the slow progress that your mother was making due again to the fact that there was a bank holiday and she did not receive any physiotherapy treatment'.

15. The A Div A told the complainant that the physiotherapy service over the bank holiday period was neither more nor less than that normally provided and that this would have been known to the consultant prior to the aggrieved's admission.

16. The AHA told me that the provision of an emergency physiotherapy service only over bank holiday periods was a practice common to most general hospitals. They did not accept that the alleged lack of physiotherapy was the principal cause for prolonging her stay beyond the two weeks originally anticipated.

17. The superintendent physiotherapist (the SP) showed my officer her records, which indicated that the aggrieved had been visited by a physiotherapist on 16, 18, 19, 20, 21, 22 August and 27 August. My officer pointed out to the SP that the nursing records indicated that the aggrieved had also been seen by a physiotherapist on Sunday 17 and Saturday 23 August. The SP said that these visits would have been carried out by the physiotherapist on emergency week-end duty. She explained that a physiotherapist came in every weekend, and over a bank holiday, and carried out scheduled visits (which would be recorded in the SP's records) and any other physiotherapy for patients requested at the time by the medical or nursing staff (which would not be so recorded). A physiotherapist told my officer that the physiotherapist on emergency duty was often asked, in passing, to see patients in respect of whom no prior request had been received. She also said that no record would be kept by the physiotherapist of such visits.

18. The consultant told my officer that he knew from his experience that the physiotherapy service provided over weekends and bank holidays was an emergency service only. He said that the duty physiotherapist would see any patient whom a doctor referred but that there would be no routine physiotherapy. He said that he had not requested physiotherapy for the aggrieved over the bank holiday period and that he had seen her on Sunday 24 August.

Findings

19. The AHA did provide their usual emergency physiotherapy service over the bank holiday weekend and if the consultant had so decided physiotherapy could have been given to the aggrieved. I do not therefore uphold

the complaint that no physiotherapy was available. The consultant's decision not to request it was taken solely in the exercise of his clinical judgment and I cannot question it.

(c) *The complaint that the consultant told the complainant that his mother was a private patient for only eight days*

20. The complainant wrote to the area treasurer (the AT), on 25 October 1980 about the account for his mother's stay and said that the consultant was firmly of the opinion that his mother should be regarded as a private patient for eight days only and that thereafter the treatment she received was under the National Health Service. He paid the account in respect of the eight day's stay. I have seen that the consultant wrote to the complainant: ' (the aggrieved) was admitted as a private patient to ward 10, which has four private beds. She stayed there for about a week and then, due to some problem with the roof, she was transferred to a gynaecological ward, and from what I understand from the records officer, she was then a National Health Service patient. I gather that at this time there were no other single private rooms in the hospital and therefore from this time on the treatment she received was all on the NHS and certainly not private. I would be surprised if you were sent a bill for private treatment for more than eight days. Of course, as you realise, her transfer from ward 10 could not have been anticipated.'

21. The A Div A replied to the complainant's letter to the AT and told him that the Health Service Act precluded any patient who began treatment as a private patient reverting to the National Health Service. He told the complainant that there should, however, have been a reduction in the account in view of the time that the aggrieved had spent in shared accommodation. An amended account was then sent but the complainant continued to dispute it and he wrote to the AA, and met him on 30 December.

22. Arising from that meeting the AA wrote to the complainant on 9 February and 3 March saying that he had made further enquiries and that there were insufficient grounds to justify the standard charges being waived. He explained to the complainant that it was clear that the consultant was unaware of the exact nature of the arrangements for private practice in the NHS and that the advice that the complainant had received from the consultant was therefore to some extent based on this lack of knowledge.

23. My officer asked the consultant if he could identify the records officer concerned but he could not remember to whom he had spoken. The consultant said that there was a very high turnover of records officers. He told my officer that he now knew that he had been mistaken in his belief that if a patient was moved out of a single room she ceased to be a private patient.

24. The AT told my officer that he would have liked to negotiate a reduced charge for the complainant but said that this would have been contrary to advice given to him by the DHSS audit branch. The AA told my officer that after investigating the matter and speaking to the complainant he had thought there were grounds for reducing the complainant's bill but he had felt obliged to accept the advice of the AT that standard charges could not be waived.

25. I have seen that paragraph 21 of the DHSS Circular HC(80)5 'Charges for Private Resident and Non-Resident Patients' states:

> 'Patients who enter hospital as private patients should not later be allowed to transfer to NHS status except in very exceptional circumstances, where it can be shown that the required length of stay is considerably longer than could reasonably have been foreseen, eg a patient entering for a minor operation is found to be suffering from a different, more serious complaint. (The patient is liable for charges for the period during which he was a private patient).'

Findings

26. It is incontrovertible that the consulant did advise the complainant that his mother should be regarded as a private patient for eight days only. The consultant was mistaken in giving this information but I accept his assurance that he did so in good faith. I uphold this complaint.

(d) *The handling of the complaint by the AHA*

27. The complainant complained to me that the AHA appeared to adopt a 'take it or leave it' attitude which he said that he strongly deprecated. He told my officer that at his meeting with the AA on 30 December 1980 he had been left with the clear impression that a reduction would be made in the hospital's charge, and that the AA had expressed the view that the complaint had been handled clumsily at the hospital. He was therefore surprised when he had received the AA's letter of 9 February 1981 advising him that the charges would not be waived.

28. The AHA told me that at the meeting on 30 December the complainant had been told that his complaint would be pursued in more detail and that this had been done. The AA also told me that he had encouraged the complainant to raise the matter with me and he told my officer that he had been dissatisfied with the way that the complaint had been dealt with at hospital level.

Finding

29. The AHA made a very full investigation into the complaint and I am satisfied that had they been able to reduce the charge they would have given it sympathetic consideration. I do not uphold the complaint that the AHA were unconcerned or that they were guilty of any maladministration in their handling of the complaint.

Conclusion

30. I have upheld the complaint that the accommodation that the aggrieved was given after the first eight days was not such as she had been led reasonably to expect nor such as the AHA and the consultant intended to offer her when the agreement was made. The complainant had good reason to question the account in view of the consultant's letter which he could reasonably regard as being authoritative. The AHA were not responsible for the misinformation given by the consultant but I am glad to say that

although the Health Authority have no power to reduce the charges made to the aggrieved they have agreed to make an *ex gratia* payment of £100 to her. I regard that decision as a satisfactory outcome to my investigation.

Case No. W.115/81-82—Care of patient suffering pregnancy complication

Background and Complaint

1. On 19 December 1979 a woman was admitted to hospital with a complication of pregnancy. Apart from short visits home she remained in the hospital until 21 January 1980 when, according to her husband, the foetus showed signs of distress. At 7.30 p.m. the following day the baby died in utero and was delivered at noon on 23 January.

2. The husband complained through his Member of Parliament (the Member) that:

(*a*) at the time of the foetal distress his wife questioned the significance of a drop in the foetal heart rate and was told that the foetal heart monitoring equipment was faulty; it was disconnected, but a few hours later it was refitted without any repairs having been made;

(*b*) he had difficulty in communicating with the medical staff familiar with his wife's care, in particular with the consultant obstetrician and gynaecologist (the consultant) to whom he was unable to speak early on 22 January because he had not observed the protocol of seeing the houseman and registrar first; and

(*c*) the Area Health Authority (the AHA) refused to release to him a copy of the post mortem examination report and to investigate the reasons for the unexpected death.

The complainant sought the help of the Member when the AHA's replies to his complaints failed to satisfy him. The Member wrote to the secretary of the hospital and to the area general administrator of the AHA (the AGA) on the complainant's behalf but the complainant continued to be dissatisfied; he was particularly critical of a letter of explanation sent to the Member by the area administrator (the AA). The Member then wrote to me and asked me to investigate. After obtaining an assurance from the complainant that it was not his intention to bring proceedings in a court of law about any matter relating to his complaint I agreed to undertake an investigation.

Jurisdiction

3. When the complainant first wrote to the AGA he also complained of the failure of the hospital's medical staff to take any action to deliver his wife's baby alive on 21 January when, he alleged, there was clear evidence of foetal distress. But before I started the investigation I explained to the Member that under the provisions of the National Health Service Act 1977 I could not investigate actions taken by doctors which in my opinion were taken solely in consequence of the exercise of their clinical judgment. How ever, during the course of my investigation one of my officers drew the complainant's attention to a new procedure known as the 'second opinions

procedure ' introduced on 1 September 1981 and under which health authorities may deal with complaints or those aspects of complaints which arise from the exercise of clinical judgment. Under this procedure the regional medical officer of the relevant regional health authority may in cases where he thinks it appropriate, obtain second opinions from two consultants in the specialty concerned but not involved in the particular case. The complainant wrote to the AA asking for further information and after an exchange of correspondence the regional medical officer of the Regional Health Authority decided to invoke the new procedure for that part of the complaint which concerned the clinical judgment exercised by the doctors attending the complainant's wife in the hospital. In the meantime I continued my investigation into the remaining aspects of the complaint which are set out in paragraph 2.

Investigation

4. In the course of my investigation I have seen the relevant papers from the AHA including copies of the correspondence relating to the complaint and the clinical and nursing notes. I have also obtained written comments from the consultant. One of my officers discussed the complaint with members of the medical, nursing and administrative staff concerned and also met the complainant and his wife.

(a) *The faulty monitoring machine*

5. In his letter of 30 May 1980 to the AHA the complainant said that when his wife questioned the significance of a drop in the foetal heart rate recorded by the monitor she was told the machine was faulty. But he contended that at no time was the monitor tested for accuracy, nor was any suspected fault corrected. In discussion with my officer his wife confirmed that it was during the morning of Monday 21 January that she first became alarmed at the tracings recorded by the monitor. When she drew these to the nurse's attention the nurse remarked that they had had trouble with this machine in the past and then proceeded to disconnect her from it. But to her astonishment the nurse fitted the machine to one of the other two patients who shared the ward. The complainant's wife told my officer that later the same afternoon she was refitted to the machine just before her husband came to visit her.

6. In correspondence with the Member both the AGA and later the AA assured him that there was nothing wrong with the foetal heart monitoring equipment used on the complainant's baby. When my officer saw the staff midwife (the midwife) who had monitored the baby on the morning of 21 January she too denied that the machine was faulty. She explained that when the foetal heart rate was checked the monitor was usually connected for 20 to 30 minutes. Towards the end of the monitoring session the complainant's wife queried one of the tracings recorded by the machine. The midwife said she told her not to worry as it was just the machine. By this she meant the machine was faulty in the sense that the reading was inaccurate due to the transducer not being correctly positioned over the baby's heart. She did not mean that the machine itself was faulty. The midwife added that she tuned the machine so that the baby's heart beat was audible and

both the patient and herself could hear it quite distinctly. Before she went off duty the midwife showed the ward sister the tracing which had worried the complainant's wife. The midwife assured my officer that if the machine had been faulty she would have reported it immediately and used the other machine.

7. The ward sister who arrived on duty at 12.45 pm on 21 January (the sister) confirmed to my officer that the midwife who had earlier monitored the complainant's baby told her that she had been unable to get a clear tracing of the baby's heart beat. The sister explained to my officer that monitoring machines were extremely delicate instruments. The slightest physical movement by the baby or the mother would make a difference to the quality of the tracing. If the transducer was even slightly out of position and not immediately above the baby's heart a poor tracing would be recorded. The sister confirmed to my officer that after she came on duty that day the monitoring machine used on the baby was working normally and she made the point that the patient herself did not mention the difficulty to her. But she added that she had been somewhat concerned about the readings that afternoon and had brought them to the notice of the medical staff. The consequent decision by the medical staff is not for me to question.

8. In her written comments to me and in discussion with my officer the consultant said she had checked all the tracings from the other patients on the monitors on 21 and 22 January and she was satisfied that the monitor used on the complainant's baby was working normally. She said it was absurd to believe that a midwife would have continued to use faulty monitoring equipment.

Findings

9. It is clear from the evidence I have obtained that there was a misunderstanding between the complainant's wife and the midwife who was monitoring her baby at the time. The complainant's wife understandably misinterpreted the midwife's remarks about the faulty machine to mean that the monitoring equipment itself was malfunctioning. But in evidence to my officer the midwife and the sister have both said that the monitoring machine they used to monitor the progress of her baby was working normally. The consultant has also checked the tracings and has found no evidence to suggest that any of the monitoring equipment used at that time was faulty. I am therefore satisfied that the monitoring equipment used on the baby was working normally. I do not uphold this complaint.

(b) *The difficulties in communication*

10. In his correspondence with the AGA and in discussion with my officer the complainant said that when he visited his wife on Monday 21 January he was very disturbed at her condition. There were clear indications of foetal distress. Because of his concern he tried to telephone the consultant the following morning but when he spoke to her secretary he was told that he must observe the protocol of seeing the senior house officer (the SHO) first followed by the registrar ; if he remained unhappy he could then speak to

the consultant. The complainant said he refused to accept this and requested the consultant to return his call but this was refused and instead he was told by the secretary that a message would be left for the SHO to see him. But when the complainant visited his wife later that evening he was amazed to find that both the SHO and the registrar were off duty. When he spoke to the doctors who were on duty they denied all knowledge of his wife's case and could not help him. Soon after 7 pm the foetal heart monitor was attached to his wife. This indicated a rapidly failing foetal heart rate and a little later he was informed that the baby had died. The complainant subsequently learnt from the SHO that when he returned to duty on Wednesday 23 January he had received a message that the complainant wished to see him.

11. The consultant's secretary explained to my officer that she did not deal with enquiries about obstetric patients or with appointments for their relatives. Her duties were restricted to the consultant's gynaecological patients and she referred all enquiries in connection with obstetric care either to the hospital ward or to the sister in charge of the ante-natal clinic. She said enquiries about obstetric in-patients were usually quickly resolved by relatives speaking to the senior house officer or registrar on duty and if the relatives were not satisfied the medical or nursing staff arranged for them to see the consultant either at her clinic or during her ward round. The consultant's secretary said she remembered taking a telephone call from the complainant on the morning of 22 January. He wished to speak to the consultant and after establishing that his wife was an obstetric in-patient at the hospital she suggested he spoke to the sister or the senior house officer. She denied that she had mentioned the procedure described by the complainant although she conceded that she might have refused his request for the consultant to return his telephone call.

12. In her written comments to me the consultant said she had not been told the complainant had asked to see her on the morning of 22 January. At that time she was in the clinic but if she had known about his request she would certainly have made herself available. The consultant explained that the procedure which the complainant understood had to be observed was quite unnecessary. Patients and their husbands often asked to see her direct. She said she had since made it clear to midwives that in future she must be told if a husband wished to make an appointment to see her. In discussion with my officer the consultant said that she assumed it was one of the nursing staff rather than her secretary who had told the complainant of the procedure and she confirmed to my officer that her secretary was not responsible for making appointments for relatives of obstetric patients to see her.

13. The sister who was on duty when the complainant visited his wife on 21 January told my officer she recalled talking to him about his concern for his wife's condition. He asked whether an appointment could be arranged for him to see the consultant the next day after her ward round, but the sister told him that this would not be possible because the consultant would be going from her ward round to give a lecture to midwives. The sister suggested to the complainant that he ask the consultant's secretary about the

consultant's movements to get an idea of the best time to catch her. The sister explained to my officer that she had not realised that the complainant was seeking a formal appointment with the consultant.

Findings

14. I believe that the complainant experienced unnecessary difficulty in trying to speak either to the junior medical staff familiar with his wife's case or to the consultant about the concern he had for his wife's condition. I was therefore pleased to learn that the consultant had subsequently made it clear to the midwives that she must in future be told when husbands wished to see her. As the secretary's duties did not include making appointments for relatives of obstetric patients, the sister's well-intentioned reference to her was of little purpose. Despite the limitation of the secretary's duties I think she should have adopted a rather more flexible approach in dealing with the complainant's request at a most distressing time. I uphold this complaint.

(c) *The AHA's refusal to release a copy of the post-mortem examination report and to investigate the reasons for the unexpected death*

15. The consultant told my officer that six weeks after the complainant's wife was discharged from the hospital she saw her again for a post-natal check-up. She spoke to her about the cause of her baby's death and gave details based on the finding of the post-mortem examination. Shortly afterwards the consultant received a letter from the complainant seeking a copy of the post-mortem examination report, explaining that he had requested the examination. He added that at the time of the baby's death he had believed the most probable cause to be asphyxia but he wanted to be certain that there were no other physiological or organic reasons for it. The consultant discussed the request with the histopathologist and sought advice from the AHA's solicitors. She decided that in this case they should not deviate from the practice of not disclosing a copy of the post-mortem report to the next of kin when the examination was not performed at his or her request. Accordingly the consultant pointed out in her reply of 18 March that the complainant had not requested the examination and said that she could not send him a copy of the report because the records did not belong to her. She explained that they were held by the hospital for the AHA. However she told him how the baby had died and that there were no congenital abnormalities.

16. On 12 April the complainant wrote to the AHA seeking the release of the report ; he contended that the form he had signed authorising the examination would show that he had requested it and that he had not just consented to it. The AGA replied after he had obtained legal advice. He confirmed that the post mortem examination report was the property of the AHA and said the complainant did not have an absolute right to see it or a copy of it. He explained that regardless of the question of the legal ownership of the document it was not the normal practice at the hospital to make available copies of such reports and it was not for him to suggest that an exception be made in this case. The AGA also pointed out that the complainant was mistaken in thinking the post mortem examin-

ation was undertaken at his request. The form he signed recorded not a request but a declaration that he did not object to such an examination being carried out. The AGA suggested that the complainant might take up with the consultant the medical matters he had raised.

17. The complainant replied that he was not prepared to discuss further with the consultant details of the treatment his wife received when she was a patient at the hospital ; instead he requested an investigation of the circumstances of his wife's treatment. On 10 July the AGA wrote again to the complainant and said he did not think he could usefully conduct an investigation without knowing what circumstances the complainant was referring to ; nor could he do it without enquiring into matters of clinical judgment. He repeated his offer to arrange for the complainant to see the consultant and said he thought this would be more constructive than further correspondence.

18. On 17 August the complainant sought the help of the Member informing him that the AHA had declined to investigate the matter and had also failed to tell him of a procedure which would enable him to have his complaints investigated. He asked the Member for advice about how he could instigate an inquiry into the tragic events and in a subsequent letter added that he would have expected the AHA to have acted spontaneously to investigate the reasons for an unexpected death in their hospital. He said it was as if the AHA were actively repressing a formal study of what went wrong. Later in discussion with my officer the complainant explained that there was little advantage in taking up the AHA's offer of seeing the consultant because her attitude immediately after the death of his baby had been off-hand. The complainant added that he thought the AHA must have independent medical expertise at their disposal to determine what had happened.

