Health Service Commissioner : Second report for Session 1981-82 : Selected investigations completed October 1981-March 1982.

Report of the Health Service Commissioner

Selected Investigations completed October 1981–March 1982

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HEALTH SERVICE COMMISSIONER

Second Report for Session 1981-82

Selected Investigations Completed October 1981-March 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.

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HEALTH SERVICE COMMISSIONER

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Section 119(4) of the National Health Service Act 1977 and Section 96(5) of the National Health Service (Scotland) Act 1978, 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 October 1981 to March 1982. Those for England have the prefix 'W', those for Scotland the prefix 'SW' and those for Wales the prefix 'WW'.

In the last two volumes of selected investigations, I have reported two cases, W.387/80-81 (April to September 1981 volume) and W.279/79-80 (October 1980 to March 1981 volume) where I found that the complaint was justified but had not been remedied. I am pleased to report that following appearances before the Select Committee on the Parliamentary Commissioner for Administration, both Family Practitioner Committees have agreed to provide the apologies I recommended.

May 1982

C M CLOTHIER
Health Service Commissioner

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APPENDIX

This selection of 23 reports is taken from a total of 51 cases on which full investigations were completed during the period October 1981 to March 1982.

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The following cases were published in the Third Report of the Parliam entar Commissioner for Adminstration, Session 1981/82—HC. 327.

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Case No. W.271/77–78 –Nursing care given to late wife and explanation about her death

Background

1. On 24 October 1977 the complainant complained to my predecessor about aspects of the nursing attention given to his wife who had died in the intensive therapy unit (the ITU) of a hospital (the hospital) on 30 November 1976, and also about a delay in the subsequent release of her medical records to an independent assessor. My predecessor investigated these complaints, which were made against an area health authority (the AHA) as the responsible authority and issued his report on 13 December 1978.

2. As a result of subsequent representations to them by the complainant the General Nursing Council for England and Wales (the GNC) made enquiries about the two nurses primarily concerned with the complainant's late wife's care on the night of her death and on 26 February 1980 they wrote to me to express their serious doubts about the qualification of one of the nurses (the agency nurse) who had been engaged through a nursing employment agency (the agency) and whom my predecessor had described as 'the person closest to the patient'. In all the evidence submitted to my predecessor she had been referred to as a 'staff nurse', that is to imply a state registered nurse (SRN), and it was also said that she had undertaken a special ITU course. After a detailed investigation the GNC told me that she was not an SRN but a less highly qualified state enrolled nurse (SEN) and also that she had *not* undertaken such a special course. Concurrently the AHA informed me that inadvertently they had given inaccurate information about the qualifications of the agency nurse to my predecessor.

3. In the light of this fresh and material evidence which I did not consider was reasonably available to the complainant at the time of my predecessor's investigation, I decided to re-open the investigation into the first of the original complaints, namely that aspects of the nursing attention given to the complainant's late wife were unsatisfactory and that he was not given a satisfactory explanation of the circumstances of her death. I did not re-open the investigation into the second complaint about the release of medical records as the fresh evidence had no bearing on that issue.

4. The findings and conclusion of my predecessor were as follows:–

> '*Findings*
>
> I have been assured that the number and competence of the nursing staff in the ITU on 30 November was satisfactory, and I do not question this. The exact time that the wife's deterioration was recognised or a doctor called is uncertain. An independent medical opinion obtained by the complainant said that there was no evidence that the nurses on duty were negligent or failed to take proper observation of the patient, but that they were guilty of an error of judgment in that they did not recognise her restlessness was due to a respiratory obstruction and consequently did not call the medical staff in time. The opinion further said that, had the restlessness been recognised as due to obstruction,

and had the medical staff been called 10 minutes earlier, it was possible that there might not have been a fatal outcome. I accept that the nurses' action was taken within their professional judgment and I therefore do not comment on it. It is unfortunate that the person closest to the patient was not asked for a statement by the AHA when the events were fresh in her mind. I consider that the AHA should review its instructions on the completion of nursing records and ensure that there is a proper procedure for making corrections.'

'I understand the complaint of a lack of explanation that night about the circumstances of the complainant's wife's death, but I think it is clear that when he was told at 11.02 pm that his wife had suffered a cardiac arrest and that efforts were being made to revive her, this was an accurate picture of events as they were then known. Subsequent developments, including the approach to the AHA through his solicitors, caused this point of complaint to be left unconsidered, but the AHA cannot be criticised as it was never clearly and specifically put to them.'

'Conclusion

I have not found cause to criticise the standard of nursing care given to the complainant's late wife. However I find it regrettable that no statement was obtained from the agency nurse directly caring for her. I sympathise with the complainant over the loss of his wife in such tragic circumstances, and I hope this report of my investigation will help him.'

Procedure

5. During the re-opened investigation I examined the relevant evidence given to my predecessor and I obtained further documentary evidence from the AHA, the GNC, and the Coroner's Court. My officers interviewed members of the medical and nursing staff concerned with, or having responsibility for, the late wife's care, the Coroner, his Assistant Deputy (who presided at the hearing), the consultant neurologist from whom the complainant had obtained the independent assessment (the assessment) in June 1977 and a manager of the agency (the manager). The anaesthetic senior registrar, who had taken up a post in Australia, provided me with written evidence. Information about ITUs was obtained from the Department of Health and Social Security and about ITU qualifications from the Joint Board of Clinical Nursing Studies.

6. I have been unable to trace the present whereabouts of the agency nurse although a visit was made to her last known home address and I sought the help of the GNC, and of the National Insurance, Inland Revenue, Home Office and Immigration authorities. However, I have noted that she told my predecessor that she could remember nothing of the events of that evening and so even if I had been successful in contacting her, it is unlikely that she would have given me significant evidence.

The Re-opened Investigation

7. In his original letter of complaint the complainant said that his wife had had a successful operation for an artery defect on 30 November. The consultant surgeon had seen her between 10 and 10.15 pm and was satisfied with her condition but shortly afterwards she had become restless. The complainant said that at 11.02 p.m. he had received a telephone call from the hospital to say that his wife had suffered a cardiac arrest and that doctors were doing all they could to resuscitate her but he had later learned that she had in fact died at about 10.40 pm from asphyxia. He said that when he had visited his wife during the evening there were four patients in the ITU with only two nurses and that it had been stated at the inquest that no sister was on duty that night. He said that a 'very young SEN' who was identified by my predecessor and to whom I refer as 'the senior SEN') was in charge and that the agency nurse was looking after his wife. He criticised the hospital for failing to ensure that the ITU was adequately staffed and said that while he did not blame the nurses in any way for what happened, as they had done what they thought best, the assessment had indicated that they had made an error of judgment in not calling medical staff at an earlier stage. My predecessor's report included evidence that the nursing records showed originally that at 10.25 pm the patient was 'still restless', that the anaesthetist was informed and that at 10.35 pm she 'arrested'. He also stated that these times had subsequently been altered to 10.35 pm and 10.45 pm respectively (see paragraph 10 below). The complainant told the AHA that he found this most disturbing as it could indicate that the nurses did not recognise what was happening, or that the medical staff were called and did not come immediately.