19. The AA replied to the Member on 23 February 1981 ; he said the reason the AGA had suggested the consultant would be best placed to answer the complainant's questions was that, principally, they involved matters of clinical judgment. The AA said it was unfair to say that the hospital had refused to answer these questions when it was clear that they would have to be put to the consultant and her junior medical staff. Furthermore it was inaccurate to assert that the AHA had actively repressed a formal study of what went wrong. The AA said the complainant misunderstood the function and powers of an area health authority if he believed that every unexpected death was investigated at management level and the findings scrutinised ; such deaths were the professional concern of the hospital's medical practitioners and clinicians and where appropriate, HM Coroner.

20. The AA told my officer that there were no general rules for determining whether an unexpected death should be investigated by the health authority. He explained that before the introduction of the new second opinions procedure, complaints about clinical judgment were referred to the area medical officer (the AMO) who in turn consulted the area chairman to decide whether an inquiry was justified. An inquiry was not set up simply because a relative demanded it. As for the complainant's claim that

he had not been advised of any procedure which enabled him to request a formal investigation, the AA told my officer this was because before the introduction of the new second opinions procedure there was no formal procedure available. The AA also confirmed to my officer the AHA's policy not to provide patients' relatives with copies of post-mortem examination reports. He said this was because the reports were part of the patients' clinical records. He added however, that he had no doubt relatives were usually given details of the post mortem examination findings.

Findings

21. I have seen a copy of the post-mortem declaration form signed by the complainant. Although this shows that he did not object to a post-mortem examination being carried out it did not constitute a request by him for one. I have also seen copies of the consultant's letters of 12 February and 18 March 1980 addressed respectively to the family practitioner and to the complainant in which the cause of the death is set out. I am satisfied that these letters together with the consultant's earlier explanation to the complainant's wife, were adequate responses by the consultant to the complainant's request for information. She decided however not to release a copy of the post-mortem report and I know from other cases I have examined that it is the practice of administrators to obtain the agreement of the consultant concerned before releasing clinical records. The complainant also complained about the refusal by the AHA to investigate the reasons for the unexpected death of his baby. The decision by the AHA not to hold an inquiry was a discretionary one and I have found no evidence of maladministration in reaching it. I am satisfied that the request was made too early for the health authority to contemplate invoking the second opinions procedure. I do not uphold this complaint.

(*d*) *The AA's reply*

22. On 25 May 1981 the complainant wrote to the Member giving his comments on the AA's letter of 23 February. He said that the AA had failed to study fully the events that led to his baby's death. He was concerned that the AA acting on behalf of the AHA could make a judgment on an incomplete study and decide no further action was required. He said the AA had not referred to all the evidence of the case ; he had omitted to explain why the readings recorded by the 'Cardiff' system (one of the three diagnostic aids used to monitor his baby's condition) had been ignored. In discussion with my officer the complainant said he was also dissatisfied with the way the AHA had investigated his complaints because he felt it was impossible for them to claim they had investigated thoroughly his allegations when they had not spoken to him in person. He believed an administrator should have offered to see him.

23. The AA told my officer that he did not think any purpose would have been served by an administrator inviting the complainant along to discuss his complaints. This was because administrators were not competent to reply to the inevitable questions that arose in cases like this. The AA said he believed that he had responded to the complaints appropriately. Except for his failure to refer to the 'Cardiff' system he believed all the points raised

by the complainant had been covered adequately and that the explanations given were reasonable. Although the AA was sorry that the complainant had found the explanations unacceptable he was not sure what more the AHA could have done. He had been advised that the treatment had been in accordance with good obstetric practice but he suspected that the complainant would not be content until it was admitted that an error had caused the death of his wife's baby.

Findings

24. It cannot be disputed that the AA failed to refer to the 'Cardiff' system in his letter to the Member, but I consider the AA's response to be a full and reasonable one. Moreover I am inclined to agree that there would have been little benefit in the complainant seeing an administrator as it is clear that the administrator would not have been in a position to answer detailed questions of a clinical nature. Indeed I find it surprising that the complainant should complain that he did not meet an administrator when he had consistently turned aside suggestions that he should meet the consultant and his wife's family practitioner. I do not uphold this complaint.

Conclusion

25. The main complaint was the failure of the medical staff to take any action to deliver the complainant's wife's baby while she was still alive on 21 January. But I am satisfied myself that this decision was taken solely in the exercise of clinical judgment and that it was not one therefore that I could question. However I was able to inform the complainant of the introduction of the second opinions procedure and I was later pleased to learn that the regional medical officer had decided to invoke it in this case. I have recorded my findings on the remainder of the complaints in paragraphs 9, 14, 20 and 24 of this report. I have upheld his complaint about the difficulties he had in trying to speak to the medical staff and I believe that he was entitled to more cooperation than he received in this respect. I therefore recommended that the District Health Authority (the DHA) which, following a reorganisation of the National Health Service, have taken over responsibility for the hospital, should remind all their staff associated with maternity units of the particular importance of ensuring that the way is made as easy as possible for husbands who wish to see medical staff in times of stress. I am pleased to record that the successor DHA have agreed to do so and have also asked me to convey to the complainant and his wife their apologies for the difficulties they experienced. This I gladly do.

Case No. W.156/81-82—Care and treatment of patient suffering from congestive heart failure

Background and complaint

1. The husband of the complainant was admitted to hospital A on 9 January 1981, suffering from congestive heart failure. He was transferred to hospital B on 25 February. The complainant visited her husband during the

afternoon of 26 February and was alarmed by the apparent deterioration in his condition. Later that day he was transferred to hospital C, where he died on 4 March.

2. She complained to me that, while at hospital B:—

(*a*) her husband's bed was in a noisy part of the ward although he needed rest;

(*b*) the attitude of the ward sister (the sister) was dismissive when she expressed concern at her husband's condition; and

(*c*) there was a delay in her husband receiving medical attention after he had shown signs of collapse on 26 February.

Investigation

3. During the investigation I examined the relevant correspondence and my officer interviewed the medical and nursing staff involved, apart from one doctor (the duty SHO), who was, and remains, seriously ill. An officer also met the complainant.

(a) *The complaint that her husband's bed was in a noisy part of the ward although he needed rest*

4. The complainant wrote to the area administrator (the AA) on 2 March 1981 and said, *inter alia,* that her husband had been advised to rest but could not do so due to the general confusion caused by disturbed and disorientated patients and a television set only a few feet from her husband's bed. In an interview with my officer the complainant said that when she complained to the sister and asked for her husband's bed to be moved to a quieter part of the ward she was told that the staff would 'see about it later'.

5. The AA said in a letter of 4 June to the complainant that when she complained about the noise the nursing staff considered moving her husband's bed but they had thought it better to wait until the evening when less disturbance would be caused to other patients. He explained that at the time two other wards were closed for building work and this had meant that extra beds had had to be put up in the ward. He hoped that, while this did not excuse the overcrowding, it would explain why it was so when her husband was a patient.

6. The consultant in geriatric medicine (the consultant) responsible for the care of the complainan'ts husband told my officer that his treatment had progressed to the point at which it was considered that he would benefit from rehabilitation. The emphasis in the acute geriatric ward at hospital B was to encourage rehabilitation and prepare the patients, so far as possible, to resume a more active role in life. The geriatric ward would inevitably have been noisier, but the patient's condition on admission did not require him to be in a quiet part of the ward. The consultant said that the complainant might not have expected such a contrast between the type of patients to be found in the geriatric ward at hospital B and the acute medical ward at hospital A.

7. My officer interviewed the medical assistant (the first MA) who had attended the complainant's husband during the late morning of 26 February after he had been told that the complainant's husband had appeared unwell at breakfast time that day (see paragraph 2(*c*) above). The MA said that after examining him he had prescribed medication for him and advised the nursing staff that he should rest in bed. He told my officer that by ' rest ' he meant only non-exertion, not necessarily sleep. He was satisfied with the patient's location in the ward and said that it was probably immaterial where his bed was.

8. My officer interviewed separately the sister and the staff nurse who were on duty on the ward, at different times, on 26 February. They each said that the activities of the patients sometimes caused the ward to be noisy. The sister said that although the ward was busier than usual because of the accommodation of additional patients, she did not remember it being unusually noisy. She said that when the complainant had asked for her husband's bed to be moved she had agreed and said that it would be done later. At the time of the request there had been patients seated at tables in the centre of the ward and the sister thought she had explained that an immediate move would have been disturbing to the other patients.

Findings

9. I do not doubt that the complainant considered the ward to be noisy when she visited her husband during the afternoon of 26 February and I do not find it surprising that she was concerned lest her husband could not rest. It is not possible to assess the extent to which her husband was disturbed by the amount of noise ; what is acceptable to one person may be intolerable to another. But, in the opinion of the doctor who examined him on 26 February, he was able to have the rest which his medical condition demanded. I do not therefore find this complaint made out.

(*b*) *The complaint that the sister's attitude was dismissive when the complainant expressed concern at her husband's health*

10. In her letter to the AA the complainant said that she visited her husband shortly after 3.00 p.m. on 26 February (a Thursday) and thought he looked very ill. She saw that the pulse in her husband's neck was beating rapidly at it had prior to a recent heart attack that he had suffered. She spoke to the sister of her concern at the apparent deterioration in his condition and mentioned the pulse, but was taken aback by the sister's resentful and dismissive attitude. The sister told her that her husband had been out of bed during the early part of the day but had collapsed and a doctor had advised that he should rest in bed for the remainder of the day. The complainant said that the sister was unable to explain the nature or cause of the collapse as she was not on duty at the time. She made no attempt to examine her husband, nor did she ask any other member of staff to do so. The complainant said that the sister merely said that her husband was quite alright ; that he was probably missing the familiar staff of his previous ward ; and that he would be all right ' within two or three days '. She had replied that if her husband's rapid deterioration continued ' he would not be alive in three days '. She alleged that the sinster dismissed this out of hand and told

her that if she was not satisfied she could make an appointment to see the consultant when he visited the hospital the following Monday. The complainant told my officer that the sister had conferred with a state enrolled nurse (the SEN) but she still had not been given any helpful information. It was only on receiving the AA's letter of 4 June that she learned that her husband was receiving four-hourly observations and that at about 2.00 p.m. the sister had seen her husband. Had the sister told her this she said she would have felt he was being cared for properly.

11. The sister told my officer that shortly after arriving on duty at about 1.50 p.m. she examined the complainant's husband. He said that he had no pain and that he wished to get up. A medical assistant (the second MA) had visited the ward at about 3.00 p.m. and she told him there were no problems. At about 3.30 p.m. the complainant came to the ward office and she was very distressed. She asked why her husband was in bed and the sister said she explained that he had collapsed in the morning and was seen by a doctor who advised that he should rest in bed. She was unable to explain the nature of the collapse to the complainant as she had not been on the ward at the time. The sister said that the complainant had complained about the state of the ward and had expressed the opinion that the hospital was not a suitable place for her husband. The sister said she tried to explain to the complainant that her husband was comfortable ; that his condition was satisfactory when she had examined him at 2.00 p.m. ; and, that it would take him a few days to get used to the unfamiliar ward surroundings. But the complainant replied that if her husband's deterioration continued he would be dead in a few days. She had again tried to reassure the complainant and told her ' not to think like that '. When the complainant continued to express dissatisfaction she suggested, in accordance with normal practice, that she could telephone the consultant's secretary to make an appointment to discuss her husband's case. The sister said she thought that she had accompanied the complainant to her husband's bedside and had taken his pulse and found that his condition had not altered since she last checked at 2.00 pm. She did not remember anyone else being present during the conversation and said she did not confer with the SEN.

12. My officer spoke to the SEN who said she thought she had first spoken to the complainant at about 4.00 pm as she appeared to be worried. She had tried to reassure her. She had no recollection of being present during the conversation between the complainant and the sister.

13. The consultant told my officer that the term ' collapse ' was misleading and he thought it unlikely that the complainant's husband had suffered a heart attack. He could not be sure of the cause of the incident but he thought it might have been the result of a sudden drop in his blood pressure—an occurrence not uncommon in a case such as this. The staff nurse who handed over to the sister confirmed that he did not know the cause of the patient's collapse.

14. The consultant, the responsible senior nursing officer (the SNO) and the nursing officer variously described the sister's manner as being quiet, diffident and undemonstrative. All testified to her professionalism and

considered it most unlikely that the sister would have been intentionally dismissive.

Findings

15. The evidence of the complainant and the sister differ in many respects and, in particular, as to whether the sister told the complainant that she had attended her husband not long before her arrival and whether she examined him again after she had been told of the complainant's disquiet. I am, however, satisfied that the sister had no intention of being dismissive, and that, as the complainant now accepts, her husband's condition was regularly monitored.

(c) *The complaint that there was delay in her husband receiving medical attention after he had shown signs of collapse on 26 February*

16. In his letter of 4 June to the complainant the AA told her that her husband had shown signs of collapse at breakfast time and this led to a visit by the first MA at 11.50 am. The complainant wrote again to the AA on 6 August seeking an explanation of this apparent delay; and the AA replied on 26 October. He said that the nursing staff, after putting her husband back to bed, tried to get in touch with the junior doctor on-call, and 'my further investigations . . . have now shown that the junior Doctor concerned was in fact ill and the ward staff were unable to contact him. They therefore had to make a judgement about whether to seek another Doctor, or wait until [the first MA] returned to the ward, which they knew would occur about lunch-time. As by this time your husband was feeling better, the ward staff decided to wait until [the first MA] returned to the ward'. In a letter to me the complainant said she found this reply unsatisfactory.

17. My officer interviewed the staff nurse who was on duty on the ward at the time of the incident. He said that at about 8.45 am he saw that the complainant's husband looked pale and he had told him that he felt 'strange'. He put him to bed and took his pulse, which was within normal limits, and stayed with him for about ten minutes by which time his condition had improved and he was asking to get out of bed. He told him that he must stay in bed until a doctor had seen him. He said that he considered a doctor's opinion was necessary and he tried unsuccessfully to get in touch with the duty SHO. He then tried a second senior house officer who, although not on duty, might have been available. He also approached the first MA by telephoning his surgery but was told by the receptionist that he had already set out for the hospital. The staff nurse said that the first MA regularly visits the ward at between 8.30 am and 8.45 am but that on that day he had not arrived by 9.30 am. He had then telephoned some of the other wards in the hospital to ask if the first MA was visiting patients elsewhere. All these attempts proved unsuccessful. When the first MA arrived at about 11.45 am he immediately asked him to see the complainant's husband. After examining him the first MA prescribed medication and advised that he should rest in bed for the remainder of the day.

18. The first MA told my officer that he regularly visits the ward at about 9.00 am but on the day of the incident he had not arrived until 11.30–11.45 am ; he could not recollect the reason for the delay. He was asked to see the complainant's husband who, he was told, had looked pale and unwell at breakfast time. He spent some time looking through the case history as he had not treated him previously. He examined the patient and found him to be well ; he was not unconscious ; he had no pain and the 'collapse' appeared to have been 'something very mild'. He told my officer that he was happy with the patient's clinical condition. He considered that additional medication was required and recommended that he should rest in bed.

19. The consultant described the medical staffing arrangements in the hospital. Two resident SHOs work alternate 24-hour shifts on weekdays and alternate weekends. They are the first medical point of contact for the ward nursing staff but additional medical support is provided by two general practitioners who work part-time at the hospital as medical assistants. On 26 February the duty SHO to whom I refer in paragraph 3 was ill and had absented herself from the hospital without informing her medical colleagues or any other member of the hospital staff.

20. The SNO told my officer that she visited the ward at about 11.00 am on the morning of the incident. The staff nurse told her that he wanted a medical opinion upon the patient's condition and she found that he had made all reasonable attempts to summon a doctor. Before leaving the ward she checked the patient's condition with the staff nurse and was satisfied with his condition.

Findings

21. The AA's second reply to the complainant was both inaccurate and misleading ; the letter said that a clinical decision was taken by the staff nurse not to seek the attendance of another doctor when the duty SHO (whom they erroneously referred to as 'him') was found to be unavailable. My investigation has shown that this was manifestly not so. Nor was the first MA's 'return' expected at lunchtime ; he was expected to arrive at about 9.00 am but did not do so. I believe that the response to the complainant was made in good faith and was not intended to mislead her, but I nevertheless criticise the AHA's failure to establish basic facts about the incident complained of.

22. More importantly, I criticise the medical staffing arrangements. The AHA could not have foreseen the absence of the duty SHO but I find maladministration in the fact that the staff nurse, who clearly thought that a medical opinion was needed, was unable to obtain one for several hours. I accept however that the first MA did not, in his clinical judgement, find any cause for alarm in the patient's condition at the time and I believe therefore that in the event the delay had no effect on the subsequent course of his illness.

Conclusion

23. I have given my findings in paragraphs 9, 15 and 12-22. Although I have found fault with the AHA I do not believe that their maladministration had any effect on the course of the patients illness. The Health Authority, who are the relevant successors to the AHA, have asked me to convey in my report their apologies for the shortcomings to which I have referred and this I gladly do. They have also agreed to review the staffing arrangements at the hospital to ensure, so far as possible, that a medical opinion will be available when required.

Case No. W.234/81-82—Communication with husband about falls suffered by his wife whilst in hospital

Background and Complaint

1. The complainant's wife was admitted to hospital (the first hospital) at the age of 75 in February 1978 suffering from chronic schizophrenia. Between then and January 1981 her ability to walk reduced and according to the complainant she fell twice during 1980 on each occasion sustaining head injuries. She fell again and on 19 January 1981 was transferred to another hospital (the second hospital) where it was found that she had a fracture of the right femur.

2. The complainant contended that:

(*a*) after his wife's second fall, a nurse refused to allow him to see a doctor;

(*b*) despite his requests for more help for his wife when walking, she she was not adequately supervised and fell again, fracturing her femur; moreover he did not receive any satisfactory explanation of the accident; and

(*c*) he learned of this fall and the transfer to the second hospital only after it had been decided to admit his wife there.

3. The complainant wrote twice to the Area Health Authority (the AHA) about the events leading to the fracture but he was dissatisfied with their reply to his first letter and complained to me when they had failed to answer his second more than four months later.

Investigation

4. During the investigation I obtained the written comments of the AHA and examined the correspondence about the complaint and the clinical and nursing notes. One of my officers discussed the complaint with members of the nursing and administrative staff at the first hospital and with the consultant psychiatrist responsible there for the care of the complainant's wife (the consultant). He also met the complainant.

(a) The refusal to let the complainant see a doctor

5. In a letter to me and in discussion with my officer, the complainant explained that his wife suffered from a chronic mental disorder. She had been treated for this condition at the first hospital for more than ten years ; during this time she became less mobile, her right leg being particularly troublesome. Early in 1978 the complainant found he could no longer manage his wife at home and she was admitted to the first hospital as a long-stay patient. After admission her problems with walking continued and reached the stage when, in the complainant's opinion, she could not walk safely without assistance.

6. In conversation with my officer, the complainant said that he thought his wife had fallen twice in 1980. He was not sure exactly when the accidents had happened but he became aware of them when, during visits, he saw his wife had head injuries. On the first occasion, he noticed a plaster on her head and he asked a nurse what had happened. She said that his wife had fallen while getting up from a chair. The complainant said the second fall came to his notice when he saw a very bad bruise on his wife's forehead. On that occasion he asked the same nurse whether he could see a doctor to find out how this had happened but she refused his request and made no suggestion about how he might make an appointment to see the consultant. He told my officer that he also asked the nurse to make sure his wife did not try to get up from her chair without help because he was worried she might fall and fracture her femur. He said that the nurse replied that this would never happen. The complainant did not know the nurse's name but he was able to describe her to my officer. He said that following the second fall he wrote to the consultant on 2 October 1980 expressing concern about the assistance his wife was given.

7. I have seen that four injuries to the patient's head are recorded in the clinical and nursing notes for 1980. The first three injuries were to the back of her head but the fourth, which occurred on 29 September, was to the left side of her head.

8. The ward book recorded that the patient had received visitors on 1 October and the staff nurse who was in charge of the ward on that day (the staff nurse) met the description the complainant had given. She told my officer that she remembered both the complainant and his wife. She said it was possible that the complainant had asked her on that day whether he could see the consultant, because he had made this request to her and other nurses at various times whenever he was worried about a particular aspect of his wife's care. The staff nurse said that she would certainly not have refused to allow him to see the consultant. She did not know exactly what she said to him, but she would probably have suggested he telephone the consultant's secretary for an appointment. She would not have offered to telephone on his behalf because she would have thought it better for him to make arrangements which were convenient to him. The staff nurse strongly denied that she had ever suggested to the complainant that his wife could never fracture her femur.

9. The nursing officer responsible for the ward when the complainant's wife was a patient there (the NO) told my officer that, in his opinion, the staff nurse

was an excellent nurse and he thought it very unlikely that she would have refused the complainant's request to see a doctor. He said he would have expected the staff nurse's response to such a request to depend upon which doctor the complainant wished to see. This was because medical supervision on the ward was provided in two ways. General medical care was undertaken by local family practitioners who visited the ward on a regular basis and the complainant could have seen a visiting family practitioner without prior appointment during the doctor's regular visit. On the other hand long-term psychiatric treatment was provided by the consultant and his team of doctors. A duty doctor was on call at all times and if the complainant had asked to see the duty doctor this could have been arranged immediately, although this would probably not have been very helpful because the duty doctor would not necessarily have had first-hand knowledge of the patient. But, if the complainant had asked to see the consultant, an appointment would have been necessary. The NO thought that in such a case the staff nurse should normally ask a relative to telephone or write to the consultant's secretary. But if the complainant had been upset or seeemed unable to do this himself, the staff nurse should have telephoned the secretary on his behalf. The NO recognised that this arrangement might have drawbacks because in the event of the complainant telephoning himself he might more easily have found a mutually convenient date to meet. In discussion with my officer the consultant said he had not seen the complainant for some time and had not been aware that he wished to see him. But it would have been a simple matter for the complainant to telephone his secretary to make an appointment.

Findings

10. I have been unable to establish precisely what the staff nurse said to the complainant. But I think it is unlikely she told him his wife would never fracture her femur since it is obvious that this could happen to anyone, particularly an elderly person prone to falls. I also think it is unlikely that the staff nurse positively refused to allow the complainant to see a doctor. Since he wrote to the consultant the following day, it seems to me probable that he had in mind seeing a consultant when he spoke to the staff nurse. It is normal practice at the first hospital for nursing staff to ask relatives to contact the consultant's secretary if they wish to see him. I appreciate that on a long-stay geriatric ward where visits from the consultant are infrequent. it is necessary for appointments to be made. But I believe nursing staff have a liaison role to play between relatives and medical staff and I would expect, at the very least, that they should offer to take an active part in arranging such appointments especially when, as in this case, the relative was himself elderly and frail. Although I do not uphold the complaint that a nurse refused to allow the complainant to see a doctor I have found that the practice adopted at the hospital meant that nurses were not as helpful as I think they should have been in the circumstances of this case.

(b) The supervision of the complainant's wife

11. On 2 October 1980 the complainant wrote to the consultant to express his concern about his wife's falls. He said the ward nurses had told him that

his wife injured herself by getting up impatiently from her chair and falling over. He found this difficult to understand because, in his experience, his wife had always been reluctant to leave one chair for another. But he realised that his wife was unsteady on her feet and needed help when getting up from a chair or when walking. He asked the consultant to speak to the sister in charge of the ward about this. The consultant replied that he had spoken to the ward staff who confirmed that she was fairly unsteady on her feet. The consultant said that this was probably the principal reason for her falls.

12. After his wife's fractured femur was diagnosed on 19 January 1981, the complainant wrote again to the consultant on 21 January. He pointed out that for two years he had repeatedly expressed concern to the ward staff about her tendency to fall. He said he had been assured that she could walk without help, but he disagreed and her falls showed him to be right. The nurses had told him that since her previous falls his wife was always taken from one chair to another or to the lavatory, but if this was the case, he could not understand why she had suffered another fall causing the fracture.

13. The area administrator (the AA) assumed responsibility for replying to the complainant's letter to the consultant. In a memorandum the consultant said he thought the patient's walking had been a bit uncertain for some time, although much of the time she was capable of walking without assistance. He made the point that it was his policy to take a calculated risk with elderly patients such as the complainant's wife by encouraging them to keep reasonably mobile, even at the risk that they might fall. He said the alternative was to put patients in geriatric chairs when, he found, they rapidly lost their ability to walk and were much more likely to get pressure sores or hypostatic pneumonia. 'In one sense the risk of letting them walk is often less risky.' The consultant's comments were communicated to the complainant by the AA in a letter dated 18 March 1981. The AA also said he had been assured that every effort had been taken by the nursing staff to protect the complainant's wife from injuring herself, while at the same time encouraging her to keep reasonably mobile.

14. The complainant responded on 22 March to the AA's letter, pointing out that the AHA's investigation had not brought to light how and why his wife's accident had happened. He said that when he telephoned the first hospital on 19 January 1981 he was told his wife had fallen in the lavatory. He refused to accept that she had found her way there unaided and he assumed she had been taken there and left for some reason. He said he would appreciate an explanation because he had found it nearly impossible to get his wife out of a chair without help and she had always been reluctant to move. The AA replied on 13 August 1981 and said it was not known how the fracture occurred since the patient drew attention to it while sitting in a chair. He had been unable to trace the person the complainant spoke to on 19 January, but it seemed certain the fracture could not have occurred as a result of being taken to the lavatory by a member of staff since it was the practice for the complainant's wife to be taken to the commode in the day room. He apologised for any misunderstanding that had occurred as the result of the telephone conversation on 19 January.

15. In discussion with my officer, the complainant said he had no complaints about the general nursing care his wife received on the ward. She was always well looked after and whenever he saw her she was perfectly groomed. But there were occasions when there were insufficient nursing staff on the ward and patients were left unsupervised. The complainant said he disagreed with the consultant's view that his wife could walk without assistance. Although she was capable of walking a few steps, she could not do so safely without help. Moreover, on the rare occasions he saw her walking she was not usually accompanied by a nurse. But, generally she rarely moved anywhere and preferred to stay in her chair. He did admit, however, that he had on occasions seen his wife suddenly attempt to get up from her chair and he was prepared to believe the falls in 1980 were caused by this. He said he thought the nurses should have strapped her into her chair to prevent her injuring herself in this way.

16. In his interview with my officer, the consultant said that under no circumstances should the complainant's wife have been strapped into her chair for her own safety. He strongly disagreed with the concept of restraining patients who were merely difficult to nurse and said it had been shown elsewhere that once nursing staff restrained patients as a matter of routine, their attitudes changed and nursing practices became oppressive and unacceptable. The consultant told my officer that the fracture had probably resulted from a fall ; it was usually only in cases of malignancy that such breaks otherwise occurred. But he thought it would not have been unusual for it to have remained undetected for a short while.

17. The NO and other members of the nursing staff told my officer that the complainant's wife was a difficult patient who tended to make sudden movements ; even had it been possible for a nurse to be constantly standing by, there would still have been a risk of her falling. The NO did not think the provision of extra staff would have helped and said that during the day the 28 patients and the four nurses who staffed the ward were usually all in the day room together.

18. The ward sister and the charge nurse who were jointly in charge of the ward during the period when the complainant's wife fractured her femur (the ward sister and the charge nurse) told my officer independently that she was confused and very restless. The charge nurse said that when sitting she frequently got up and moved to another chair. This happened particularly when she was sitting on a commode because she tried to return to an easy chair. She had strong legs, but because she walked with her knees bent she had a very unsteady gait and it was dangerous to let her walk unattended. She was therefore supervised as much as possible and she was always accompanied by a nurse when she was required to walk.

19. The ward sister added that the complainant's wife always ate her meals in the day room. She was provided with a chair which incorporated a tray which clipped on the front, but it was a simple matter to remove the tray and she could easily get up without warning. The ward sister said she did not agree it would have been a good practice to strap her into her chair for her own safety. That was against the basic nursing concept

of encouraging patients. The ward sister explained to my officer that few of the patients on the ward were capable of walking to the lavatory unaided and at various times of the day they were 'commoded'. This meant they were put on wheeled commodes and then moved either to their beds, where they were screened for privacy, or to the lavatory where they were helped on to WCs. These occasions were particularly busy for the nurses and it was inevitable that some patients were not supervised the whole time, particularly those who wished to be wheeled to the lavatory and who liked privacy when there.

20. The staff nurse and a nursing assistant who worked on the ward while the complainant's wife was there told my officer in separate conversations that, although she was usually wheeled to either her bedside or the lavatory on commodes, she was sometimes walked to the lavatory to give her exercise. But on these occasions there were always two nurses in attendance. Moreover, she was never left sitting on the lavatory alone and the door to the cubicle was never closed. The staff nurse said that the complainant had often spoken to the nursing staff about various aspects of his wife's care. Because of this, and knowing that the complainant had once written to the consultant about his concern for his wife's safety, the nurses were particularly careful with her.

21. The charge nurse said he had been on duty on 19 January 1981. He had noticed that the complainant's wife was not moving as much as usual and that she had a bruise on her leg. He asked a visiting family practitioner to examine her and he diagnosed a possible fracture. The charge nurse said he did not know how the fracture had occurred but he thought it possible that she had fallen in the lavatory. He discounted the possibility of her falling unnoticed on the ward because other patients would have called out. The nurses would not necessarily have recorded a fall as an accident if there was no apparent injury. The charge nurse said he went off duty at about 8.30 pm on 19 January and could not remember speaking to the complainant on that day.

22. I have seen a copy of the accident report form which was prepared on the day the fracture was discovered. The cause of the accident is shown as 'unknown' and there is a record that at the time of discovery the patient was sitting in a chair. The contemporaneous nursing notes show that the complainant's wife complained of pain in her right leg on 18 January and spent a restless night on 18/19 January, but there is no similar reference to her complaining of pain on any of the days immediately before that.

Findings

23. It is clear to me that, while she was on the ward, the complainant's wife was a difficult patient to nurse. She was confused and restless and although she was able to walk a little by herself she could not do so safely. Three of her four accidents in 1980 happened as a result of her slipping while getting up from her chair. I accept that if such movements are made suddenly they cannot be prevented by the presence of nursing staff; physical

restraint is the only effective method. But the consultant has said he is strongly opposed to such a practice and that is a matter for his clinical judgment which I do not question. There is no record of the complainant's wife having injured herself while walking and I accept the nursing staff's evidence that she was adequately supervised when required to walk.

24. I have been unable to establish how the complainant's wife fractured her femur. The complainant's recollection is that he was told on the day the fracture was discovered that his wife had fallen in the lavatory. The charge nurse who was on duty thought this was a distinct possibility and I think this view was conveyed on 19 January when the complainant telephoned. The consultant has said the fracture was probably the result of a fall and I think this was the case. I also think that the fall is likely to have occurred on 18 January, one day before the complainant's wife was transferred to the second hospital for confirmation of the preliminary diagnosis. I am satisfied that there was not unreasonable delay in taking action on the injuries she sustained. I do not uphold the complaint that supervision was inadequate but the comment made by the AA in his letter of 13 August (paragraph 14) is not supported by the evidence given to my officers.

(*c*) *The transfer to the second hospital*

25. When the complainant wrote to the consultant following the discovery of his wife's fracture he asked why he had not been informed of his wife's transfer from the first hospital. He said that the doctor at the second hospital assumed he knew about the transfer but he was unaware of it until he received a telephone call from the second hospital. He was extremely distressed over this incident as he thought it could have been avoided. In a subsequent letter to the AA the complainant said he was not notified of the transfer by the second hospital until the late evening of 19 January and if he had visited his wife that day at the first hospital as he had intended he would have had a fruitless journey. Fortunately, he had not been able to visit that day. But he pointed out that he had to make a 15-mile journey by car to visit his wife in the first hospital and the cost of hiring a car for the journey was considerable. He said that he lived on a very low income and could do without any unnecessary journeys and that he had asked the hospital staff to inform him when his wife was transferred from the ward so that he would know where to find her.

26. In correspondence with the complainant and in a letter to one of my officers, the AA said that patients at the first hospital were taken to the second hospital for examination if they fell or had an apparent injury. If relatives were telephoned every time this happened undue anxiety would be caused, since the results were often negative and the patient was returned to the first hospital. The AA said that if an injury or fracture was confirmed and the patient was admitted to the second hospital, the relatives were informed by that hospital. The AA told the complainant that this practice was followed when his wife was transferred to the second hospital. He was sorry the complainant had not been telephoned when his wife was taken to the second hospital, but pointed out that if she had not been admitted there

and had returned to the first hospital, he could have had an unnecessary journey to the second hospital. The AA said he had drawn the complainant's comments about a possible wasted journey to the attention of all concerned, so that if similar circumstances arose in future the same delay in notification should not occur.

27. In discussion with my officer, the charge nurse said the complainant's wife had been examined by a visiting family practitioner and transferred to the second hospital during the afternoon of 19 January. The complainant told my officer that he was first informed at about 6 pm, when he received a telephone call from a doctor at the second hospital. The doctor seemed surprised that he had not been informed before. I have seen the accident and emergency record at the second hospital and the clinical and nursing notes for her stay in that hospital. The record shows she was in the accident and emergency department at 6.15 pm and admitted to a ward at 9.30 pm.

Findings

28. In the event, the complainant did not travel to the first hospital on 19 January and he therefore suffered no financial hardship. But this was entirely fortuitous. The nursing staff at the first hospital were well aware that he was concerned about his wife and I think they were wrong not to telephone him as soon as the decision to refer her to the second hospital was taken. Next-of-kin have a right to be kept informed about the condition of their relatives and I do not accept that the AA's argument about transfers causing undue anxiety can be applied without question. The response of relatives of long-stay patients to the news of a transfer to another hospital is likely to vary and in a case such as this one where the patient had a spouse who was very caring, it should have been apparent to the nursing staff that early notification of the transfer would have been appreciated. I think the actions of nursing staff in such circumstances should be more sensitive and imaginative. I was pleased to see that the AHA drew the staff's attention to the complainant's comments and apologised for the delay in communication with him.

(*d*) *The handling of the complaint*

29. Following the discovery of his wife's injury, the complainant wrote to the consultant on 21 January. He made the points I have already set out in paragraphs 12 and 25 and asked for explanations. The AA replied on 18 March in the terms I have stated in paragraphs 13 and 26 but the complainant was not satisfied. He wrote to the AA on 22 March and in particular questioned the AA's remark that much of the time his wife was capable of walking without assistance. He also enlarged upon some of his previous points and raised new ones (paragraph 14). The AA acknowledged his letter on 25 March and said he had asked the hospital administrator (the HA) for further information. However, the complainant heard nothing more and wrote a reminder letter to the AA on 16 May. The AA wrote again on 26 May apologising for the delay and saying that the HA was awaiting comments from the consultant. The AA said he would let the complainant have

a full reply when he received the HA's report. The complainant wrote to me on 3 August having heard nothing further from the AHA.

30. After I had started my investigation the AA enclosed a copy of a reply he had sent to the complainant dated 13 August. The reply included an apology to the complainant for the delay in replying to his letter of 22 March and offered him a meeting with the consultant and/or senior nursing officer if he was not content with the reply. The complainant later told my officer that he was also dissatisfied with this reply ; however, he did not intend to see the consultant or the senior nursing officer.

31. In discussion with my officer, the HA said it was standard practice for the AA to reply personally to letters of complaint. The procedure at the first hospital was that the HA, on receiving a letter of complaint, sent a copy to the relevent departments in the hospital and asked for their comments. He sent the original letter to the AA with a note telling him that comments had been requested so that a draft reply could be prepared. Once he received the comments he drafted his reply and sent it to the AA for his consideration. The HA said that in the case of the complainant's letter of 22 March, he had been asked by the AA on 30 March to prepare a draft reply. He wrote to the consultant and the divisional nursing officer the same day asking for comments. He received the nursing comments on 14 April but, despite sending the consultant reminder letters on 22 April, 7 May and 20 May, and speaking to him on the telephone on various occasions, he heard nothing from the consultant until 6 June when he was told that the complaint was about nursing and the consultant had no comments. The HA said he drafted his reply and sent it to the AA on 15 June. On 28 July a revised draft was returned by the AA for the consultant's approval and this was sent to the consultant on 30 July. The consultant replied with comments on 3 August and these were returned to the AA on 11 August. The AA finally replied to the complainant on 13 August.

32. The HA told my officer that it was standard practice for a consultant to approve all draft replies containing references to clinical matters. This procedure had not of itself seriously delayed the reply to the complainant's letter. The main reason for the long delay were the two months the consultant had taken to decide he had no comments on the complainant's letter and the six weeks it had taken the AA to consider the HA's draft reply.

33. In discussion with my officer the consultant said he accepted responsibility for much of the delay in replying to the complainant's second letter. He was under considerable pressure of work at the time and when he eventually read his copy of the letter he found it was so poor he had to ask for a further copy. When this was provided and when he managed to look at the correspondence again in more detail, he concluded that the matters were principally about nursing.