8. The consultant surgeon in his interview with my officers reaffirmed his original evidence that post-operative patient care was a team effort involving surgeons, anaesthetists and nurses in which he would expect the nurses to make routine periodic observations. He had examined the patient at 10 pm and was quite satisfied that they had carried out their responsibilities correctly. He said that he had served on a committee which had amongst other things considered the staffing of the ITU and he had not been worried by the nursing situation that night. He said that the patient was already critically ill when he had operated and he knew that she could deteriorate rapidly at any time. He said that what had happened had been a sudden terminal event and an unstoppable hazard. He had not been aware of the agency nurse's qualifications, which were not his concern, but, he told my officers, in his view it had made absolutely no difference whether she was an SRN or an SEN. He said that he could not comment on the alteration of the nursing records but that under the circumstances it was inevitable that the initial records would have been written hurriedly.

9. The anaesthetist told the Assistant Deputy Coroner that after her operation the patient was in the theatre recovery unit until 4.30 pm when she was transferred to the ITU. He described her condition and the medical attention which she received in the ITU and said that at about 10.40 pm he was informed by the nursing staff that she was becoming increasingly restless and

that there was some respiratory embarrassment. He said that he went at once to the ITU and, as he entered, an emergency 'cardiac arrest' call was broadcast and he found that the nursing staff were already performing external cardiac massage and were using a face mask. He said that there were four people at the bedside when he arrived. He assumed responsibility for the resuscitation which was abandoned at 11.10 pm. The anaesthetist in his very full and informative letter told me that he did not believe that the agency nurse's qualifications had any bearing on what had happened; she had shown competence and adequate experience of ITU and post-operative nursing procedures on that occasion and he said that he had been surprised to learn from my enquiry that she did not have a formal qualification. He said that he recalled that the nursing staff showed a high degree of competence when dealing with the emergency that had arisen and had supplied medical staff with the drugs and equipment necessary for the attempted resuscitation promptly and efficiently. He said that he was unable to comment on the times recorded for events but said that his watch and the hospital clock often differed. In his opinion it was the time which elapsed between the events which was the important consideration. This was constant. He said that he could not recall any discussion about the alterations. I have seen that he recorded in the medical notes that he was called to see the patient at 10.40 pm and that the 'cardiac arrest' call was broadcast at 10.45 pm. He suggested to me that the hospital switchboard might corroborate the time of the 'cardiac arrest' call and the AHA have told me that it was logged at 10.50 pm and that 'all correct' is noted beside the entry which means, they say, that everyone responded.

10. The night duty nursing officer (NO) told the Assistant Deputy Coroner that she had been responsible for four wards and the ITU on 30 November and that as the sister was on leave she visited the ITU more frequently than usual. She said that there were four patients in the ITU with four staff whom she understood to be three SENs and one SRN (the agency nurse), all with ITU qualifications. As the most senior permanent member of the staff the senior SEN was in administrative charge and the agency nurse, who was apparently the most highly qualified, was assigned to the complainant's late wife who was the most ill patient. The NO, who had not been interviewed previously, told my officers that she always wrote down important events soon after they happened and could therefore remember that evening very clearly. My officers found her a very impressive witness. She said that at about 9.30 pm she had visited the ITU and found that the agency nurse, who responded to the word 'staff' (the mode of address to staff nurses), was sponging the patient. At about 10.30 pm, the NO said, she had received a telephone call from the consultant surgeon about the patient's treatment and she relayed his instructions to the ITU immediately. She had then visited another ward and the accident and emergency department then went to the ITU. On her way she had met the anaesthetist and as they reached the doors the 'cardiac arrest' call sounded. She said that while the other nurses assisted the anaesthetist with resuscitation she looked after the other patients. She told my officers that it was she who telephoned the complainant and that when she did so resuscitation was still in progress although in her opinion the patient was already clinically dead. It was not the hospital's policy to give

such news by telephone unless the death was expected by the relative and she had therefore told him that his wife had suffered a cardiac arrest and that they were doing all they could for her. The complete entry in the nursing record is as follows:

'Patient became very restless at 10.25 pm

Omnopon 15 mg and Maxlon 10 mg i/m given at 10.30 pm at 10.35 pm [see below] patient was still restless

Dr was informed at 1045 pm [see below] patient arrested recus aban [see below] doned at 2310 hrs.

(10.30 pm Message from [consultant surgeon]. – No Largactil to be given

Tip patient to relieve oedema. Remove skin temp. leads.

I.T.U informed–)

Recus abandoned at 2310 hrs

Priest came.'

I have seen that '10.35' and '10.45' are over-written entries which appear to have been timed originally at 10.25 and 10.35 respectively and 'recus aban' has been lightly scored through. The NO said that she wrote the entry from '(10.30 pm' to 'ITU informed)' and when she did so the times in the earlier part of the record had not been altered. The District Nursing Officer (the DNO) told my officers that in an emergency the staff would be concerned with the care of the patient and records were sometimes completed later. It was possible, she said, that a nurse had thought again about the incidents concerning the patient after the critical time and had decided to enter more accurate times. She said that action had since been taken locally to prevent alteration without verification by another member of staff.

11. The senior SEN was interviewed on separate occasions by my officer and by the GNC and the following summary includes evidence from both interviews. She confirmed that she had been in charge of the ITU and came on duty at 9 pm when she was told that the complainant's late wife was the most seriously ill patient. She therefore allocated the agency nurse, whom she understood to be an SRN, to care for her. She could not recall why she thought that the agency nurse was an SRN but said that she had responded to being called 'staff'. The senior SEN said that the consultant surgeon saw the patient at about 10 pm when he stayed for some fifteen minutes, examined the nursing records and said that he was satisfied with the patient's condition and with her nursing care. Soon after he left, she began to become restless but not distressed. The senior SEN said that at first they did nothing, hoping that she would settle, but as her restlessness continued she decided, in conjunction with the agency nurse, to give medication which had been prescribed. Shortly afterwards the NO telephoned to relay the consultant's instruction and they elevated the patient's head a little. At about 11.30 pm or 10.35 pm the agency nurse drew the attention of the senior SEN to the patient's breathing which had become noisy. The senior SEN asked another nurse to check the patient's respiratory rate and telephoned the anaesthetist who said that he would come at once. She said that very shortly after this telephone call, at about 10.45 pm, the agency nurse had called out that the patient was going into a respiratory arrest. The senior SEN said that she went to the

bedside and inserted an airway; an oxygen mask had been ready on the pillow. Another nurse made the 'cardiac arrest' call and cardiac massage began. At that moment the anaesthetist came and took over the resuscitation. The senior SEN said that she thought that the nursing record had been written by the agency nurse and that she was unaware that the times in it had been altered. It seems to me that the signature in the record is likely to be that of the agency nurse. There were two other nurses on duty in the ITU. One, in a statement which confirmed the senior SEN's account, said that because the patient had deteriorated the anaesthetist had been called at about 10.40 pm. The other said that the anaesthetist had arrived at 10.45 pm. This SEN also said that there were five patients in the ITU which the AHA have since confirmed. They have also told me that the other four patients would not have required a high level of attention.

12. At the inquest on 7 January 1977 the Assistant Deputy Coroner found that the patient had died from asphyxia and shock due to haemorrhage into the tissues of the neck due to carotid endarterectomy (the operation) and that her death was due to misadventure. In a detailed summing-up he had said that it had been a lengthy case because 'there was some comment about the post operative care'. After detailing the patient's treatment and her operation he turned to the post operative care and said that after the consultant surgeon had visited her at 10.15 pm there was 'a period from 10.15 to 10.40 when . . . everything happened' and that 'It is evident that something dramatic took place between 10.15 and 10.45 pm . . .' but he concluded that he was sure that when the catastrophe was recognised everything possible was done that could have been done. In his summing-up he had also said that although the sister was not on duty there was a staff nurse and four other nurses in the ITU. My officers told him that he had been misled about the qualifications of the agency nurse; he considered this point carefully and told my officers that as the qualifications of the nurse who had been observing the patient had no direct bearing on the inquest, he would not have altered his findings in any way. The Coroner, who was also present, concurred with this opinion.

13. My officers also interviewed the consultant neurologist who prepared the assessment for the complainant (see paragraph 5). The assessment, in which the agency nurse was referred to as a 'staff nurse', had also stated that the ITU staffing level had been acceptable and that an SEN might be fully competent for ITU duties. It had said that there was no evidence that the nurses on duty were negligent or failed to take proper observations on the patient. The consultant neurologist told my officers that he had studied the contemporary medical and nursing record when making the assessment and that the times in the nursing record had not then been altered. He said that provided the agency nurse had had some ITU experience his conclusions would not have been affected.

14. A nursing officer at the Department of Health and Social Security told my officers that ideally the staff to patient ratio in an ITU should be 1:1 but 4:5 was acceptable. She said that maintaining this high ratio was a 'constant headache' to nurse managers and that it was very common to have agency nurses working in ITUs. She said that normally she 'would be un-

happy' if an ITU was staffed entirely by SENs but it was common practice to have a non-agency SEN in administrative charge.

15. The DNO and the divisional nursing officer told my officers that because of their difficulties in recruiting suitably qualified permanent night staff for the ITU they regularly used agency nurses although the particular agency was used only occasionally. A decision would be taken to use agency nurses for specified duty two or three days in advance. The DNO said that the hospital should have checked the agency nurse's qualifications but unfortunately it was not possible to verify that this had been done because the detailed record had since been destroyed. She said that she would also have expected the agency to have checked the qualifications. The DNO said that practical experience in ITU work would have been recognised as equal to an ITU qualification and she and the divisional nursing officer said that the agency nurse would have been engaged if she had been understood to have had experience, even if she had not indicated that she had the qualification. The DNO said that it was the responsibility of the duty nursing officer to instruct agency staff on their duties and to certify the hours they had worked. The agency's invoice would have been checked by the senior nursing officer (the SNO) or the duty nursing officer. The NO told my officers that it was the normal practice for the SNO to engage agency nurses by telephone, and to check their qualifications with the agency concerned. The NO said that she had asked the SNO for an SRN for 30 November and therefore she had no reason to doubt the agency nurse's description of herself in the hospital's records as an SRN with an ITU qualification. She recalled having introduced her as 'staff' to one of the SENs and said that she had still believed her to have been an SRN when she gave evidence at the inquest.

16. The manager told my officers that the agency, which had provided nurses for the National Health Service since 1948, had reorganised their office since my predecessor's investigation and had destroyed a number of old files including that which referred to the agency nurse. My officer showed the manager the hospital's copy of the agency's invoice for the nurse and he confirmed that the amount appropriate to an SEN, and not that for an SRN, had been charged. He said that no additional charge would have been made if the agency nurse had had an ITU qualification. He said that the qualifications of all new recruits to the agency were checked with the GNC, normally in writing but occasionally by telephone, and that the GNC required, and were given, details of all nurses taken on to the agency's books. I have seen that the invoice was certified by the SNO but my officers were unable to interview her as the AHA have told me that she had left the District in 1977 and had subsequently died. The AHA confirmed that the payment was made at the SEN rate.

Findings

17. Although the agency nurse was neither an SRN nor held an ITU certificate, I have been impressed by the evidence of the consultant neurologist, the anaesthetist and the NO and also by the comprehensive summing up by the Assistant Deputy Coroner about the level of competence that was shown in providing nursing care for the complainant's late wife. After reviewing *all*

the evidence I would assure him that his misgivings about this are unfounded and I concur with the conclusion reached by my predecessor.

18. The alteration of the nursing records apparently took place after they had been examined by the NO and no firm explanation for the changes has been found. It added to the complainant's suspicions but I accept the assurance that the alterations had no significance in regard to his late wife's care. I have been told by the AHA that, in accordance with the request of my predecessor, they have reviewed their instructions on the completion of nursing records and have ensured that there is a proper procedure for making corrections.

19. In the NO's opinion the patient was in fact clinically dead when she telephoned the complainant but death had not been certified by a doctor and resuscitation was still in progress. In deciding what to say the NO exercised her professional judgment and although I may not comment on it I recognise its kindly motivation.