34. The assistant administrator at the AHA who handled the letter of complaint at the area office told my officer that she was unable to give an explanation for the delay in her office, except that the complaint was complicated. She said delays often occurred because so many people

needed to see or comment on complaints. She thought in this case the consultant could perhaps have been reminded by the AA himself, but this had been left to the HA.

Findings

35. The complainant's dissatisfaction with the AA's first reply stems from his disagreement about the mobility of his wife while she was on the ward. In my opinion the AA's first reply was a reasonably comprehensive response to the complainant's letter of 21 January and I do not criticise him for it. The complainant did not receive a substantive reply to his second letter until the AA's reply of 13 August—a delay of nearly five months. I do not consider the points the complainant made were unduly complicated and I find the delay unacceptably long. I uphold this complaint.

Conclusion

36. I am well aware of the difficulties nursing staff can encounter when looking after geriatric patients who are demented. I was therefore pleased to record that the complainant was complimentary about the general nursing care his wife received during her time on the ward. I am also pleased to add that my officer, when he visited the ward, was impressed by the standard of hygiene there and the appearance of the patients. I have not upheld the main complaint that the complainant's wife was inadequately supervised but I have identified certain weaknesses about communication with relatives. I therefore invited the Health Authority, who took over responsibility for the first hospital on reorganisation of the Health Service on 1 April 1982, to review the practice of expecting relatives to make their own appointments to see medical staff. I also asked them to consider whether a more flexible approach could be adopted about keeping relatives informed at a very early stage about the transfer of patients. I am pleased to record that the Health Authority agreed to undertake these reviews. The District Administrator informed me that a new procedure has been introduced for patient transfers to other hospitals. In addition, staff have been reminded of relatives' right to be kept informed of a patients' condition and told that they should give positive assistance to relatives to obtain an appointment to see a consultant or registrar if it is requested. This, together with the apologies the complainant has already received for the delay in communicating with him on 19 January and for the long time it took to send a reply to his letter of 22 March, I regard as a suitable remedy for those aspects of the complaint I have upheld.

Case No. W.420/81-82—Lack of information given to parents of baby suffering from congenital hip dislocation.

Background and complaint

1. The complainant's daughter was born in hospital (the hospital) on 1 July 1981. Several weeks after she was taken home she developed a high temperature, and was taken back to the hospital where congenital

dislocation of the right hip was diagnosed. She was admitted to the hospital on 6 September and a tenotomy was performed the following day. A plaster of Paris cast was applied and she returned home on 8 September. She was readmitted with a history of being irritable and unwilling to feed on 28 September. The plaster was found to be foul-smelling and it was removed that evening. On 8 October an abduction splint was applied and she was discharged home on 12 October.

2. The complainant contended that:

(*a*) he and his wife were not properly informed about how to care for the plaster and weekly follow-up appointments were not arranged until after the removal of the plaster ;

(*b*) following his daughter's readmission on 28 September he was not able to see a doctor until 3 October when he was given information which was contradicted the following day ;

(*c*) the consultant orthopaedic surgeon responsible for his daughter's care (the consultant) was arrogant, suggesting during a discussion that the complainant should take his daughter elsewhere if he was dissatisfied with her treatment.

He complained through his Member of Parliament (the member) to the Area Health Authority (the AHA) but was dissatisfied with the reply because it suggested that misunderstandings between doctors involved jointly in the care of a patient were inevitable ; it also made a reference to the family's child-minder which the complainant considered offensive.

Jurisdiction

3. When the complainant first complained he made it clear that he was principally concerned about the failure to diagnose his daughter's condition earlier. I explained that was a matter for the clinical judgment of the doctors concerned and was outside my jurisdiction.

Investigation

4. In the course of the investigation I obtained the written comments of the AHA and examined the clinical and nursing notes and copies of the AHA's correspondence on the complaint. One of my officers discussed the complaint with members of the medical, nursing and adminstrative staff at the hospital. She also met the complainant. Another of my officers took evidence from members of the medical staff who had left the hospital.

(a) *Care of the plaster*

5. In a letter to the Member and in discussion with my officer the complainant said he telephoned the first ward on Sunday 20 September to ask whether the plaster could be changed because it appeared to be going soft and deteriorating. A nurse returned his call saying that the consultant would be at the orthopaedic clinic at 2 pm the following day and that if his wife took the child there the plaster would be seen. The complainant's wife

went to the clinic with her daughter at about 1.30 pm the next day, 21 September, and saw a male member of staff. He told her that although the plaster was soft from the knee downwards and rather fetid, unless a crack appeared in the area of the groin there was no need for the plaster to be removed. The complainant's wife still felt the condition of the plaster warranted attention but because she thought she was perhaps being a little anxious she took her daughter home. A week later on 28 September she again took her daughter to the hospital and this time she was admitted. The plaster was removed and she was found to be suffering from plaster sores which, according to the complainant, the charge nurse responsible for the first ward (the charge nurse) later described as the most severe he had seen. It took about two weeks for them to heal.

6. The complainant told my officer that when the plaster was first applied he and his wife were given some instructions on its care by the nursing staff; but they were given no advice by the doctors. They were just told not to put their daughter in a bath, not to put talcum powder inside the plaster and to tuck the nappies inside. He said they should have been warned about the possibility of plaster sores and told to return to the hospital if they were worried about the condition of the plaster. The consultant had later told them that plaster sores were almost inevitable and if that was the case it strengthened their view that they should have been properly informed. The complainant added that when his daughter was fitted with an abduction splint he and his wife received information from all quarters about how to care for her and the splint. This was in marked contrast with the information they had been given when the plaster was put on. He also pointed out in a letter to the Member that although he and his wife were never asked to return regularly to the hospital for examination of the plaster, weekly visits were arranged for examination of the splint.

7. The hospital records show that the complainant's daughter returned to the hospital for an X-ray on 14 September, one week after the plaster was applied. She was examined in the out-patient's department by one of the consultant's registrars (the first registrar) and he decided she should return in one month for a further X-ray. But this was overtaken by events. There is no record of her attendance on 21 September but when she returned to the hospital on 28 September she was at first admitted to the second ward where she was examined by a paediatrician. He decided that a member of the orthopaedic team should see her and later that evening the first registrar examined her and removed the plaster. She remained in the second ward until 30 September when she was transferred to the first ward. There is a record in the contemporary nursing notes that before her final discharge on 12 October, weekly follow up appointments were requested by the consultant. According to the note this frequency was to satisfy parental anxiety and did not arise from strict need.

8. I deal first with the mother's attendance on 21 September. She described the member of staff who advised her that day as Asian but the consultant told my officer that no member of his team at that time met that description. He said that although the description was inaccurate, she just might have seen the plaster technician if they arrived at the clinic before the

medical staff were there. But later, in written comments to another of my officers, the consultant added that it was very doubtful that the plaster technician gave advice on 21 September. He would not have given an opinion on a doubtful plaster and would have sought advice from a member of the Orthopaedic Department. Moreover in comments to the Sector Administrator at the hospital (the SA), the plaster technician said he did not recall seeing them. I have not been able, therefore to take this point further.

9. In discussion with my officer the ward sister responsible for the second ward (the ward sister) confirmed that when the complainant's daughter arrived on that ward on 28 September she was examined by a paediatrician. The plaster had a most offensive smell and they decided to call in the orthopaedic team with a view to removing the plaster. The plaster was removed that evening and under it were two sores which were producing offensive green pus. The sores were cleaned then and regularly thereafter so that the pus did not recur. The ward sister told my officer it was hard to describe the sores but she thought they were slightly worse than superficial. She added that although plaster sores did not occur in every case, they were not uncommon. She could not say why they might have developed in this case and did not think anyone could be blamed for them.

10. The first registrar and another of the consultant's registrars (the second registrar) who examined the complainant's daughter on more than one occasion said at independent interviews that their recollection of her plaster sores was that they were very superficial. This was confirmed by the charge nurse who saw her the day after her transfer to the first ward. According to the charge nurse at that time her sores were minimal skin depth sores only, in size less than one and a half inches by half an inch, and they were clean. He denied that he had told the complainant they were the worst he had ever seen ; in fact he described them to my officer as being not very different from nappy sores. I have noted that in the contemporary notes the first registrar, when he removed the plaster, recorded that the patient had 'Extremely sore nappy rash in groins, no infection at tendon site . . .'.

11. The charge nurse told my officer that the complainant's wife had been instructed by a staff nurse (the staff nurse) on how to care for the plaster before she went home on 8 September after the plaster was first applied. He said parents were told how to position and carry a child, how to apply a nappy and how to protect the plaster from soiling. Parents were also advised to check the plaster regularly to ensure it was not restricting circulation and to get in touch with the ward either by telephone or by calling in for informal advice if they were worried. The charge nurse added that parents were told that if a plaster became soiled it might cause nappy sores. They were therefore advised to use disposable nappies which tucked inside the plaster. The charge nurse said that at present there were no written instructions on the care of plasters although this would be desirable. He had been in charge of the first ward for only about a year and had not yet had time to introduce all the new systems he considered necessary. He said the instructions for the care of children in splints were issued by the physiotherapy department who were responsible for putting the child into the splint. The charge nurse said that after the abduction splint was applied the orthopaedic

team wanted the child to have weekly follow-up appointments in the orthopaedic clinic. The complainant and his wife were very upset about this because it would have meant bringing their daughter to the hospital during the day when they were both at work. It was therefore arranged by the nursing staff that they should bring her to the first ward every Sunday afternoon or evening for a check-up so that if there was any problem the nursing staff could refer her to the orthopaedic clinic the following day. But it was not the practice to have a routine check-up at regular intervals after a plaster had been applied, although she had in fact been seen in the orthopaedic clinic on 14 September.

12. In discussion with my officer the staff nurse said she remembered giving instructions to the complainant's wife on how to care for the plaster. She recalled discussing how to keep the nappy away from the plaster and gave her a supply of the nappies used in the hospital because they were not generally available to the public. The staff nurse told her that she could telephone the ward at any time or bring her daughter back if she was at all worried. But the staff nurse said she did not warn her about the possibility of plaster sores because it was not common for such sores to develop and she did not want to cause any more anxiety.

13. The consultant told my officer that he expected doctors on his team to warn parents that a plaster might possibly need replacing during the treatment of a child because, for instance, the child could grow and the plaster would no longer fit. A plaster might also need changing if sores developed or it became very soiled. The consultant said he recalled that the complainant was very concerned that the plaster sores had occurred. The complainant had said that he had been told that such sores should never happen and that they were very unusual. The consultant had tried to tell him this was not so but the complainant was not willing to believe him.

14. The second registrar told my officer that it was standard practice at the hospital for patients to be given an early appointment in the fracture clinic after their discharge. Further appointments were then arranged at the discretion of the doctors and the frequency of the appointments varied. He did not remember seeing the complainant's daughter before her discharge on 8 September; but when my officer drew his attention to an entry in the nursing notes that he had seen her he agreed he may have done so. The second registrar said that if the parents were on the ward he would probably have given general advice about caring for the plaster. He would have told them to return to the ward if there were any difficulties. He would not however have given detailed advice about plaster care; this was the responsibility of the nursing staff who had more contact with the parents and were more closely involved in the specific problems of nursing care.

Findings

15. It is common ground that the complainant and his wife were given some instructions on the care of their daughter's plaster before she was discharged home on 8 September. But these were given orally and no mention

was made of the possibility of plaster sores developing. To that extent I uphold the complaint about lack of advice. I have been unable to identify the member of staff who examined the plaster in the orthopaedic clinic on 21 September. However I do not doubt the complainant's account of events and I believe his wife was told there was no need at that time for the plaster to be removed. Such a decision if it were made by a doctor would have been made in the exercise of clinical judgment and as such would be outside my jurisdiction. But I have discovered that this may not have been the case here. I am concerned that there was even a possibility that the advice was given by a plaster technician with such authority that the complainant's wife concluded that she must act on it.

(b) *Communication with doctors*

16. In discussion with my officer the complainant said that after his daughter was admitted on 28 September and the plaster was removed, he asked the nurses repeatedly whether he could see a senior doctor. After about five days he saw a house officer (the HO) who told him that a congenital dislocation of the hip caused no problems so long as the condition was diagnosed by the time the child was about seven years old. The following day the complainant saw the first registrar who was quite helpful in trying to explain about congenital hip dislocations and spent some time talking to him. But the first registrar told the complainant that if he was not satisfied he should see the consultant. The first registrar also contradicted the information given to the complainant by the HO and said he should not listen to junior doctors. The complainant said that some days after his daughter's admission the charge nurse had suggested he made an appointment with the consultant's secretary to see the consultant and this he did.

17. The ward sister told my officer that she was sure that the complainant's wife must have seen at least a junior member of the paediatric team after the plaster was removed because there was always a houseman about on the second ward and after the first day she stayed in the hospital. The charge nurse said that on 1 October, the day after his daughter was transferred to the first ward, the complainant asked him whether it was possible for him to see the consultant. He seemed to want the meeting urgently and the charge nurse therefore suggested to the complainant that he telephone the consultant's secretary to arrange an appointment. The charge nurse also told the complainant that if he went to the orthopaedic clinic the following day he would be able to see a senior member of the consultant's firm.

18. The HO told my officer that he remembered very little about this case. As a house officer he was not responsible for management decisions and he had not been involved at all until the complainant's daughter was readmitted with her plaster sores. The HO's only clear recollection was meeting the parents, although he could not remember the conversation in detail ; nor could he remember the date and time of the meeting. But the HO remembered that the complainant was quite agitated during the discussion. He was very upset that the dislocated hip had not been diagnosed at birth and he was threatening to complain to the Member. The HO said he tried to calm the complainant so that he could explain that his daughter's condition may

not have been present at birth and that hip dislocations sometimes happened post-natally. He also tried to reassure the complainant that there was no cause for concern about his daughter's condition but he denied he had said that congenital hip dislocations caused no problems so long as they were found within seven years. The HO said this was a sweeping statement and not one he would use. He told my officer that the complainant was not satisfied with his explanation and he therefore decided to refer him to one of the registrars. He understood the first registrar had subsequently seen the complainant but he knew nothing about the conversation. The HO added that he had not been aware that the complainant urgently wished to see a doctor or that there had been any difficulty in this respect. He pointed out that he, himself, was usually available on the ward unless he was required in the theatre. The consultant confirmed to my officer that in the period 28 September to 3 October members of his firm were also visiting the wards and would have been available to parents during the day. However there might have been problems if the complainant was visiting in the evening when doctors were less likely to be on the ward.

19. In discussion with my officer the first registrar recalled meeting the complainant on 3 October. He was clearly upset and said that he was going to complain to the Member. The first registrar tried to explain the child's condition but the complainant did not seem to understand fully what he was being told. The first registrar could not recall any reference to another doctor and he could not remember telling the complainant not to listen to junior doctors. But if someone had told the complainant that a congenital dislocation of the hip was nothing to worry about provided it was diagnosed before the child was about seven, he would have contradicted this statement. He said he had not been aware before seeing him that the complainant urgently wished to speak to a doctor.

Findings

20. I accept the evidence that junior medical staff were in regular attendance on both the first and the second wards. The complainant and his wife could therefore have spoken to one of these doctors without undue delay. But the complainant said he wished to see a senior doctor and I think this contributed to his difficulties because senior staff would not have been so readily available. In the event the complainant saw the HO on 2 October and the first registrar the following day. Moreover on 1 October the charge nurse offered the complainant advice on how to make an appointment to see the consultant. I do not therefore find that the hospital staff acted unreasonably in this respect. As for the complainant's allegation that he was given information which was later contradicted, I believe in his anxiety he misinterpreted the HO's reassurances about his daughter's condition. The first registrar may well have contradicted what the complainant said he was told but I believe he was only trying to be helpful. I do not find this complaint made out.

(c) *The attitude of the consultant*

21. The complainant told my officer that when he met the consultant another doctor was also present. He said he asked the consultant some general questions about the incidence of congenital hip dislocations but neither the

consultant nor his colleague seemed to know the answers. At one stage the consultant said in an arrogant manner that if the complainant did not like the treatment his daughter was receiving he could take her elsewhere. However for the rest of the meeting the consultant was quite civil although it was obvious he was convinced he was in the right.

22. In discussion with my officer the consultant said that when he met the complainant he had spoken in his normal tone and had not intended to be arrogant. He had been trying to explain that if the parents were dissatisfied with the care their daughter received he had no objection to them having a second opinion. He explained to the complainant that there were two possible ways of going about this: either he would arrange it for them or he could write to their family practitioner and ask him to do so. The consultant said he always made the position clear to patients because they were often reluctant to ask for a second opinion. He added that he saw the complainant in the orthopaedic clinic; his secretary was present and he thought one of his registrars would also have been there.

23. The consultant's secretary confirmed to my officer that she had been present when the consultant spoke to the complainant. She said she had worked for the consultant for many years and he had never been arrogant to her; nor was she aware that he had been arrogant to anyone else. She confirmed that the consultant had told the complainant that if he was dissatisfied he could take his daughter elsewhere for treatment but he did so by telling the complainant that he had no objection to him seeking a second opinion. And when another of my officers met the second registrar he too was sure that the consultant had not been arrogant. He was present at the meeting and he remembered only a general discussion. The second registrar said it was standard procedure for dissatisfied patients to be told that they were at liberty to seek a second opinion and he thought the complainant might have misinterpreted the consultant's remarks.

Findings

24. By the time he met the consultant the complainant had seen at least two other doctors about his daughter's condition. However it seems to me that he was either unwilling or unable to accept the reassurances that were offered. I do not believe the consultant was arrogant in his manner and I dismiss this complaint.

(d) *The AHA's reply*

25. The SA wrote on behalf of the AHA to the Member on 4 November in answer to the Member's letter of complaint. In his reply the SA said the alleged comments by a junior doctor which were subsequently contradicted by his senior were unfortunate. But both medical and orthopaedic firms had been involved in the complainant's daughter's admission and treatment and with the number of people involved, he said, there was always the possibility of misunderstandings. The SA also said that if the complainant and his wife felt they were not sufficiently advised about the care of the plaster, the AHA owed them an apology. But he believed there might have been an added complication in that they were both at work all day and their daughter was cared for by a baby-minder.

26. In a letter to the Member and in discussion with my officer the complainant said he was dissatisfied with the SA's reply. He did not accept the explanation that misunderstandings sometimes occurred when doctors from different firms were jointly involved in a case. He said that good communication must always operate between different departments in a hospital and they should ensure that misunderstandings did not occur. The complainant also said that he found the SA's reference to the child-minder offensive. The lady in question was a close friend of his wife whom she had known for a period of ten years. Moreover it was not true that he and his wife were both at work when their daughter was in plaster: his wife did not start work until 5 October and the child-minder took care of their daughter only from 14th October, after she was discharged from hospital in the splint.