20. It has not proved possible to determine with any certainty who was initially responsible for the mistake made about the agency nurse's status and qualifications. Clearly she was accepted at the time at her face value by all the staff who were engaged in the patients care. Subsequently the GNC established the truth. Fortunately the mistake has not proved to be relevant to the complaint about care. I am however pleased to have received a further assurance from the AHA that the qualifications of staff are now checked as a matter of routine.

Conclusion

21. This is the first time in the experience of my Office that it has been deemed appropriate to re-open an investigation. I hope that the additional evidence now given in my report will provide the complainant with the further re-assurance which he has sought for so long.

Case Nos. W.172/79–80 and W.364/81–82—Provision of adequate medical cover

Complaint and background

1. On Saturday 5 August 1978 the complainant's wife, then aged 66, who was almost totally paralysed below the waist from polio and also had respiratory paralysis, was admitted to hospital (the hospital) after referral there by her family practitioner because she was having more difficulty than usual in breathing. She collapsed suddenly at about midday on 9 August and was transferred from the hospital ward (the ward) to the intensive therapy unit. On 13 August she was transferred to another ward at hospital but her condition gradually deteriorated. The complainant arranged for his wife to be transferred to a special chest unit at another hospital on 22 August and she died there on 24 August.

2. He complains that:

(*a*) there was inadequate medical cover during his wife's first five days in hospital;

(*b*) he is satisfied neither with the investigations carried out into his complaint by the Area Health Authority (the AHA) and the Regional Health Authority (the RHA) nor with the remedial measures taken as a result.

Jurisdiction

3. The Act which defines my powers specifically precludes me from investigating actions taken by doctors which, in my opinion, arise solely in consequence of the exercise of clinical judgment. The complainant was therefore told that I could not comment on the treatment given to his wife and in this report I refer to the medical aspects of the case only in order to place the complaints in their context.

Investigation

4. During the investigation, I obtained the written comments of both the AHA and the RHA and I have examined these together with the other relevant papers, including the wife's medical and nursing notes. One of my officers interviewed members of the medical, nursing and administrative staff concerned. She also met the complainant.

(a) The complaint about inadequate medical cover

5. The complainant, who is a medical practitioner, told my officer that, after returning from a picnic on 5 August, his wife who had also been a medical practitioner, said that she did not feel well; that she was having more than her usual difficulty in breathing; and that she had a pain in the right side of her chest. The complainant telephoned the local family doctor and a locum family practitioner (the FP) who had not previously attended his wife came to see her. The complainant gave him full details of his wife's medical condition and together they decided that she should be admitted to hospital. The FP who had recently worked in the hospital knew that the consultant listed as on call that weekend (consultant A) was away and therefore he telephoned and spoke to a senior house officer (the SHO) giving him full details of the wife's condition and offering advice on her treatment. The complainant said that the FP appeared to know more about the treatment of polio cases than the SHO but he was assured that, in the absence of consultant A, another consultant would be called to examine his wife if there was any problem.

6. When his wife was admitted to hospital, a little later that day, the complainant spoke to the SHO who seemed, he said, to be reluctant to speak or listen to what he had to say about his wife's medical history. He visited his wife, with members of their family, on 6 August and found little change in her condition. Two of their children visited her on 7 August, when he was unable to do so and he was content with a report that she had had 'a satisfactory day'. He visited her again on the afternoon of 8 August and found her sleepy and looking cyanosed. He saw the SHO and asked him if his wife had yet been seen by a consultant. The SHO replied that she had not, because the consultant had only just returned

from holiday. The complainant was concerned that his wife was not receiving the correct treatment and that she had not been examined by a senior doctor but he said that, because of professional etiquette, he had been reluctant to demand that the SHO arrange for another doctor to see her.

7. The complainant said that he received a telephone call from the ward sister at about 8 am on 9 August and was told that his wife 'had had a turn' during the night. He then insisted that she be seen by a consultant immediately and the sister agreed that if consultant A was not available, she would arrange for another consultant to examine his wife. At 2 pm, he received a message asking him to telephone consultant A and the consultant told him that his wife had collapsed and was being transferred to the intensive therapy unit. The complainant told consultant A that he was not satisfied with the treatment his wife had received and that she had not been seen by a consultant during the five days since her admission. Consultant A had expressed surprise that no other consultant had seen her in his absence and had explained that one of the other consultants in chest medicine (consultant B) had been standing in for him when he was away. However, the complainant said, when he spoke to consultant B about this, he denied that he was responsible for the wife's treatment during the first five days she was a patient.

8. At the material time there were three consultant physicians working at the chest and isolation unit (the unit) in the hospital which consisted of two wards for chest cases and one isolation ward. Consultant A, who has since retired, was a specialist in chest medicine; consultant B was a consultant in both general and chest medicine; and consultant C was a specialist in chest medicine and infectious diseases and was also responsible for medical administration at the hospital. The consultants had a rota system, one being on duty each day providing consultant cover for the junior doctors and also accepting into their care all patients admitted on that day except those who had previously received treatment from one of the other consultants. A registrar and two senior house officers, one for each ward, were also employed on the unit. At weekends one junior doctor was on duty and he worked to the duty consultant. Copies of the weekly duty rotas were given to the ward sisters and the switchboard operators who were also notified of any amendments to the rotas. Lists of new admissions were drawn up daily by the ward clerks and distributed to the consultants so that they would be aware of all new patients in their care. Admissions on Saturday and Sunday were included in the Monday lists.

9. The SHO, who has since left the hospital, told my officer that he was the only resident doctor on duty in the unit during the weekend of the complainant's wife's admission. Although he had not been given any specific instructions as to when to call a consultant, it was generally understood that the consultant on call would not be notified immediately about every routine or non-urgent admission; but he would not have been reluctant to call in the duty consultant if he thought it necessary. He said so far as he knew there was no time limit within which consultants had to be informed of new admissions. He had had experience of treating cases similar

to this and was satisfied with the patient's progress. He had therefore had no reason to ask the consultant on call to examine her but if the consultant had visited the hospital over the weekend he would have told him about her admission. The SHO said that consultant C had visited the ward to examine another patient on Monday 7 August but he did not remember speaking to him about the complainant's wife. He did, however, ask the registrar to see her on either the Monday or Tuesday, not because he was concerned about her condition, but because he was Indian and both the complainant and his wife had recently spent some time in India and he thought they might enjoy talking to each other about the country. Consultant A had seen the complainant's wife during his ward round on the Wednesday morning (9 August) after which she unexpectedly collapsed. The SHO said that he had been satisfied with her progress until this time and consultant A had not criticised him for not having called in a consultant to examine her earlier.