27. In written comments to the assistant district administrator (patient services) the SA said that his comment about misunderstandings occurring may have been taken slightly out of context. He was trying to say that the more people you ask about something the greater the number of opinions which may be proffered. When clinical and personal opinions were being sought, different specialties and therefore different expertise might be involved. As for the reference to the child-minder this was certainly not intended to be offensive. The SA told my officer that he had included this in his letter because the consultant and the nursing staff seemed to think it was a significant factor in the care of the child. At the time they believed the complainant's daughter was being cared for by a child-minder and thought that although the care of her plaster had been explained to the parents, the child-minder might not have received instructions on how to care for it or may have been less careful in doing so. The SA said that if he had failed to mention the child-minder the complainant might easily have complained to the hospital that they seemed unaware of the existence of the child-minder and that she had not been instructed in caring for the child.

Findings

28. In the complainant's view misunderstandings should never occur between different departments in a hospital. In an ideal world that would be true. But I think he is being less than realistic if he expects perfect communication to be achieved in practice. Indeed I have already suggested that the complainant himself misunderstood information he was given by the HO (paragraph 20). I have seen that there is a number of references to the child-minder in the clinical and nursing notes. She was authorised in writing by the complainant to collect his daughter when she was finally discharged and she visited the ward for instruction on the care of the splint. But all the references were made after his daughter had been readmitted on 28 September. The complainant and the SA's reply about instructions on the care of the plaster referred to the period before this and the SA was mistaken therefore in suggesting that the child-minder was an added complication at that time. To that limited extent I uphold this aspect of the complaint.

Conclusions

29. I have not upheld the major aspect of this complaint but I have found that the complainant and his wife were not warned about the possibility of

plaster sores and to some extent I have upheld the criticism of the AHA's reply to the Member. The Health Authority (the successor HA) which following a reorganisation of the National Health Service have taken over responsibility for the hospital, have asked me to convey through this report their apologies for these shortcomings. This I gladly do. I have also expressed concern about the possibility of a plaster technician giving advice on 21 September, although I am not satisfied that this actually occurred. I do not think that advice about the necessity for removing a plaster *should* come from such a source and I invited the successor HA to make arrangements to ensure that it does not do so. I am pleased to record that they have so agreed. There remains the question of whether oral insructions to parents on the care of a child's plaster are sufficient. The charge nurse told my officer that written instructions would be desirable and in my view this complaint illustrates the need for such instructions. I therefore invited the successor HA to consider issuing written instructions on plaster care and I am pleased to report that they have agreed to do so. I regard these two assurances from the HA and the apologies as an appropriate outcome to my investigation.

Case No. W.444/81-82—Delay in accident and emergency department before admission and in-patient care

1. The complainant's husband, aged 71, became ill on holiday and on 13 September 1981 was admitted through the Accident and Emergency Department (the A and E department) to a ward (the ward) of a hospital (the hospital); he was discharged home the following day. The complainant alleged on behalf of her husband through her Member of Parliament that:

(*a*) although a family practitioner who first attended her husband (the first FP) was told that a bed would be immediately available, he was left unattended on a stretcher in the A and E department for nearly six hours;

(*b*) the wait was without refreshment and the food supplied on the ward was cold and inadequate, and unsuited to his diet;

(*c*) the atmosphere in the hospital was poor; in particular while on the ward he was cold in the night but was told no extra blankets were available; a tablet was given him which had been dropped on the floor; nurses were 'horseplaying' with wheelchairs while on duty on 14 September;

(*d*) discharge arrangements were unsatisfactory;

(*e*) the condition of the lavatories (described as being down a long slope near the entrance) was disgraceful.

Investigation

2. During the investigation I obtained the written comments of the Area Health Authority (the AHA) and saw the relevant correspondence and medical and nursing notes. One of my officers met and discussed the complaints with members of the medical, nursing, radiography and administrative staff

involved, and with the complainant and her husband. Evidence was also taken from the first FP and from the husband's own family practitioner (the second FP).

(*a*) *Delay in providing a bed*

3. In discussion with my officer and in correspondence, the complainant and her husband said that the first FP saw the husband at their hotel on 13 September and said that hospitalisation was necessary ; he suspected the husband to be suffering from hepatitis. The FP telephoned the hospital and, they believed, a member of the staff there confirmed to him that a bed was immediately available. They arrived at the A and E department by ambulance between 12 and 12.15 pm. The husband was isolated in a large cubicle in the department because of his suspected hepatitis although the complainant was later allowed to join him. They both alleged that until a doctor examined the husband at 6 pm nothing was done ; he was x-rayed at 7 pm but it was not until 8 pm that the complainant was able to return to the hotel having finally left her husband on the ward.

4. The complainant recalled enquiring of A and E department nursing staff on a number of occasions about the wait and one explained that there might be a long delay ; at 4 pm a doctor said then they would not have to wait long. She added that ' the sister ' (in fact the on-duty radiographer) in the x-ray department asked whether she had complained to anyone in the A and E department and she replied that it was like speaking to a brick wall.

5. My officer established that the A and E department was open on Sundays only for medical emergencies and other very serious cases. There was therefore no casualty officer on duty and it fell instead to a doctor on the team of a consultant physician (the consultant) to examine the complainant's husband. Three doctors, the normal complement, comprised the team on 13 September—a registrar, a senior house officer (the first SHO) and a house officer (the HO). The registrar said that under this arrangement the doctors on duty not only had to cover those patients requiring attention in the A and E department but also had to deal with those on the wards. He remembered the weekend in question as extremely busy and in particular a patient had had a cardiac arrest with which he was dealing for some three quarters of an hour. He said that in many circumstances patients might be admitted direct to the ward and be examined by a doctor after admission but the diagnosis of suspected hepatitis made that impossible.

6. The first SHO remembered examining the complainant's husband although he could not remember at what time he did so. He believed that his examination would in itself have taken about half-an-hour but that he was, he thought, called away to another patient in the course of the examination for about an hour. No tests were undertaken before the examination was completed and this was normal practice. He acknowledged that the complainant and her husband waited a long time but he too remembered the case against the background of a very busy weekend during which time, he believed, he himself saw 19 patients in the A and E department. He did not consider that there was any clinical reason for the tests to be carried

out as an emergency procedure. The HO said that he was not involved with the examination but he recalled that between 4 and 5 pm one of the nursing staff mentioned to him that the complainant's husband had been waiting a long time. He therefore took the initiative in going to them and apologising for the delay.

7. My officer established that of the seven A and E department nursing staff on duty for all or part of the relevant period, three had some definite memory of the complainant and her husband. The sister in charge remembered apologising to the complainant about the wait, but explaining to her that there were other patients needing attention who were in a worse condition. The complainant appeared worried and had said that the wait was not good for her husband's nerves. The sister also remembered that she allowed the complainant into the isolation room to join her husband. Two staff nurses also remembered apologising to the complainant and her husband ; one believed he told them several times the reasons for the delay and found them to be very understanding at the time. All three nurses vividly recalled the weekend being exceptionally busy ; in particular they recalled a cardiac arrest and a patient who appeared three times having taken two separate overdoses of drugs. The sister told my officer that she would not pretend that the complainant's husband was not in need of quick attention, but they had other patients needing *emergency* treatment. She said that although her duty times were officially 7.45 am until 5 pm she was unable to leave until considerably later, and one of the staff nurses remarked that he was unable to take any break during his duty time from 1 pm to 9 pm.

8. The radiographer on duty in the x-ray department on 13 September produced records showing that the complainant's husband arrived at her department at 19.25 and left at 19.45. She remembered the complainant being dissatisfied with the earlier delay but she took this to be a general grumble rather than an official complaint. She could not remember how she responded to her although she thought she would have sympathised and might have said that the day was the busy one she remembered it to be.

9. The first FP said that although he certainly thought that the complainant's husband should be admitted to hospital he did not give the complainant and her husband any indication that a bed might be immediately available.

10. The return for the ward at midnight on 13 September shows that twenty-seven of the twenty-eight beds were occupied and that there were five admissions and four discharges during the preceding 24 hours. The A and E department register shows that the complainant's husband arrived at 13.10. Twenty-five other patients arrived there on Sunday 14 September, fifteen of them '999' emergencies ; and four arrivals immediately prior to the complainant's husband were all emergencies and of seven further patients arriving between 13.10 and 16.40, four again were emergencies ; eighteen of the total attending required hospital admission. Comparative figures for attendances on the other Sundays in September 1981 were fourteen, nineteen, and fifteen. And the radiographer told my officer that her department had not had such a busy weekend in the interval between 13 September and March 1982 when he took evidence from her.

Findings

11. The complainant believed that she and her husband arrived in the A and E department between 12 and 12.15 pm whereas the hospital records show 1.10 pm But as it is common ground that arrival on the ward was not until 8 pm, they waited an unconscionably long time. The actions of family practitioners are not subject to my investigation but the first FP denied that he told them that a bed was immediately available. I know from previous investigations I have undertaken that it is for the hospital rather than for an FP to decide whether or not admission is justified and it follows that the FP would not have been in a position to promise admission, immediate or otherwise. The large cubicle in which the complainant's husband waited was, my officer confirmed, separate from the main area of activity and I can understand the resultant feeling of isolation. But the preliminary diagnosis made this essential. Four members of staff separately told my officer that the complainants were kept informed on various occasions and the complainant also remembered approaches by them. There was an undeniable and most unfortunate delay but I do not find it was the result of maladministration by the hospital staff.

12. Three interlinked factors caused the delay. First, as the AHA chairman explained in his original reply to the complainant's Member of Parliament, it was clear that there was heavy pressure on beds and one was not immediately available. The AHA told me that the doctor who examined the complainant's husband in the A and E department requested nursing to be undertaken in a 'reverse barrier' procedure, that is to say, one which will prevent the patient's illness from being communicated to other people in the hospital. This had to be carried out in a single room and slightly extended the time required to arrange a suitable bed. Second was the need for the complainant's husband to be examined by a doctor before admission because it was suspected that he had hepatitis; this was a precaution which, in view of the provisional diagnosis, the hospital would have been foolish to disregard. Third was the exceptionally busy weekend, the staff's vivid memories of which are supported by the statistics.

(b) *Food*

13. The complainant said that she told a nurse in the A and E department three times that her husband had eaten nothing since a breakfast of porridge but she was told that he could not be given anything until tests were undertaken to see whether he was infectious. She also said that she told staff both in the A and E department and on the ward that her husband was on a diet. She explained to my officer, and emphasised she told the staff similarly, that this meant that he could eat nothing fatty, nor anything with pips or skins, nor new bread. The complainant's husband said that when he was eventually transferred to a bed in a room on the ward he was very hungry. But a junior nurse told him that dinner was finished and he felt generally that 'he was in a café after the kitchen was shut'. However he was told that the staff would try to find him something and he was eventually given a Scotch egg, cucumber, tomato and new bread, all unsuited to his diet. In the end, all he had was bread and butter and a cup of coffee 'worse than BR can serve'.

14. The next day, his early morning tea was too 'stewy'. He also had to ring for breakfast at 8.30 am only to be told that he had been forgotten; he asked for porridge but was told initially that there was none; some was eventually provided but, as it was cold, he did not eat it. Mutton stew, again unsuited to his diet, was provided for lunch. He said that although he thought he made his feelings known, he did not complain much at the time, because the staff were clearly junior and he did not see that they could have been expected to do much about the food.

15. The registrar said that the nurses in the A and E department would not normally give refreshment to a patient awaiting attention in case that patient needed an operation. I have seen that the first FP had also questioned whether the complainant's husband had an obstruction and it followed that the husband could not be given food until the medical staff at the hospital were satisfied that no urgent surgery was required.

16. Sixteen nursing staff were on day or night duty on the ward at various times during the husband's stay; of these one, who had left, proved untraceable and another eleven remembered nothing about the complainant or her husband. The remaining four had some memory of them although none could remember anything specific regarding problems with food or of complaints being made about it. The nursing officer in overall charge of the ward (the NO) said that supper finished at 6.30 pm but a salad could usually be obtained until the kitchen closed at 8 pm. After that, things might become difficult until the kitchen reopened (for night staff meals) much later in the evening. Tea and coffee were prepared directly on the ward.

17. The hospital catering manager explained that the hospital operated a central tray service and offered a choice of food. All patients completed a menu card every 24 hours for the following day's meals. For patients on a diet, a special sticker would be attached to the card. The catering manager explained that the complainant's husband was not admitted in time to complete a card for breakfast. But as regards lunch, he said that for patients who had been admitted the previous evening it varied from ward to ward whether cards were completed and returned to the kitchen in time; he rather thought the husband's ward was likely to 'miss the system' in that respect. Speaking generally, he said that a ward sister would normally get in touch with him if there were complaints but he frequently visited the wards during meal times, with the object of resolving problems on the spot and so preventing complainants from becoming more dissatisfied. In twelve months he had received just three complaints and the number of compliments exceeded complaints.

Findings

18. I am concerned that the complainant's husband went so long with so little refreshment. While he was in the A and E department he was refused food in accordance with prudent medical practice and that cannot be criticised. Regarding his difficulties about food in the ward I appreciate his concern for the junior staff but I think it would have been better had

he made his feelings clearly known to senior staff at the time as it is always difficult in such cases to establish exactly what happened after the event.

19. There was clearly misunderstanding about his diet since the 'history from patient', recorded in the nursing kardex, states 'Meals—normal—but does not eat fat'. At this distance in time I cannot clearly establish what went wrong but I believe that in two areas at least the hospital were at fault. First, they should ensure that when patients are kept waiting for a long time without food, adequate catering arrangements are available whatever the time of admission. Second, while the problems over lunch might have been avoided had the complainant's husband completed a menu card—he told my officer that he did not do this—he was not afforded an opportunity to do so. The system in practice, was insufficiently flexible to meet the needs and wishes of patients admitted too late to fill up a menu card.

(c) *Nursing care incidents*

20. The complainant and her husband felt that the atmosphere in the hospital was generally poor and gave three separate examples, relating to the husband's stay on the ward.

(i) *Lack of blankets*

21. The complainant's husband said that the night of 13-14 September was unexpectedly frosty and because he was provided only with a cotton sheet and a cotton cover he rang the bell for attention. The nurse who came was holding her cardigan tight around her against the cold and she told him that there were no blankets available. He formed the impression that they were still locked away for the winter. The nurse was not unpleasant but was just unable to help through no fault of her own. He said that he slept only intermittently.

22. No member of the night nursing staff could remember the episode. The NO said that two *blankets* were standard issue; there were no problems with storage and it would be easy for a nurse to get a spare blanket from store. Other junior nurses when separately interviewed by my officer confirmed this. The nursing kardex records that the complainant's husband 'slept well' although the NO explained that in hospital this would not necessarily mean that a patient's sleep was unbroken.

(ii) *Dropped tablet*

23. The complainant's husband said that some time during 14 September a nurse dropped a tablet on the floor before giving it to him. He explained that two nurses were involved, one to check the other, but that because he was isolated only one actually entered his room. This nurse, whom he believed to be trained, had the tablet in a pot but somehow dropped it; she then put it back in the pot before giving it to him.

24. Again no nurse remembered dropping a tablet. The NO confirmed that two nurses would be involved in the drugs round and that, because of the husband's isolation, one only would have entered his room. The sister in charge of the ward on 14 September believed that she herself did the

drug round that morning and she certainly did not drop a tablet. The junior nurses confirmed the procedure that if a tablet was dropped it would be flushed down a sink.

(iii) *Horseplay*

25. The complainant said that during the morning of 14 September (her husband told my officer that he thought it was the afternoon) the nurses had nothing better to do than to give each other rides in wheelchairs. The complainant's husband explained that he heard laughing and saw two or three staff through a crack in the door, which was partly open but he was unable to describe anything more specific to my officer regarding their actions.

26. No member of staff admitted to misbehaving. They thought that the only possible explanation was that the action complained of related to the transfer of a wheelchair patient. The NO said that if anything untoward occurred it was almost inconceivable that it happened in the morning when the doctor's ward round was made. The AHA told me that two or three consultants made their rounds on this ward on Monday mornings and it was one of the busiest times of the week for the nursing staff there.

Findings

27. As to the lack of blankets, I have no reason to doubt the complainant's husband's assertion that he felt cold in the night of 13/14 September. There is no evidence that he was offered extra blankets and he should have been. I am critical of this neglect which should not have occurred.

As to the dropped tablet, I am not satisfied that this occurred as he said. But even if it did, he had of course the option of refusing to swallow the tablet.

As for the alleged 'horseplay' I am not satisfied on the evidence that there was any misbehaviour by nurses of which I ought to take notice.

(d) *Discharge arrangements*

28. In her original letter of complaint the complainant alleged lack of co-operation by a junior doctor in making arrangements for her husband's discharge. Her husband said that the consultant saw him at about 12.30 pm on 14 September in the course of his ward round. The consultant said that he had jaundice but not hepatitus and could go home. One of the three junior doctors with him offered to telephone the second FP. The consultant seemed to agree and the husband thought that once this was done he could go home. The consultant's team then left the ward and the complainant's husband asumed he would be discharged shortly afterwards. However, after lunch a nurse said that he could not go home because they had not yet been in touch with the second FP. The complainant herself offered to contact the second FP and said that her husband was leaving anyway once she had gone back to the hotel to pack. But on her return another of the junior doctors who was with the consultant's

team in the morning did what was required. Apparently the doctor whose task they thought it was had left for a clinic elsewhere. The complainant and her husband eventually left between 5 and 5.30 pm.

29. The complainant and her husband also complained that no ambulance transport to their home was provided and that after examining his patient on their return, the second FP found the discharge summaries so inadequate that he was obliged to seek further information by telephoning the hospital.

30. The consultant remembered that during the ward round he took the view that further clinical investigations could be carried out either at the hospital or in the patient's own home town, and since he obviously wanted to go home, he should do so. He said that it was a very busy morning; the registrar had to go to another hospital in the afternoon and the HO handled the discharge. He saw nothing wrong with the summary to the second FP prepared by the HO or the more detailed report sent subsequently by a third member of his team (the second SHO).

31. The registrar confirmed that during the ward round it was generally felt that the complainant's husband was well enough to be discharged. He confirmed that it was the HO who organised the actual discharge. He also remembered the second FP telephoning him the following day when he seemed content with what he was told. The second SHO, who was also present on the ward round, generally confirmed the registrar's account of the discharge arrangements and explained that he and the registrar had an arrangement to visit another hospital in the afternoon. He remembered noticing that the complainant was still at the hospital when he returned there at about 5 pm although he had no direct contact with her.