10. The registrar, who has also left the hospital's employment told my officer that he had been on duty on 7 and 8 August and had spoken to the complainant's wife about her experiences in India. He had not examined her, but had he been concerned about her condition he would have asked consultant C who was on duty to look at her.

11. Consultant A told my officer that when the complainant's wife was admitted to hospital, he was 'nominally' the consultant on call and therefore 'on take' so she had become his patient. He was however away on the day in question ; consultant B had been standing in for him and could have been called by the SHO to see the patient if he had thought this necessary. Consultant A said it was the usual practice for the duty doctor to inform the consultant on call immediately about any case which he felt unable to handle himself, although when a senior house officer and the registrar were on duty together, the house officer would generally first seek the advice of the registrar. Similarly, if the ward sister, who was a very experienced and capable nurse, was unhappy about a patient's condition, she could get in touch with the consultant on call herself and ask him to visit the patient. Consultant A said that when he was on call at the weekend he invariably visited the hospital on both Saturday and Sunday to ask if there were any problems or new cases requiring his attention.

12. Consultant A said that he carried out ward rounds on Mondays, Wednesday mornings and Fridays. He had returned from leave on Tuesday 8 August but he had not received a list of new admissions from the ward clerk, as usual, because the clerk was on leave. He had been busy with clinics all day but before he went home on Tuesday evening, he had telephoned the ward sister and asked her if there were any patients that she wished him to see. The sister told him that consultant C had been on the ward during the day and he knew that consultant C would have examined any of his patients if this had been necessary. Consultant A said that he met the SHO before the Wednesday morning ward round and they had discussed the new cases. He was told about the complainant's wife's admission and her husband's obvious anxiety about her and he had seen her during his ward round at approximately

11.00 am when she appeared to be relatively comfortable and content with the treatment she was receiving. About one hour later, he was informed that she had collapsed and he returned to the ward. He had telephoned the complainant and told him that his wife had collapsed and been transferred to the intensive therapy unit. He said that the collapse was unexpected but patients with such conditions could collapse at any time without warning. He had been satisfied with the treatment she had received in his absence and in his opinion it had been unnecessary for the junior staff to have called in a consultant earlier. He denied that he had ever told the complainant that a consultant should have been called to see his wife in his absence.

13. Consultant B told my officer that, because he was responsible for patients at two hospitals in the district, he did not have time to visit the hospital routinely when he was on call at the weekend – only when asked to do so by the duty junior doctor. He could not remember whether or not he had been standing in for consultant A on the weekend of the complainant's wife's admission but a copy of the duty rotas did not indicate that this was so. He was however certain that he had not called into the hospital during the weekend in question and the first time he saw the patient was after she had received treatment in the intensive therapy unit. He also said that he did not remember speaking to the complainant about which consultant was responsible for his wife's treatment during the first five days of her admission to hospital.

14. Consultant C told my officer that he normally called in at the hospital on Saturday and Sunday when he was on weekend call to ensure that there were no problems. He stressed to the junior staff, when he briefed them on appointment, the need to keep consultants informed about their patient's condition and told them that 'he would not be cross if he was called unnecessarily but that he would be if he was not called when he should be'. On his ward rounds he told house officers which patients he considered ought to have been referred to a consultant immediately so that they could learn by experience. He said he had a clear recollection of the events surrounding the admission and subsequent treatment of the complainant's wife at the hospital as he had carried out his own investigation shortly afterwards because he had been concerned that a patient had been in the hospital for five days before the consultant responsible for her treatment knew of her existence. At the time of his own enquiries consultant B *had*, he said, been aware that he had been standing in for consultant A during the weekend in question.

15. Consultant C said that he had been on duty on 7 August and had been told of the wife's admission by the FP. He had spoken to the registrar, the SHO and the ward sister about her and been told that her condition was satisfactory. He was unaware that she had not been seen by consultant A into whose care she had been accepted ; had he known this, he would have telephoned him and asked if he himself should look at her in his absence. Both he and consultant B had spent a considerable amount of time on the ward on 7 and 8 August treating another patient and had thus been available if the junior staff had considered that they needed assistance with her treatment. He met consultant A in the morning of 9 August, and was told by him that he had only just learnt of the wife's admission. They both expressed concern

that she had been a patient in hospital without the consultant responsible for her treatment being made aware of her existence.

16. The ward sister told my officer that she was on leave on 5 August, the day of the complainant's wife's admission. When she returned to duty on 6 August, she thought that a consultant had already examined her otherwise she would have telephoned the consultant on call herself and asked whether he wanted to see her. Both consultants B and C had spent a great deal of time on the ward on Monday (7 August) and consultant C had questioned her about the complainant's wife and had read through her medical and nursing notes although he had not examined her. She said she could not remember receiving a telephone call from the complainant on the Wednesday morning or him demanding that a consultant should see his wife. Consultant A had examined the patient during his routine Wednesday morning ward round and she had collapsed shortly afterwards.

17. During my investigation I was told that since this complaint was received, but not because of it, there had been a reorganisation of the unit; the department of chest medicine had been fully integrated into the department of general medicine and this gave the unit's staff the added support of the registrars and the senior registrar in general medicine and enabled a full three tier system to operate. The duty and take-in rotas for the consultants remain unaltered.

Findings

18 It is clear from the evidence that there was a consultant available to see the complainant's wife throughout her first five days in the unit. It was however not considered by the junior doctors who saw her or the nursing staff who attended her on the ward that her condition warranted the attention of a consultant other than on a routine ward round. I cannot comment on their decisions because they stemmed in my opinion solely from the exercise of clinical judgment but I am satisfied that adequate medical cover was available and I do not uphold this aspect of the complaint. Nevertheless there was administrative failure in the delay in advising consultant A about the admission of his patient: furthermore I question whether a consultant standing in for the duty consultant should not also be on 'take' so that patients are not put in the 'nominal' care of a consultant known to be unavailable.

(b) *Complaint about the investigations by the AHA and RHA and the remedial measures*

19. The complainant told my officer that on 2 November 1978 he handed to the chairman of the AHA (the chairman) a letter in which he called for a detailed inquiry by officers independent of the AHA 'to investigate this particular case and to recommend measures that will ensure that in future patients who are admitted to the hospital suffering from a serious condition receive prompt medical treatment under the supervision of a consultant in accordance with accepted and modern professional standards'. The chairman told him that all complaints relating to consultants were dealt with by the

RHA and he left the meeting with the impression that the investigation would be handled by the RHA. However, he received a letter from the chairman shortly afterwards telling him that he would ask the area medical officer (the AMO) to look into his complaint and that he himself would then consider how best the inquiry should be carried out; the chairman also told him that it might have to be undertaken by the RHA as the employer of consultants. A further letter from the chairman dated 8 November 1978 advised him that the AMO had discussed the complaint with consultant C who 'already had sufficient misgivings over your wife's care to have already instituted his own enquiry within the Department. I think that this has already highlighted certain failures and errors'. The chairman suggested that the complainant should meet him, consultant C and the AMO to discuss the matter further with a view to ensuring that the chance of a repetition of these events was avoided. The complainant replied that he would consider such a meeting but before doing so he would like to know the full details of consultant C's investigation and also whether the chairman had reconsidered his original intention to hold an early inquiry conducted by doctors from outside the AHA. The chairman had replied on 21 November 1978 that it had been his intention following the AMO's enquiries to have an informal talk with the complainant and let him know the results of their preliminary enquiries; following this meeting he would have written to him formally with his findings and advised him of what further action, if any, the AHA proposed to take. However, because the complainant had now asked him to answer specific questions before their meeting took place, the chairman said that he considered it best to reply formally when their enquiries were completed and that this would enable the complainant to judge better whether he wished to take the matter further.

20. On 4 December 1978 the complainant wrote to the chairman asking for a progress report on the investigation and for his complaint to be put before the RHA. The chairman replied on 5 December 1978 that as the investigation was to be as thorough as possible it would take some time; and, further, the doctors concerned would probably wish to consult their medical defence organisations before discussing their involvement in the case. The complainant also received a letter from the district administrator (the DA) dated 11 December 1978 saying that he had been instructed to deal with the complaint through the normal complaints procedure and that it might be some weeks before the AHA could reply formally. The complainant replied to the DA on 13 December 1978 that, as he had no intention of pursuing legal action, he hoped that no time would be wasted in obtaining guidance from defence organisations and that in his opinion the matters raised in his complaint were serious enough to be looked at by an outside body. On 15 December, he wrote again to the DA saying that, in order to expedite matters, he would be willing to meet certain of the persons concerned as suggested earlier by the chairman (see paragraph 19).

21. The chairman sent the complainant the AHA's formal reply under fifteen headings on 25 January 1979. Under the heading 'Independent Medical Conclusion' he said that '[the SHO] on duty at the time of admission was unwise not to have informed a consultant at once that he had accepted a patient

in whom a rapid deterioration might be anticipated and certainly he should have informed [consultant A] of [the patient's] admission within a reasonable period, say 24 hours. In spite of this the clinical condition was not adversely affected by this at this stage'. The complainant was also told that the SHO, who was no longer employed by the AHA, would be counselled by letter about the importance of calling his consultant's attention to the admission of such cases. The complainant was not satisfied with the reply and sent detailed observations on it to the chairman on 12 June. When he returned from a prolonged trip abroad he asked for further information on various aspects of his wife's treatment, suggesting that '*every* acute medical case admitted should *normally* be seen by a consultant within at least 24 hours of admission' ; he also asked for a meeting with the chairman, the AMO and consultant C. The chairman replied on 26 June that he had taken his investigation as far as he could. The complainant, he said, was now questioning the competence of individual doctors; the clinical actions of doctors were matters which could not be judged by the AHA, only by a court of law and that it was up to him to decide what further action he wished to take.

22. After writing to inform me of his complaint, the complainant then wrote to the regional medical officer (the RMO) of the RHA on 8 August 1979 asking him, in view of the unsatisfactory reply of the AHA which had suggested that his only recourse was to the courts, which he did not intend to use, whether the RHA could undertake an investigation by officers not involved in the complaint. The RMO replied on 10 August that he would make enquiries and get in touch with him again in due course. The complainant was visited at home by the regional specialist in community medicine (the RSCM) on 12 September 1979 and as a result a meeting was proposed between him and the consultant staff involved together with representatives of the nursing staff. This meeting took place on 3 December 1979 and was attended by the RSCM, the AMO, the area nursing officer, consultant A, the secretary of the local Community Health Council and himself. The complainant said that he was extremely disappointed that neither consultant B nor consultant C attended this meeting as he had been led to expect and he was not satisfied with the reason given that they had been advised against attending by their medical defence organisation. He said that he had already made it perfectly clear that he had no intention of taking legal action against the doctors involved. The complainant said that at the meeting, consultant A had been very sympathetic and agreed that his wife should have been seen by a consultant earlier. Both the RSCM and the AMO had agreed that some written guidelines were required on the need for junior medical staff to notify their consultants about new admissions. He had produced his own suggested outlines on this guidance together with a paper produced by St Thomas's Hospital headed 'A Charge for Housemen' as an example of the type of instructions issued elsewhere. He had left the meeting assured that something along the lines of the draft he had submitted would be produced and issued to all the staff within the AHA.

23. The complainant said that he did not receive any minutes of the December meeting but the AMO wrote to him on 14 January 1980 informing

him that a proposal to include in the staff handbooks some guidance on the general responsibilities of house officers to patients and to their consultants was being considered by the individual hospital medical staff committees who compiled the existing handbooks. The complainant heard nothing further and therefore wrote to both the RMO and AMO in June 1980 asking for a progress report on the redrafting of the staff handbooks. He also asked whether the admissions' lists (paragraph 8) sent daily to consultants indicated whether the condition of the patients was unusual and required an immediate visit by the consultant. The AMO replied on 20 June 1980 that the senior medical staff were reluctant to introduce guidance of the type he suggested because it would be rigid and would inhibit the use of intelligence and initiative by the junior medical staff and that he agreed with this view. However he had asked for a strengthening of the existing wording which was that 'Junior staff are appointed to one or more consultants or to a department and are responsible to them for all aspects of their clinical work. Consultants tend to have their own particular ideas on the details as to how their firm is to be run and they will personally instruct you in these. They vary so much that it is not possible to include them in a booklet of this nature'. He also told the complainant that the daily lists of admissions sent to consultants did not include any indication of the patients' conditions as the consultant should be informed immediately about anything of an unusual nature concerning a patient. The purpose of the lists was to ensure that never would a consultant find himself in the position of being 'nominally' responsible for the care of a patient of whose existence he had no knowledge.