32. The HO was quite sure that it was his duty rather than the registrar's to arrange discharge although he said it would have been in consultation with the registrar. He believed the ward round, which included wards other than the husband's would have ended at about 1 pm. He would then have had lunch before taking any action regarding the husband's discharge. He confirmed that this involved ordering and awaiting delivery of drugs from the pharmacy and preparing the initial discharge summary. He also thought that he telephoned the registrar at the other hospital in the course of making the arrangements to confirm that it was all right for the husband to leave without the results of some of the tests being available.

33. In written evidence to my office the second FP expressed concern about the *nature* of diagnostic examinations of the complainant's husband, but he offered no criticism of the discharge summaries.

34. As to ambulances, the complainant told my officer that she did not ask for one and she had her car with her. None of the staff remembered any discussion on the subject and many spoke of the inevitable delay that would ensue before one could have been provided; it would certainly not have been reasonable to provide the complainant's husband with transport to his home on 14 September, when his wife was able to drive him home and had a car.

Findings

35. The complainant's husband was understandably anxious to go home but this meant that if he did, he left before the results of tests were available. In those circumstances the hospital clearly had a duty to try to ensure that the second FP was informed of the situation and to ensure that the husband left with his prescribed drugs. But there can be no doubt that he was left with the impression sometime before 1 pm that he was to be discharged and it is certainly unfortunate, since two fairly simple procedures only were involved, that he and his wife did not leave until after 5 pm. I cannot be certain why this happened. But I have found no grounds to criticise any individual member of staff and I think it likely to be yet another result of the pressure under which the staff were working.

36. I do not find anything amiss with the discharge summary and it seems likely that the FP's concern about the nature of the tests (a matter of clinical judgment) led to misunderstanding by the complainant on this point.

(e) *Lavatories*

37. The complainant and her husband said that following his discharge, they used public lavatories within the hospital before leaving and found the facilities for both sexes to be disgraceful ; even outside the smell was appalling, they said.

38. My officer had some difficulty in identifying the lavatories concerned (the AHA had believed the complainant to be referring to the ward lavatories when initially replying) but he found that those almost certainly concerned had been upgraded since the complaint. He found them to be clean and tidy and without any smell from outside.

Findings

39. I have no reason to doubt the complainant and her husband's assertion that the lavatories were generally unsatisfactory and I hope they will accept my assurance that the situation has been remedied.

Conclusions

40. I have upheld some of the complaints of the complainant and her husband, as recorded in previous paragraphs of this report. Although I did not find that the long delay in the A and E department was caused by maladministration, the chairman of the AHA has already very properly apologised for it. It was indeed unreasonably long. The successor authority have asked me to convey through this report their apology for the further shortcomings to which I have drawn attention. I regard these expressions of regret as an appropriate outcome to my investigation.

Case No. W.541/81-82—Handling of complaint by Family Practitioner Committee

Background and Complaint

1. On 13 February 1981 Mr and Mrs A complained to the Family Practitioner Committee (the FPC) about the failure of Mrs A's family practitioner

to provide adequate ante-natal care for her. Shortly afterwards the FPC tried to resolve the complaint informally but Mr and Mrs A remained dissatisfied and asked for it to be investigated formally under the National Health Service (Service Committees and Tribunal) Regulations 1974 (the Regulations). On 5 March 1982 the Community Health Council (the CHC) complained to me, on behalf of Mr and Mrs A, that the FPC had not implemented the formal procedure and, moreover, that there had been no written communication from them to the complainants, although in November 1981, in response to a telephone enquiry from Mrs A, the administrator of the FPC (the administrator) had told her that there had been difficulties but that he would look into the matter again.

Jurisdiction

2. The Act which defines my powers specifically excludes me from investigating action taken by a Family Practitioner Committee in the exercise of its functions under the Regulations. It was not apparent from the papers sent to me by the CHC whether or not the complaint to the FPC had been dealt with under the Regulations. I therefore embarked upon enquiries into their complaint, conscious that I might, at any time, discover facts which placed the actions of the FPC outside my jurisdiction, when I would have had to discontinue them. I have not addressed myself to the complaint by Mr and Mrs A against the family practitioner as this is a matter for the FPC and is outside my jurisdiction.

Enquiries

3. During my enquiries, I obtained the written comments of the FPC and I examined the relevant correspondence. My officer interviewed the chairman of the Medical Service Committee of the FPC (the MSC chairman) and the administrator and he also met the complainants.

4. The complainants told my officer that, when they advised the administrator at the informal hearing of their complaint on 27 February 1981 that they were not satisfied with the explanation they had been given, he had said that their complaint was complicated because more than one doctor was involved and that the investigation would take several months. They received a letter from the FPC dated 6 March which asked for Mrs A's authority for her husband to act as the complainant ; for the dates on which certain incidents complained about occurred so as to enable the administrator ' to determine whether and/or which parts of your complaint should be regarded as ' out of time ' ' ; and for the acknowledgement slip given to Mrs A by the family practitioner who was the principal in the practice (the FP) when she was accepted for maternity medical services. Mrs A gave the requisite authority but was unable to provide all the information required or the slip given to her by the FP in acknowledgement of her booking for maternity services. About a month later Mr A visited the FPC offices and asked what progress was being made in regard to his complaint. The administrator repeated that it was a difficult case and it would, therefore, take some time to deal with it.

5. The CHC, who had helped Mr A put his complaint to the FPC, wrote to him on 29 September enquiring what had happened. The complainants

said that, although they had heard nothing further from the FPC, they did not get in touch with the administrator immediately because of the warning he had given them. In November Mrs A spoke on the telephone to the administrator about the complaint and he told her that there had been difficulties because two of the doctors involved had left the district and the FP would not accept responsibility for their actions; but he promised to look into the matter again. There was however no further response from the FPC and on 3 March 1982 the complainant asked the CHC to put their complaint to me.

6. In his written comments on this complaint on behalf of the FPC and when interviewed by my officer, the administrator said that on 4 March 1981 Mr A returned the form he had been given at the informal hearing; he signified that he was dissatisfied with the outcome of the hearing and that he wanted his complaint to be considered under the formal arrangements. Further information was needed before the case could be referred to the MSC chairman—the first stage of the formal procedure—and the administrator wrote to the complainants on 6 March (see paragraph 4). On 16 March, as he had not received a reply from the complainants, he wrote to the FP requesting information from her records. He received the complainants' reply on 17 March but they could not supply all the information he required and it was necessary for him to speak to the FP on several occasions to obtain the dates on which certain of the events which had given rise to the allegations occurred; he also asked her to submit the relevant Form P24—a form which *inter alia* is an acknowledgement by a doctor of the acceptance of responsibility to provide maternity medical services for a patient. On 14 April he referred the correspondence, together with other information he had obtained, to the MSC chairman for his decision as to whether or not it disclosed reasonable grounds for complaint. In his covering letter the administrator suggested that the MSC chairman might 'give some thought to the 'out-of-time' aspects (if any) of parts of the complaint'.

7. The administrator said that the MSC chairman had then discussed the case with him. The opinion of the MSC chairman was that the statement of complaint disclosed reasonable grounds for complaint but that there was some doubt as to whether some parts of the complaint were out-of-time and should therefore be considered under the procedure for dealing with late complaints. He asked the administrator to give further consideration to this aspect prior to seeking the formal observations of the doctors concerned in the complaint—the next stage in the formal procedure.

8. In their 'Notes on Service Committee Procedures' the Department of Health and Social Security (the department) give the following guidance in regard to time limits for making complaints:—

> 'A complaint against a doctor . . . may not be investigated by a service committee if it is received more than 8 weeks after the event which gave rise to the complaint unless:—
>
> (*a*) the service committee are satisfied that failure to give notice in time was due to illness or other reasonable cause, and

(*b*) (i) the doctor, . . . consents to an investigation, or

(ii) the Secretary of State's consent has been obtained in accordance the procedure indicated in Regulation 5(2) [of the Regulations].

In a medical case the event which gave rise to the complaint must relate to an alleged act or omission by the doctor, not to the date when the complainant became aware of a possible breach of the terms of service. For example, where a patient dies in hospital the event in relation to the family doctor must be some occasion when there was an alleged failure in treatment by the family doctor, not the date of death or some other date when the patient was not under the care of the family doctor '.

9. The administrator said that there were aspects of the complaint which were clearly within the time limit; but there were others concerning the alleged failure of the FP to act during Mrs A's pregnancy on information which was available in her medical records at any early stage of the pregnancy ; a failure which the complainant believed may have led to the death of their baby in hospital. He was unsure whether this part of the complaint could be considered within the time-limit or whether it should be dealt with under the procedure for late complaints and he sought the advice of the department. He was told, however, that this was a matter for his FPC to decide ; the department could not make the decision for them as this might prejudice the Secretary of State's actions should the complainant exercise his right of appeal against the FPC's decision. The administrator said that whilst he had to have regard to the Regulations and the department's guidance he also wanted to ensure, as was his practice, that the complainant's rights were respected. He had been unable to make up his mind on this issue and decided to leave it until the Form P24 was received from the FP. Unfortunately he omitted to ensure that the receipt of the form (it was received on 6 August) was brought to his notice and this resulted in the complaint being overlooked.

10. The administrator remembered Mrs A telephoning him in November about the complaint ; he had been in a meeting at the time and the conversation was brief. He could not clearly recall details of the conversation but he thought he might have told her that there had been difficulties with the family doctors and also that he had been very busy. He did, however, promise to give the complaint his attention ; but he had not done so. The administrator explained that he, himself, and his office generally were at that time under great pressure of work. In March 1982 he received a letter from the CHC in which he was told that they were concerned at the lack of action by the FPC and that they had referred this complaint to me. He discussed the case with the FPC and MSC chairmen on 11 March and was instructed to obtain the family doctor's formal observations on Mr A's complaint so that the MSC chairman could decide whether or not a formal hearing of the MSC was required. He wrote to the family doctors on 31 March shortly after his return from leave.

11. In his written comments to me the administrator said that he accepted entirely the responsibility for the delays in dealing with the complaint and that he regretted the unfortunate lapse and the inconvenience or distress that might have been caused to the complainants. He told my officer that he

had failed to give the necessary attention to the complainant which, in any circumstances, was inexcusable. He later told me that the chairman of the FPC and the MSC chairman had written to the complainant to apologise for the delay in dealing with their complaint and the distress and inconvenience thereby caused to them and to tell them of the progress of their investigation.

12. The MSC chairman confirmed to my officer that Mr A's complaint was referred to him and that he had discussed it with the administrator in April 1981. He had been concerned as to whether all aspects were within the normal time limit required by the Regulations and he had asked for further enquiries to be made. He had been cautious, he said, because there had been a previous occasion when they had considered a case under the formal procedure and later found that they had been incorrect to do so because it was out-of-time. In regard to this complaint he had heard nothing further until March 1982 when the administrator raised the matter and it was decided to obtain the observations of the family doctors. My officer asked if he had therefore been satisfied that the complaint had been made within the time limit; the MSC chairman said that as they had allowed the complaint to lie for so long, it had been decided that they should go ahead with the formal procedure and that any further consideration of the time issue could, if it proved necessary, be given at a later stage in the event of the case being heard by the MSC.

13. The MSC chairman said that he should accept some responsibility for the mishandling of the complaint. He was aware that it had not been resolved but did not question the administrator about it. He had not done so because he was aware that it was a complex case and that such matters took time. To his knowledge this was the first complaint of this nature made against the FPC; they had an excellent administrator and there had been no previous occasion when his handling of complaints had been questioned. He also said that the administrator had been very busy at the material time and that the delegation of the administrator's functions in dealing with complaints was not permitted under the Regulations. There was no system in operation by which members of the FPC could monitor the handling of complaints by the administrator or his staff and he, himself, was unaware of complaints unless they were put to him for consideration for investigation under the Regulations.

14. The department's 'Notes on Service Committee Procedures' say in regard to the initial stage of the formal procedure:—

> ".... a copy of the complainant's statement must—under Rule 1(1) of Schedule 1 to the Regulations—be submitted to the Chairman of the service committee as soon as it is received (subject to what has already been said about the informal procedure) *or as soon as any question of time-limits has been cleared'* (my italics).

My enquiries have shown that the MSC chairman was not satisfied that the question of time limits had been cleared before the complaint was submitted to him and he referred it back to the administrator for him either to confirm that all aspects of the complaint were within the time limit or to carry out

the late complaints procedure for any aspects which were not. These administrative actions should have been carried out prior to the referral to the MSC chairman—the first stage of the formal procedure which is set out in Schedule 1 to the Regulations—and he quite properly judged that he was not in a position to proceed with what was, in effect, an incomplete submission. It is clear therefore that the delay in dealing with Mr A's complaint stemmed from the *preparation* of the case for consideration under the Regulations; it follows that this complaint lies within my jurisdiction and I accordingly make this report on it.

Findings and conclusions

15. It is abundantly clear that there has been inordinate and inexcusable delay in dealing with Mr A's complaint against the FPC. I regard this as a serious lapse because, after so long an interval, the memories of the people concerned are likely to have faded and this could be prejudicial to the fairness of the outcome. The FPC have already apologised to the complainant (paragraph 11) and I do not consider that they can do any more in this case beyond ensuring that their investigation is completed as quickly as possible. This they have assured me they are doing.

16. I consider, however, that the FPC have a duty to monitor the service they are providing and that, to this end, they should be informed regularly of complaints received and of those still unresolved. Had there been a procedure of this kind it is most unlikely that this case would have been allowed to drag on for so long. I invited the FPC to introduce such a monitoring procedure and I am glad to report that they have agreed to do so.

Case No. W.559/81–82—Insufficient supervision of patient admitted after attempted suicide

Background and complaint

1. Following a suicide attempt the complainant's 24 year old daughter underwent an emergency operation at a hospital (the hospital) on 13 December 1979. On 17 December she jumped from a window in the general surgical ward on the fifth floor of the hospital (the ward) where she was recovering from her operation and she died as a result of her injuries. The complainant said that although he had told nursing staff and a doctor that his daughter had threatened to jump out of the window, and a psychiatric registrar (the psychiatric registrar) had told staff that he thought it likely that she would again attempt suicide, she was left unsupervised in a room with no safety catches on the windows. He is dissatisfied with the circumstances leading up to his daughter's death at the hospital.

Investigation

2. In the course of my investigation I obtained the comments of the Area Health Authority (the AHA) and have examined relevant documents from their files including the medical and nursing records. I have also seen the notes made at the inquest into the death. One of my officers visited the

hospital and interviewed medical, nursing and administrative staff involved. He also met the complainant and his two other daughters. The complainant's evidence in the following paragraphs is taken from his letters to the AHA and to me, from his interview with my officer and from his evidence given to the Coroner's Court.

3. The complainant explained that his daughter, who already had one daughter in care, had become depressed when her second daughter was taken from her the day after her birth in September 1979. Shortly afterwards she took an overdose of sleeping tablets and thereafter received psychiatric treatment at a hospital ('the second hospital'). In the early hours of 13 December when at home she inflicted a serious stab wound to her throat and was taken to the hospital where she underwent an emergency operation.

4. The complainant said that as soon as his daughter woke up after her operation she told him she wanted to come home, but he told her that she must get strong first. However the following day she told him that she might jump out of the window. She told him that the nurses had been 'taking the mickey' out of her and that if they did not stop she was going 'straight out of that window'. She also said that she had made this threat to the nurses and one nurse told her that she could jump out of the window if she was mad enough—'it won't be any skin off my nose'. The complainant was unable to identify which nurse said this and he told my officer that none of the nurses had been nice to his daughter. He said that from the moment she entered the hospital they had picked on her and he believed that they had no time for her because her injury was self-inflicted and because she was alleged to have injured her first child.

5. One of the other daughters told the Coroner that on one occasion she had heard her sister threaten to jump from the window. The complainant said that she had repeated this threat 'many times'. When he last saw his daughter on 16 December she had apparently been told that another patient might be coming into her room the following day and she said that if this happened she was going 'straight through that window'. She also repeated that she wanted to come home, but the complainant said this was impossible as she could not eat or drink. The complainant also said that she told him that the nurses were gossiping and telling other patients about her and this had upset her further. She told him that the two ladies in the next room had told her that the nurses were laughing about her and saying she was 'crackers'. The complainant said that these ladies were discharged before he had the opportunity to speak to them.

6. The complainant said that he told a lady doctor whom my officer identified as the senior surgical registrar (the senior registrar) of his daughter's threat to jump and said that he thought this might have been on the evening of 13 December. He said that the senior registrar was rather abrupt and told him that she could not jump yet because she still had bottles attached to hr. He also told the ward sister (the sister) on the evening of 14 December of the threat and the reasons for it. The sister assured him that they would keep an eye on her. On 15 December he also told some nurses of the threat to jump, but they reassured him and said that they would see she was all right. He said that he telephoned the hospital

regularly and always mentioned the matter on these occasions. He was always told not to worry. One of his daughters told my officer that she had also mentioned the threat during telephone calls she made to the hospital.

7. The complainant believed that the nurses' observation of his daughter had been inadequate. He said that frequently when he visited her there had been no nurses close to her room and that when he arrived on 16 December there had been no one in the nurses' office. One incident which he felt typified their lack of care concerned a tail comb which he had seen in his daughter's room, possibly on 14 December. He had been concerned that she might try to use the pointed end to injure herself and he had tried to speak to a nurse about this but she had said that she was busy. Therefore he telephoned the hospital from a call-box at 1.30 am. The person he spoke to (he thought it might have been the night sister) told him that she would remove the comb. She also said that she did not know what he was worrying about and that he should go home to bed. However the following day he found the comb in his daughter's room and took it home. The complainant also said that if the staff were really concerned for his daughter's safety they should have invited the family to visit as much as possible to help keep her closely observed. But that on one occasion when he arrived at the hospital it was pointed out to him by the sister that it was not yet visiting time.

8. The sister told my officer that all staff were made aware from the outset that the patient had injured herself and that therefore there was a possibility that she might try to do so again. She said that on 13 December she discussed the situation with the senior registrar who said that the patient should be carefully watched at all times. The senior registrar did not however instruct that she should be 'specialled' that is, always to have a member of staff with her. The sister said that she also spoke to the psychiatric registrar on 14 December when she asked him if there was anything more they could do. She could not remember exactly what was said but her general impression was that they should continue their close observation. The sister said that from the beginning and at each change of staff she described the patient's physical condition and her mental state and emphasised the need to watch her as closely as possible. The written statements of the nursing staff and their evidence to my officer confirm that they were all aware of the need to keep a close eye on the patient and that they attempted to do this by regularly looking in when passing her room. My officer visited the two-bedded room which she had occupied and saw that the door was only a few paces away from the nurses' office, from the window of which the bed occupied by the complainant's daughter could be seen.