24. The complainant wrote to the AMO again on 8 July 1980 expressing his disappointment that the only positive result of his complaint and the ensuing correspondence was the production of a daily list of admissions (these were in fact normally provided to consultants when the complainant's wife was a patient) and he asked how he could have the case referred to the RHA for an independent investigation. Shortly afterwards, on 1 August, as he was dissatisfied with the investigations carried out by the AHA and he had failed to obtain an independent investigation he referred the matter to me, some twelve months after his first approach to me.

25. The chairman told my officer that when he met the complainant in November 1979, the latter had requested an external inquiry to investigate his complaint. He had explained to the complainant that the initial investigation would be carried out within the AHA and, if the complainant was not satisfied with the results of it, he could then approach the RHA. The chairman said, that although he had considered it as a formal complaint, he had not immediately passed it to the DA for routine investigation because of the involvement of the consultant staff. He had spoken to the AMO and they agreed to try to investigate the complainant informally in the hope of getting better cooperation from the consultants concerned. He explained that the AHA dealt with complaints about the services they provided and where consultants were involved kept the RHA informed ; but where complaints related to possible breaches of consultants' contracts or were such that they might lead to disciplinary action they were the concern of the RHA as the consultants' employers.

26. The chairman said that initially he had great sympathy for the complainant and his complaint about inadequate consultant cover as it was his view that if it was thought necessary to employ a consultant then the consultant should be available to treat the patients. He had been most concerned for some time that no definite instructions were issued to the junior medical staff that they must ensure all admissions were seen by a consultant within a specified period of say two days. However, he said that during frequent telephone conversations the complainant began to question the competence of individual members of the medical staff and he therefore decided that the complaint should be handled under the normal complaints procedure and he passed it to the DA. This had not delayed the formal response to the complaint as the AMO had been pursuing his enquiries and had obtained information about the complaints.

27. The chairman further said that he had relied to some extent on the comments of the AMO and consultant C when composing his formal response but it had been his own view that the SHO was wrong in not realising that the complainant's wife's condition was so unusual that she should have been referred immediately to a consultant. He said that when a complainant was not satisfied with the AHA's reply further investigation might be carried out or an offer made of a meeting with the staff concerned. However, he believed from his telephone conversations with the complainant that he was intent upon taking legal action against the AHA and he therefore decided to take no further action.

28. The AMO told my officer that he thought the chairman had given the complainant's correspondence to him rather than to the DA because it was 'by a doctor about a doctor' and because it was not an obvious complaint but more of a plea for measures to be taken to ensure that certain things which happened to the complainant's wife, would not happen to other patients. As consultant A had by then retired, he discussed the complaint with consultant C and from what he learnt he had been concerned about several aspects of the case; in particular that the consultant 'nominally' responsible for her care had not known for about five days that the complainant's wife was his patient, but he thought that little would be achieved by a formal inquiry and he had therefore advised the chairman against it. He said that the tone of the complainant's letters gradually changed and it was felt that he might well be contemplating legal action. The complaint was therefore passed to the DA to be dealt with under the usual formal complaints procedure and he played no further part in the district's investigation although his notes were used as a basis for the chairman's formal reply. The AMO said that the independent medical conclusion referred to in the chairman's formal reply related to the conclusions reached by consultants B, C and himself; they were independent in that none of them was concerned in the treatment of the complainant's wife; the undertaking given by the chairman to the complainant that the SHO would be counselled by letter as he had left the AHA's employment, was not carried out when it was found that he had left the country. The complainant was not informed.

29. The AMO said that reluctantly he had continued to be involved with the complaints when they were being dealt with by the RHA and he thought this may have caused confusion. He had attended the meeting with the complainant in December 1979 where it was agreed that some effort would be made to amend the written instructions given to junior staff to make more explicit the duties of junior doctors as regards keeping their consultants informed about new admissions. The AMO said that after the meeting he had written to the medical staff committees within the AHA responsible for producing the handbooks. With some reluctance, agreement had eventually been reached to include the sentence 'you should notify the consultant as soon as practicable of all new admissions' which he thought met the AHA's requirements. Although he said it was doubtful whether many of the junior staff read the handbooks, at least the instructions on this point would now be on record. He did not think that the daily list of admissions drawn up by the ward clerk should include the provisional diagnosis of the patient's condition as made by the admitting doctor.

30. Consultant C told my officer that as the consultant responsible for the medical administrative work at the hospital, he was normally involved with complaints relating to the medical staff. The AMO had spoken to him on receipt of the complaint and he had interviewed the SHO and registrar involved and the ward clerk. He had also examined the medical records. He had been satisfied that the complainant's wife had received the correct treatment prior to being seen by consultant A but he had been concerned that she had been a patient for five days before the consultant responsible for her care became aware of her existence. The ward clerk was on leave at the time of the wife's admission but the daily list should have been drawn up by one of the other ward clerks and sent to consultant A. Consultant C said that he had been unable to discover from his own investigation whether a list of admissions which included the wife's name had been drawn up and distributed ; as a result of this complaint he now ensured that copies of admission lists were retained. He also did not think that the list of admissions should contain an initial diagnosis of the patient's illness as suggested by the complainant. He thought that the list might include some indication of the seriousness of the patient's condition but there again, if the patient was seriously ill, a consultant should be informed about the patient prior to the issue of the list. The daily lists were regarded as a double check and should not replace the junior doctor's responsibility for informing the consultant about the patients in his care. Consultant C told my officer that he had been advised by his medical defence organisation not to attend the meeting with the complainant in December 1979.

31. Consultant B told my officer that he had not attended the meeting because he had not specifically been asked to do so by the RHA: he had just been informed that a meeting was taking place. As he did not think that he was in any way involved with the complaint, he saw no reason to attend. Similarly, he saw no point in replying to the letter he received from the complainant.

32. The DA confirmed that the ward clerk was on leave on the Monday when the list which would have included the complainant's wife's admission

should have been drawn up and that no back-up system existed at the time. However the system has since been reviewed and now when the ward clerk is on leave, either the medical records officer provides a member of his staff to undertake this duty or the local administration does so by arrangement with the medical records officer.