9. The consultant surgeon (the consultant) responsible for the daughter's care emphasised to my officer that the staff were fully aware that she was a suicide risk. The nature of her wound made it clear that hers had been a serious attempt and from their enquiries they had known of her history before she went to the operating theatre. The consultant said that they had asked psychiatrists from the second hospital to see the patient and advise on her

management, and they had relied on the psychiatric registrar's recommendation that she should be observed closely. The consultant explained that she had been nursed in the ward because at the time this was the only ward in the hospital with beds allocated for the type of surgery required by her. He thought however that her determination to take her own life was demonstrated by the fact that she threw herself from the window 'virtually the minute the tubes were taken out.' He believed that in the circumstances it would have made no difference if she had been nursed on a lower floor. The consultant accepted that the nursing staff were not used to dealing with seriously disturbed patients on the ward, but he considered that they had observed this patient closely.

10. The psychiartric registrar told my officer that he had known the patient before and although she had previously taken overdoses of drugs he had not considered her to be genuinely suicidal. However, when he saw her at the hospital on 14 December he thought that she was a definite suicide risk and he had made it clear to medical and nursing staff at the hospital that he believed it was likely that she would try again. He asked them to keep a careful eye on her, but he did not ask that she be 'specialled'. He added that when he saw her she was very ill physically and was more or less attached to the bed with the various tubes in her. The psychiatric registrar said that he would have liked to transfer her to the second hospital but he had accepted that her medical condition would not allow that for the time being. He said that at the second hospital the staff were used to dealing with suicidal patients, but the observation there would have been much the same as at the hospital and he felt that the outcome would probably not have been different. He pointed out that it was almost impossible to prevent someone who is really deterined to do so from taking his or her own life.

11: The senior registrar recalled meeting the complainant and one of his daughters soon after the patient's admission when she obtained details of how she had caused her injury. She said that if the complainant had expressed general concern (see paragraph 6) about the possibility that his daughter might try again she might well have said something to him, by way of reassurance, to the effect that she could not do much with all the bottles and tubes attached to her. However, she told my officer that she could not remember actually saying anything like this and she was certain that the complainant had said nothing about a specific threat by his daughter to jump from the window. She said that had he done so she would have recorded this in the notes and would have arranged to have her 'specialled'. The senior registrar confirmed that her instructions to nursing staff were to keep a very close eye on the patient.

12. The sister thought that she had spoken to the complainant on two occasions when he had seemed very concerned about his daughter. However, she told my officer that these conversations had been about her general condition. The sister recalled that the complainant had been concerned about the possibility that his daughter might make a further attempt on her life but she was sure that he had made no mention of a threat to jump from the window, because if this had been raised it was not something she would be likely to forget. She thought that she had also spoken by telephone to the

complainant on other occasions but that there had been nothing of any significance in those conversations. The sister could not believe that the nurses would have failed to report to her if there had been any mention by the patient or her father of her threat to jump from the window.

13. The sister said that the complainant had not mentioned to her his daughter's allegation that she had been taunted by a nurse or nurses. She told my officer that had he done so she would have looked into the matter straight away and she found it strange that he had not done so. She said that she had made it clear to the patient that she should let her know if she had any problems, but that she never made any complaint or criticism about any member of the staff. The sister said that she had impressed upon her staff that because the patient was so depressed they should be careful what they said to her and not make any tactless remarks. The house surgeon, who recalled speaking to the complainant on one occasion, said that he had said nothing of this to him and added that in his opinion such behaviour would have been completely out of character for the staff in the ward.

14. I have seen written statements made to the AHA by seventeen members of the ward nursing staff, many of whom were also interviewed by my officer. All denied that the complainant's daughter had at any time said to them that she would make a further attempt on her life, or that they or anyone else to their knowledge had made the remark quoted about her jumping out of the window (paragraph 4). In her written statement a nursing auxiliary had said that she recalled other members of staff, whose names she did not remember, saying that the patient had said that she intended making a further attempt on her life. However when she was later interviewed by my officer she could recall nothing of this and did not even remember saying this in her statement. The evidence of the staff also clearly shows considerable sympathy for the complainant's daughter with comments like 'I felt very sorry for her', 'I was sympathetic towards her plight' and 'My reaction . . . was sympathetic'. A staff nurse (the staff nurse) made the point that there had been nothing about the patient which would make anyone angry with her or want to provoke her. She had been very quiet and she did not annoy anyone or cause any trouble. None of the nurses had heard her complain about any member of staff. Most of them said that she was very quiet and withdrawn.

15. The sister told my officer that the only specific point she knew had been raised by the complainant concerned the tail comb (paragraph 7). She said that when she came on duty on the morning of 15 December the night staff nurse told her that the complainant had telephoned in the early hours of the morning because he was worried about a tail comb in his daughter's locker and was concerned that she might use it to injure herself. The night staff nurse reported that she had removed the comb from the room and that it was then on a shelf in the nurses' office. The sister said that she told her staff that they would have to watch out for things like that and that the comb was to be kept in the office and taken to the patient as and when she required it. She told my officer that she had been unaware of any further problems concerning the comb but she acknowledged that she could not remember seeing it again. The house surgeon told my officer that he thought

the complainant had indicated to him that he was unhappy because the nurses had somehow let his daughter have her comb back, and the nursing officer responsible for the ward (the NO) said that when she spoke to the complainant following his daughter's death he had mentioned this incident as an example of unsatisfactory observation of his daughter by the staff.

16. The staff who were interviewed by my officer all denied that they had discussed the complainant's daughter with other patients. The sister did not believe that her staff would have 'gossiped' about her to other patients, although she could not guarantee that something had not slipped out in conversation. She said that it was not uncommon for patients to ask about other patients, particularly those who seemed very ill, but staff would answer such questions only in the most general terms. As for the allegation that other patients had told the complainant's daughter of the 'gossip', the sister said that she had not had anything to do with the other patients. None of the staff knew of her having had any contact with other patients and their view was that she would not have wished to. After such a lapse of time the staff were unable to identify the patients who were alleged to have told her that staff were gossiping about her. The psychiatric registrar told my officer that it would not be unusual for someone in her state to imagine that everyone was talking about her and I have seen that he noted on 14 December ' . . . feels everyone is against her and is talking about her'.

17. The sister told my officer that visiting times on the ward had been fairly strictly adhered to, although a lot depended on the circumstances of individual patients. She said that the relatives had never asked for an extension of visiting time, but had they done so she would have been prepared to give favourable consideration to the matter. As it was she thought she could remember them staying beyond the end of visiting time. The sister was sure that she had never spoken to the complainant about arriving too early (paragraph 7).

18. The staff nurse, who had been in charge of the ward on the morning of 17 December, told my officer that by then the patient had become more ambulant and was able to get up and have a wash. She was seen by the house surgeon who discontinued her intravenous infusion. This was confirmed by the house surgeon who recorded, and told my officer, that the patient had seemed a lot better that morning and that she did not seem so depressed. The staff nurse said that she had arranged that she and a student nurse should keep a special watch on the patient that morning, although the other nurses on duty were also aware of the importance of observing her closely. The staff nurse told my officer that she had seen her quite often during the course of the morning and that she had last seen her not more than five minutes before she jumped. She said she had been in the room beyond to check a patient who was going to theatre and on returning she had seen the patient sitting in her room. She had then stopped at a table not far from her door to prepare an injection and had gone down the ward to administer it when a nurse from the ward below arrived to say that the patient had fallen from a window. Other members of the nursing staff also recalled seeing the complainant's daughter shortly before the tragedy occurred

and they said that there had been nothing about her behaviour to give them cause for concern. A student nurse, who had taken her for an X-ray shortly beforehand, told my officer that the patient had remarked to her that she was lucky to be alive. The ward clerk told my officer that she had also seen the patient quite a few times in a short period before the incident as she had been attending to some new admissions which had necessitated passing her door regularly. She thought she had last seen her just over five minutes before she jumped. She said that she still found it difficult to believe that she had managed to get through the window in the short space of time she was unobserved. She thought that the patient must have been watching the movements of the staff as closely as they were watching her.

19. The staff nurse told my officer that the ward had been busy on the morning of 17 December, but that the staff numbers had been up to complement, and I have seen that there were six nurses on duty that morning and the ward clerk. The NO told my officer that when she returned to duty that morning her first call had been to the ward to see the complainant's daughter, to find out if the nurses were having any problems and to check on the staffing position which she found to be up to complement.

20. The NO also told my officer that the room in which the complainant's daughter was nursed had been considered 'safe'. Apart from the general difficulty of getting through a window as small as the one in that room, the patient had not been considered fit enough to attempt such a thing. The NO thought that the main concern of the staff had been the possibility that she might attempt to abscond from her room and harm herself elsewhere. The statements of the nursing staff confirmed that they had not considered it possible that the patient might get through the window. My officer saw that the window is 88 cm wide by 54 cm high but that it opens by swivelling horizontally around its centre so that the effective gap is only about 25 to 26 cm. The AHA stated that locks had not been considered necessary on the windows of the ward, particularly as it was considered very difficult for anyone to squeeze through them when open. The sector administrator at the hospital (the SA) told my officer that there had been no previous instance of a patient jumping from windows in that ward, but that there had been a number of cases over the previous six years of patients falling or jumping from windows at the hospital. The majority of these had been patients in the psychiatric unit which was also located on the fifth floor and which had since been closed. The SA pointed out that the windows in the psychiatric unit had been fitted with catches which permitted only a very small opening. This had not deterred really determined patients who had either smashed the windows or absconded to other parts of the building.

Findings and Conclusion

21. I have been impressed by the obvious sympathy and concern shown by the nursing staff towards the complainant's daughter and I have found no evidence that anyone taunted her or made untoward remarks to her. Similarly I have found no evidence that staff gossiped about her. In order to care for her properly staff had to be informed of her history (although my enquiries showed that at the time they did not know of the circumstances

in which her first child was taken into care) and in that situation it is possible that an unguarded remark might have been made.

22. The complainant believes that he told members of staff on a number of occasions of his daughter's specific threat to jump from the window. I have no doubt that he did make clear his concern that his daughter might try to injure herself, a concern which was shared by the staff. However, while he may well have mentioned the window in speaking of his general concern, I do not believe that he did so as forcefully as he recalls in retrospect. It is clear that at the time staff did not consider that there was any risk that his daughter would or could get through such a small window, particularly in her weakened state, and that their main concern was that she might try to abscond. I am fully satisfied that the nursing staff followed their instructions that she should be closely observed. It is clear that on the morning of 17 December she was seen regularly by members of staff until shortly before her death and that although the ward was busy that morning it was not understaffed. However, she was allowed to have her tail comb despite the complainant's request and the instructions of the sister and I consider that this indicates a degree of carelessnes on the part of a member of staff. The Health Authority, as successors to the AHA, have asked me to convey their apologies through this report for the failure concerning the comb. But I do not consider that this one incident detracts from the general standard of careful observation given to the complainant's daughter. Apart from this I do not uphold any part of the complaint.

Conclusion

23. The complainant and his family have my deepest sympathy. I have learned from other cases I have investigated that it is almost impossible to prevent a really determined patient from taking his or her life. Although, with one small exception, I have not upheld his complaints I hope that my report will help to reassure him regarding his daughter's care in the hospital.

Case No. SW.29/81–82—Services provided for motor cyclist after accident

Background and complaint

1. The complainer said that while on his way to visit his mother in a remote area on the evening of 31 May 1981 he had an accident when his motorcycle skidded. Subsequently he had attended an Infirmary on 3 June when he was found to have three fractured ribs and a partially collapsed lung, and was informed that there was a possibility he could have died had he delayed having treatment.

2. The complainer contends that:

(*a*) the local district nurse (the DN) initially refused to attend him following his accident;

(*b*) on two occasions on 1 June the DN assured him that he had suffered no fractures and that his pain was purely muscular, and in making this assessment of his condition she deprived him of the medical attention he required; and that

(*c*) the DN subsequently spread a rumour that he had been drunk at the time of his accident, and discussed his case with assistants in the local shop.

He complained to the Health Board (the Board) but he feels that the enquiries they made into his complaint were partial and insufficiently thorough.

Investigation

3. In the course of my investigation I have corresponded with the Board and have seen copies of relevant documents from their files including the DN's records. One of my officers saw the complainer and he visited the area and interviewed several witnesses named by him. He also interviewed senior nursing staff and the DN.

Jurisdiction

4. I am excluded from investigating action taken by family doctors (FPs) in connection with the primary care services they provide under contract with Health Boards. In this report I refer to the local FP only to help set the complaint in context.

The complaint about the DN's refusal to attend

5. In his letters and to my officer the complainer explained that he suffered his accident on 31 May when his motorcycle skidded on some loose chippings and he was rendered unconscious. When he regained consciousness he made his way to the home of friends (Mr and Mrs A) arriving at approximately 10 pm. He said that Mr and Mrs A immediately tried to summon medical help by telephoning the FP and the DN but both had refused to attend. Mrs A had then telephoned the relief district nurse (the relief DN) but she was unable to come because she was not on duty. The complainer said that it was only after two or three more telephone calls that the DN agreed to come and by the time she eventually arrived, at about 2 am on 1 June, he was ' rolling about ' in agony.

6. The DN told my officer that Mrs A did not telephone her until about 2 am on 1 June. She could be sure about the time as she recalled that on the evening of 31 May she had been out on another case until after 10 pm and had answered a telephone call in connection with that case shortly after midnight. She said that Mrs A had told her of the complainer's accident and said that she thought he had dislocated his shoulder. The DN told my officer that there had been no suggestion that he required emergency first aid treatment and indeed there was little she herself could have done if he had dislocated his shoulder. She had therefore advised Mrs A to contact the FP. The DN explained to my officer that it is the Board's policy, not merely that of the FP, that the first visit to a patient by a district nurse should be made at the request of a doctor.

7. The DN said that Mrs A had telephoned her again at about 2.30 am to say that she had been unable to get any reply from the FP. The DN had said that she would try to telephone him and when she did so the

FP answered reasonably promptly. She explained the situation to him and he asked her to visit the complainer, which she did at about 3 am, and report to him.

8. Mrs. A confirmed to my officer that the complainer had arrived at her home shortly after 10 pm. She said that athough he had been rather bedraggled and a little dazed, and was sore and grazed from his fall, he had seemed all right at first and had said that he had just had a fright. However after some time he began to suffer increasing pain. She thought that it was around midnight when she made her first telephone call which was to the relief DN who said she was off duty. Shortly afterwards Mrs A telephoned the DN who said that she was also off duty but that in any case she could not come unless the FP instructed her to. Mrs A confirmed that her initial attempts to telephone the FP were unsuccessful, but that she eventually got through to him after having spoken again to the DN. Mrs A thought that the DN eventually arrived at about 4 am.

9. The senior nursing officer responsible for nursing services in the area (the SNO) confirmed that it is the Board's policy that first visits by district nurses are made at the request of a doctor. The nursing officer responsible for the district nursing service (the NO) told my officer that this subject had been discussed at one of her regular meetings with her district nurses not too long before the incident in question and the Board's policy was made clear to them at the time. I have seen the minutes of this meeting. I have also seen the DN's records which confirm her recollection of the timing of various events. The NO explained that all records completed by DNs in respect of 'temporary residents' are forwarded routinely to her office and I have seen that the records in respect of the complainer were received before he made his complaint. The NO told my officer that she had discussed the complaint with the relief DN who thought that Mrs A's telephone call to her was at about 1.45 am.

Findings

10. I find that the DN acted in accordance with the Board's policy in asking Mrs A to speak to the FP in the first instance so that he could instruct her to visit the complainer and that she attended promptly when asked to do so by the FP.

I dismiss this complaint.

The complaint that the DN's assessment of the complainer's condition deprived him of medical attention

11. The complainer said that after the DN had examined him she had 'most emphatically' assured him that he had broken nothing and that his pain was purely muscular. Next morning, after he had taken some pain-killers, he decided to go to his mother's house some four miles away, and on the way he met the DN and spoke to her briefly. Later in the day when the effects of the pain-killers had worn off the pain returned more intensely and he went to the DN's house, which is close to his mother's. He said that he told the DN he thought there was something

seriously wrong, but the DN, after prodding him a few times, repeated her assurances that nothing was broken or cracked and that his trouble was purely muscular. The complainer told my officer that he suggested to the DN that if she thought it necessary he would be prepared to go to the nearest hospital, for an x-ray, although he told her that he would rather not go to a hospital so far from home. He said that the DN dismissed his suggestion saying it was not necessary. The complainer said that he later telephoned his wife and arranged for her to collect him by car on 2 June. He said that his wife took him to the Infirmary where he was x-rayed and found to have three fractured ribs and a partially collapsed lung. He said that he was an in-patient for a week and said that he was told that if he had not had treatment there was a 'strong possibility' he would have died.

12. The Board told the complainer that DNs were not allowed to make a diagnosis as this was within the province of a doctor, but that an experienced nurse could assess a patient's symptoms sufficiently well to make a judgement about the patient's condition without making a diagnosis. The complainer commented to me that whether one called it a diagnosis, assessment, judgment or decision the fact remained that because of the DN's error he was deprived of medical attention he desperately needed.

13. The DN told my officer that when she first examined the complainer he was complaining of pain, but he was able to move his arms fullly and when she examined his chest she could not feel anything broken nor could she hear any sounds. She had concluded that there did not seem anything broken and as far as she could recall she told the complainer that he had not 'done' his shoulder and that she did not think anything was broken. She stressed however that she had made no diagnosis of his condition and she explained to my officer that her duty as a nurse in that situation was to report the signs and symptoms she had observed to the doctor. She had therefore telephoned the FP from Mrs A's house and told him of her observations. The FP's reaction had been that they should wait and see what the patient was like in the morning. The FP also suggested that if necessary the complainer could attend his morning surgery. The DN said that she informed the complainer and suggested a suitable bus to take him there. She could not recall his reply but her impression was that he would not go to the surgery. The complainer told my officer that he knew nothing of a suggestion that he could attend the surgery by bus in the morning, but Mrs A confirmed that such a suggestion had been made. The DN said that even if she had thought that the complainer had cracked his ribs she would have considered it best at that stage for him to get some rest rather than take other action.

14. The DN told my officer that as she thought that the complainer would not attend the FP's surgery it had been her intention to call to see him when she came into the village on the morning of 1 June. However, on her way she met him on his motorcycle and she stopped him. He explained that he had taken pain-killers earlier that morning, that the pain he had the night before had gone and that, apart from some discomfort, he felt all right. The DN told my officer that the fact that the complainer looked better, felt

better, and was apparently quite capable of managing his motorcycle over such a difficult road, had resassured her that there was nothing seriously amiss.

15. The DN said that she was not aware of any attempt by the complainer to contact her during the day of 1 June. However when she was returning home early in the evening she saw him near his mother's house walking 'crouched over' and seemingly in some pain. She did not know if he was on his way to see her, but she asked him back to her house where she examined him again. She told my officer that she then thought from the amount of discomfort he was suffering that the problem might not be just muscular, although she did not consider that he had suffered a major injury and he certainly seemed in no danger. The DN said that they sat and talked for a while and the analgesics she gave him seemed to ease his discomfort. The DN said that it was she and not the complainer who had suggested x-rays, but she said that she pointed out to him that if she sent him for x-rays she would have to send him to the nearest hospital and that it might be better for him to have them done nearer his home. The DN said that the complainer told her that he was going to telephone his wife and get her to take him home by car. She advised him to wait until the following day as she felt that after a night's rest he would be better able to face the journey.

16. The DN said that at about 9 am on 2 June the complainer's step-brother telephoned to ask about the times of the FP's surgery. The DN gave him this information and advised him to telephone the surgery. However, about twenty minutes later the complainer telephoned to say that he was about to set off in his brother's car to meet his wife on the road, but that he was in severe pain. The DN said that she told him that she would come to see him, but before she could leave her house his brother arrived. She went to his brother's car where the complainer was sitting and gave him two analgesics to help him on his journey.

17. The Scottish Home and Health Department told my officer that the conditions of service and responsibilities of district nurses working in remote mainland areas are no different from those of district nurses working elsewhere on the mainland. However the SNO told my officer that in practice such nurses do tend to have a lot more responsibility thrust upon them because traditionally people tend to turn to the district nurse, especially when the doctor lives 22 miles away. He felt that the facts that the DN worked under the direction of an FP and that it was not the DN's job to make a diagnosis were not clearly understood by some residents in rural areas.

18. The second Health Board (the authority responsible for the Infirmary) told my officer that the complainer had attended the accident and emergency department of the Infirmary on 2 June when fractures of three ribs were diagnosed after an x-ray examination. He was discharged from the department that day, but because a further examination of the x-rays had revealed a patch of infection in his lung he was admitted to the Infirmary on 5 June. He was discharged on 11 June. The DN told my officer that she was quite annoyed that she had missed this fracture, and that it was the first

time that she had done so. She also said it was the first complaint against her in 30 years.

Findings

19. I am precluded by the National Health Service (Scotland) Act 1978 from investigating action taken in connection with the diagnosis of illness or the care or treatment of a patient if, in my opinion, that action was taken solely in the exercise of clinical judgment. It is my opinion that the DN's decisions were so taken, and I may not, therefore, question them. She has expressed her regret that she missed the fracture and I have noted that the complainer was not detained at the Infirmary on his first attendance there. I can see nothing in her actions which denied the complainer the medical attention he required. I do not uphold this complaint.

The complaint that the DN spread rumours and gossiped about him

20. The complainer told the Board that during a subsequent visit to the area he had become very disturbed about the DN's attitude to the whole circumstances of his accident. He said that she had spread a rumour that he was drunk and she seemed to think that this had in some way justified her decision not to come and see him immediately. He explained that he had consumed some whisky as a pain-killer at Mr and Mrs A's home but he said that whatever his condition might have been the DN had no right to discuss any patient with outsiders. He said that when the DN learned 'the true extent of my injuries, she went into the village store and angrily related to the two shop assistants [whom he named] what absolute nonsense this was. When [one of the assistants (Miss B)] told [the DN] she had heard the same account from my brother, [the DN] left saying she was going to 'phone [the Infirmary] to find out for herself'.

21. The Board told the complainer that the DN had telephoned the Infirmary to enquire about him before she went to the shop. The complainer told my officer that this was not true. He said that the DN had returned to the shop *after* telephoning the Infirmary and 'announced triumphantly' that no one by his name was here. The complainer also gave my officer the names of two people who, he said, had told him that the DN had told them that he was drunk at the time of his accident.

22. The DN denied that she told anyone that the complainer was drunk. She told my officer that the only people who had specifically said so were Mrs A and the complainer's brother. She said that during the course of her first telephone call Mrs A had said that the complainer was drunk, and I have seen that the DN in her note of that call recorded 'telephone call from friend that patient was drunk and had fallen off his motor bike . . .'. The DN said that when she saw the complainer he had seemed a bit 'merry' and had given silly answers to her questions about the details of his accident. She said, however, that it was no concern of hers whether or not he had been drinking. The DN also said that when the complainer's brother called at her home on 2 June (see paragraph 16) he made a remark about the complainer having been drunk.

23. Mrs A told my officer that when the complainer arrived at her house following his accident she had given him a very large measure of whisky. When the DN arrived she had asked the complainer if he had been drinking and when Mrs A said that he needed attention whether or not he had been drinking the DN commented that he was 'stoned'. Mrs A said that she did not know what the DN might have said to others about the complainer having been drinking, but she told my officer that the DN had said to her that she had heard that he had been drinking in various hotels on the night of his accident. My officer spoke to one of the people named by the complainer (Mr C) who denied that the DN had said anything to him on the subject. Mr C said that he had *heard* that the DN was alleged to have said that the complainer had been drunk at the time of his accident. He said that this had been said in the village pub, but he had no idea who had told him or who the DN was supposed to have told. He pointed out that in a small rural community like theirs there was always a lot of gossip about any event out of the ordinary. Mr C could not remember what, if anything, he might have said to the complainer about this.

24. The DN told my officer that she learned from the complainer's brother on 2 June that he had gone to the Infirmary. Therefore at about 10 am on 3 June she had telephoned the Infirmary to enquire about his condition. She spoke, she thought, to the senior nurse in the accident department who told her that the complainer had been x-rayed and sent home. When she asked if there had been any fractures she was told that there did not seem to be much wrong with him as he had been discharged. Shortly afterwards when she was on her way to the village shop she had seen Mrs A talking to the complainer's brother and had stopped as she had intended to say that she was glad there had been nothing seriously wrong with him. She said that she hardly had a chance to speak before she got a 'volley' from Mrs A to the effect that the complainer had smashed ribs and was fighting for his life and that it was all her fault. The DN said she did not stop to argue but went in to the shop where Miss B also spoke about the complainer. The DN said that as far as she could remember she told Miss B what Mrs A had said, but added that she had telephoned the Infirmary and understood that the complainer had not been detained and that there was nothing seriously wrong with him. Miss B said that she had heard that the complainer's wife had telephoned relatives the night before and had confirmed that he had suffered fractured ribs. The DN told my officer that this had been the extent of her conversation about the complainer and that she did not consider that she had breached any confidentiality. She said that she did not return to the shop that day. Later she informed the FP of what had occurred and he had telephoned the Infirmary and spoke to a doctor who confirmed that the complainer had suffered fractures.

25. Miss B broadly confirmed the DN's version of their conversation. She told my officer that the DN had come in to the shop rather annoyed because Mrs A had 'given her a story' about the complainer which, the DN said, must be rubbish because she had telephoned the Infirmary that morning and been told that he had not been kept in. Miss B said that she then told the DN that she had also heard of the extent of the complainer's

injuries from his brother, and the DN said that she would get the FP to telephone about the matter. The DN had not returned to the shop. Miss B did not think that the DN had said anything confidential about the complainer. In her view they had just been talking like anyone in the district would have done who knew the person involved.

Findings

26. The DN and Mrs A may well have discussed whether the complainer had been drinking, but in my opinion this arose in the course of the consideration being given to his care. As such I regard it as legitimate and not a breach of confidentiality. Apart from this there is nothing to confirm the complainer's allegation that the DN spoke to anyone about his sobriety or lack of it at the time of his accident. As for the 'gossip' in the store, the evidence satisfies me that nothing out of the ordinary or detrimental to him was said and there was no breach of confidentiality. I dismiss these complaints.

The complaint about the Board's investigation

27. The complainer told me that he felt that the Board's inquiry had been very one-sided, as when his evidence was in conflict with the DN's they had simply accepted her story without attempting to contact witnesses who could have corroborated his account.

28. I have seen the comprehensive written records of the DN and the detailed reports made by the SNO and the NO following their separate interviews with the DN and the Board have confirmed that their replies to the complainer were based on these. The SNO and the NO told my officer that they both know the area and the small closely-knit community residing there well. The SNO said that he had felt that there would be nothing to be gained by speaking to others about the complaint, and that to have done so would only create more gossip and unpleasantness in the area. I have seen that the SNO indicated this in his report to the Board, but added that he would speak to local inhabitants if more information was required.

Findings

29. I consider that the evidence the Board assembled was adequate to enable them to deal satisfactorily with the main parts of the complaint. The complaint about the rumour-mongering was presented to the Board so vaguely that it would have been impossible to investigate it in greater depth without making general enquiries in the locality which, in their view, would have been quite unreasonable and probably counterproductive. I do not find any maladministration in the way the Board made that decision. I do not criticise the way the Board handled his complaint.

Conclusion

30. I am unable to uphold any of the complaints.

Case No. SW51/81-82—Compensation for loss of spectacles in hospital

1. An elderly gentleman complained about the loss of his spectacles whilst in hospital in September 1981 and the refusal of the Health Board to make an *ex gratia* payment to cover the cost of their replacement although the sector administrator had authorised him, in a letter of 16 December, to have the spectacles replaced.

2. Documents on the Board's files showed that a search was undertaken by nursing staff when the loss of the spectacles was first reported to ward staff, but without success. When the matter was subsequently raised with the sector administrator he advised the complainer on 16 December that 'The procedure to be followed is to request your optician to have the glasses replaced and to forward the account to me and I will thereafter arrange to have it submitted to the Health Board'. The matter was then submitted to the District Executive Group (the DEG) who, after taking legal advice, decided that they could not consider making an *ex gratia* payment on the grounds that there was no evidence of lack of care by the hospital.

3. After I had begun my enquiries the Board informed me that they had reviewed the case. They said that when the DEG reached their decision they had been unaware of the terms of the sector administrator's letter of 16 December, the wording of which they acknowledged could reasonably be construed as an offer to pay the account. In the circumstances they agreed that an *ex gratia* payment to cover the cost of the replacement spectacles was appropriate and the district administrator wrote to the complainer about this on 12 March 1982 when he also apologised for the misunderstanding which had arisen.

4. The Board also informed me that staff have been instructed to ensure that in future it is made absolutely clear to claimants whether they are being offered a payment or only the opportunity to claim.

5. I considered the *ex gratia* payment and apology to the complainer together with the instructions issued by the Board to avoid such situations arising in future to be a satisfactory outcome to this case.

Case No. WW.26/81-82—Charge for replacement spectacle lenses

Background and complaint

1. In June 1981 the complainant obtained a new pair of reading spectacles under the National Health Service. She found them unsatisfactory, but when she complained to the optician who had supplied them (the first optician) he told her to persevere. In October she wrote to the Family Practitioner Committee (the FPC) and asked them if she could have another sight test. They told her that she could. She went to another optician (the second optician) who, she said, provided her with a perfect pair of spectacles.

2. She complains that, although the first pair of spectacles were useless to her, the FPC told her that the statutory charge of £6.70 for the lenses could not be refunded and that she would have to pay for the replacement pair.

Jurisdiction

3. Paragraph 19(2) of Schedule 13 to the National Health Service Act 1977 precludes me from investigating action taken by a family practitioner committee in the exercise of its functions under the National Health Service (Service Committees and Tribunal) Regulations 1974 (the Regulations) in dealing with complaints against doctors, dentists, pharmacists or opticians. After establishing that the FPC had dealt with the complaint informally (i.e. outside the Regulations) I decided to investigate their handling of the complaint. The actions of the opticians themselves are excluded from my jurisdiction by paragraph 19(3) of the Schedule and my officer explained this to the complainant at the outset.

Welsh Office Guidance

4. In March 1966 the Welsh Office issued a circular, EC 25/66 (Wales), to the, then, Executive Councils—now, Family Practitioner Committees—about the supply of substitute glasses. This circular dealt with prescribing and dispensing errors, patients' non-tolerance of new lenses, and the financial arrangements which would obtain. It said, *inter alia :* 'The National Health Service Acts . . . lay down statutory charges for the supply of National Health Service lenses and frames. If an optician supplies an applicant with glasses which the latter returns because he cannot use them, and substitute glasses are supplied, then, provided the lenses and/or frames first supplied are surrendered, the statutory charges apply only to the substitute glasses. This applies whether or not there has been an error by the prescriber or dispenser'.

Investigation

5. During the investigation I obtained the comments of the FPC and saw the relevant correspondence. One of my officers interviewed the first and second opticians, the acting administrator (the administrator) and the senior administrative officer (the SAO) of the FPC. He also met the complainant.

6. On 12 October 1981 the FPC received a letter from the complainant telling them that she could not use the reading spectacles provided by the first optician as they produced a 'blur'. She said that she had returned them to the optician who had told her that there was nothing he could do and that she needed bifocals. The complainant said she could not afford bifocals and that, as she already had a pair of spectacles for 'day wear', all she needed was a pair for reading. She asked the FPC whether she could have her eyes tested by another optician and whether she could have the lenses changed. She also said that she could not afford to pay for spectacles which she could not use.

7. In his letter of reply to the complainant, dated 13 October, the SAO said that the FPC had been told by the first optician that the difficulties she was having with her reading glasses were mainly due to her reluctance to wear her distance glasses all the time but that he was willing to re-examine her sight and, if necessary, to prescribe alternative lenses. The SAO added that if she did not wish to return to the first optician it would be advisable for her to arrange a sight-test with another optician.

8. On 29 October the FPC received another letter from the complainant in which she said that she had had her eyes re-tested by the second optician and that the trouble she had been having with her spectacles had been resolved. The complainant said that she was keeping the frames supplied by the first optician, but that the lenses were being changed. She went on to say that she did not think she should have to pay for the replacement lenses and asked whether she could have a refund from the first optician as the fault was his. In his letter of reply to the complainant the SAO said that the statutory charge of £6·70 could not be refunded.

9. In her interview with my officer the complainant said that when the second optician tested her eyesight he had discovered that the lenses she had been given by the first optician were wrong. She said that she did not go back to the first optician when she learned of this. She also told my officer that the FPC had not discussed her complaint with her.

10. The first optician told my officer that when the complainant complained to him about the spectacles he had prescribed for her he examined her and found that she was able to read with them. He had advised her that her difficulty arose from her failure to wear her distance spectacles all the time. He said that the SAO had telephoned him about the complaint and had asked him whether he would be prepared to refund the £6·70 to her; and he had told the SAO that he would not make a refund but that, although he really saw no point, he was prepared to re-examine the complainant and, if necessary, give her an alternative prescription.

11. The second optician told my officer that the complainant had come to see him with a request from the FPC for a re-test of her eyesight. He said that he had given her an eye test and that, when he examined the lenses of the spectacles supplied to her by the first optician, he found that the cylindrical component of the left lens was about 90 degrees 'out' which could have accounted for the difficulty she had experienced. He had prescribed a new pair of lenses which had a significant difference in the left lens but only a minimal difference in the right one. He said he had not told the FPC about this but it could clearly be discerned from a comparison of the two prescriptions. He added that if he had supplied the original left lens he would have replaced it free of charge but he could not supply a free replacement for someone else's error.

12. In discussion with my officer the SAO said that, in dealing informally with difficulties between opticians and their patients, he was nearly always able to satisfy the patient. He preferred to deal with complaints informally as it was quicker and was less stressful for both parties than the formal procedure. He said he had not referred the complainant's first letter to the chairman of the ophthalmic service committee because it was out of time and it seemed anyway to be a request for help in obtaining another eye test, rather than a complaint. He had said nothing about further charges or refunds in his reply to the complainant because he did not want to prejudge the issue.

13. The SAO went on to say that he had not treated the complainant's second letter as a complaint, but as a request for a refund. Had it arrived within the eight week time limit he would have referred it to the administrator for consideration under the Regulations, but as it was out of time it had to be dealt with informally. He accepted that he had not advised the complainant of the FPC's complaints procedures or given her the opportunity to explain why her complaint was submitted late. He also accepted that he had said nothing to her about her right of appeal and that he could have advised her to get in touch with the FPC again if she was not satisfied with his reply. He said that he had not done so because he did not want to give the complanant the impression that, if she did not like the decision, she could 'go elsewhere'.

14. The SAO further said that, although he thought it unlikely that the first optician would agree to refund the £6·70 to the complainant, he had telephoned him after receiving each of her letters and asked whether he was prepared to do so. On both occasions, the first optician had refused and had insisted that there was nothing wrong with the spectacles he had supplied to her. The SAO said he had not discussed the apparent error in the first prescription with either optician; he had probably noticed the difference between the two prescriptions, but this was a clinical matter which he could not question and, although the FPC had occasionally approached the local optical committee for technical advice, there was no machinery whereby they could obtain an independent ophthalmic opinion.

15. The administrator also told my officer that, in order to speed things up, the FPC tried to deal with all complaints outside the formal procedure. He accepted that they had been at fault in not giving the complainant an opportunity to explain why she had not submitted her complaint within the statutory period, and he said that her complaint might have been considered for investigation under the formal procedure if there had been a valid reason for its lateness. He added that if, on receipt of the complainant's second letter, they had been aware of the apparent error in the first prescription they would have been more likely to consider a formal investigation. They would then have asked the complainant why her complaint had been submitted out of time and they would have sought the first optician's comments. But, the administrator confirmed, they did not have access to an independent ophtalmic opinion. He told my officer that the FPC had no powers to instruct an optician to make a refund following an informal investigation. A refund could be made only after an investigation under the formal procedure when, if the complaint was upheld, the FPC would arrange for the amount to be deducted from the optician's pay. He added that the FPC had no funds for making *ex gratia* payments.

Findings and conclusion

16. I consider that the FPC mishandled the complainant's representations to them and that her complaint to me was entirely justified. It should have been clear to them that she could not tolerate the glasses with which she had originally been supplied, yet they neither followed the procedure under

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the Regulations (as the administrator now admits), nor did they take any adequate steps to see whether or not her case came within the scope of the guidance given in the Welsh Office circular to which I refer in paragraph 4.

17. I am pleased to report that during the course of my enquiries the first optician, although without admitting any negligence or error, refunded to the complainant the £6·70 which she had paid him. But this was not the result of the efforts of the FPC, who have asked me to convey their apologies to her for the unnecessary trouble she has been caused. I regard the final outcome as a satisfactory remedy for her complaints.

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