33. The RMO told my officer that he would have handled the complaint differently from the way adopted by the AHA because it concerned doctors both as patient and as complainant. He thought that an AHA officer should have visited the complainant at home to determine the likelihood of his being satisfied with an internal investigation. If it had seemed likely that the complainant would not be satisfied, arrangements could have been made for an independent inquiry by a senior consultant in chest medicine from outside the Region to assess the wife's treatment. He did not support the use of the formal complaints procedure indiscriminately as he felt that 'a letter fell short of personal contact'. He first knew of the complaint when he received a letter from the complainant in August 1979. He discussed how the complaint should be handled with the RSCM and, although he was kept informed of the investigation's progress, he was not directly involved after this and all subsequent correspondence to the complainant was from the RSCM. He thought that, with the exception of the guidance to junior staff, the complaints had been answered to the complainant's satisfaction at the meeting in December 1979. Guidance to junior staff was the responsibility of the AHA, and accordingly the RHA were not thereafter directly involved. Thus, although both he and the RSCM were kept informed about the redrafting of the guidance, the complainant received no further correspondence from the RHA after the meeting. If the complainant had written to express his dissatisfaction with the outcome of the RHA's investigation, he would have set up an independent inquiry. If he had expressed dissatisfaction with the redrafted guidance, he would have referred the matter to the regional chairman with his advice on what should be done and the regional chairman could have approached the area chairman.

34. The RMO said that he was unhappy with the original guidance given to junior medical staff. He understood the consultants' view that it was impracticable to produce one set of instructions which would be satisfactory for all specialties but he thought that the AHA as employers of the junior medical staff could insist that the individual instructions given by the consultants to their staff should be in writing.

35. The RMO did not accept a view which had been expressed by the consultants that it was impossible to list the types of patients who should be referred immediately to a consultant. He suggested that wording such as 'patients should be referred immediately to a consultant if there are grounds for thinking there are unusual clinical complexities in the patient's condition' should be included in the written instructions to junior staff and that this would cover most eventualities. He said that the RHA could only offer the AHA advice on what instructions should be given to junior staff as the services they and the consultants provided were the responsibility of the AHA. In his opinion the AHA could specify the instructions that should be given to

junior medical staff and he thought they should include a specified time within which all patients should be seen by a consultant.

36. The RSCM told my officer that the first he knew of this complaint was when the RMO passed the complainant's letter dated 8 August 1979 to him for investigation. He followed his normal procedure for investigating complex complaints and visited the complainant at his home. He thought the AHA's investigation of the complaint and their formal response had been reasonable although the chairman's final letter to the complainant had been rather abrupt. In his opinion, the SHO had been wrong in not bringing the admission of the complainant's wife to the attention of a consultant immediately and this had been acknowledged by both the AHA and the RHA at the meeting with the complainant in December 1979. He had gained the impression that the complainant was satisfied with the outcome of the meeting with the exception of the guidance to junior medical staff. It was agreed that the AMO would discuss the complainant's proposals for more explicit guidance with the consultants and medical staff committees but no commitment was made that his suggestions would be incorporated in the staff handbooks.

37. The RSCM said that in the AMO's final letter to the complainant dated 7 August 1980 describing action taken on his complaints, the complainant had been told to write to the RHA if he was still dissatisfied but he had not taken up this option. On reflection, the RSCM thought that the final reply should perhaps have come from the RHA but he said that the reply would not have been different.

Findings

38. The RHA and AHA were clearly concerned by this complaint and although I find its handling was confused and took far too long I am satisfied that the authorities investigated it conscientiously and were frank in admitting to the complainant the faults they found. I think, however, it was a pity in the circumstances of this case, that an independent professional evaluation of the medical management was not arranged at the outset. I believe that the complainant would have accepted an independent opinion and there the matter would have ended.

39. The AHA also considered the complainant's proposals for amending the guidance for junior hospital doctors and consulted the appropriate medical committees. The complainant did not consider that the subsequent revision went far enough. In my view the incorporation of wording proposed by the AMO (paragraph 29) *and* by the RMO (paragraph 35) would provide the necessary safeguard and I recommend the AHA to do so.

Conclusions

40. I have set out my findings in paragraphs 18, 38 and 39 of my report. I can understand the complainant's doubts about the health authorities' investigations and the remedial measures taken. And I was concerned with the references in the evidence to a consultant being *nominally* responsible for a patient admitted on his 'take in' day. Either a consultant is or is not respon-

sible. I am pleased to record that the AHA have told me that they have taken effective action to ensure that consultants are informed promptly about the patients for whom they are responsible. I hope that this together with my report will provide the reassurance for which the complainant has been so patiently waiting.

Case No. W.377/79-80 – Inadequate supervision of young person in hospital.

Background and complaint

1. The complainant's daughter, who was in the care of the County Council Social Services Department (the social services) was admitted to a unit of a hospital (the unit) as an informal patient on 3 March 1979 when she was aged 17. She was suffering from manic depression for which she received treatment. During her stay at the unit she met a man who subsequently accompanied her on outings from the unit. Early on 30 March she left the unit and her whereabouts are still unknown. The complainant said that:–

(*a*) the unit failed to provide adequate supervision for his daughter and she was allowed to go out with a man about whom no enquiries had been made without the knowledge or permission of the social services ;

(*b*) at some time before 6.45 am on 30 March 1979 his daughter was able to leave the unit unobserved ;

(*c*) there was undue delay by the unit in informing the police that his daughter was missing; and

(*d*) the police were not told about her dependence on the medication she was receiving.

Investigation

2. During the investigation I obtained the written comments of the Area Health Authority, (the AHA) and examined the daughter's medical records. My officer met the complainant and his wife and interviewed members of the medical, nursing and administrative staff concerned; she also saw representatives of the social services.

(a) *The complaint about inadequate supervision*

3. In the correspondence with the AHA and when interviewed by my officer, the complainant said that he considered that the staff of the unit had not shown sufficient responsibility in supervising his daughter's activities whilst she was an inpatient; in particular on 27 March they had allowed her to go out for the day with a young man whose full name they did not know and without obtaining the permission of the social worker (the SW) responsible for her or consulting either him or his wife. The complainant's wife said that the SW had told her that she had not been aware of the outing and that the deputy warden of the hostel where the complainant's daughter had been placed by the social services and where she had lived prior to her admission to the unit, had said that the daughter and the young man had visited the hostel at midday on 27 March. The complainant's wife had questioned the ward sister (the sister) of the daughter's ward at the unit about

the young man and the sister told her that she considered him 'a nice boy and . . . he seemed all right for her'. The complainant was told by the police that, after his daughter's disappearance on 30 March, the hospital staff had only been able to give them the first name of the young man.

4. The sister told my officer that the complainant's daughter was an informal patient when she was admitted to the unit on 3 March and that she herself had been aware that the daughter was in the care of the social services. However she had not considered that the fact that the daughter was the subject of a child care order required any additional supervision and she had been treated in the same way as any other informal patient of the same age and condition. Although doctors were ultimately responsible for patients, day to day decisions on the social activities permitted to informal patients were generally left to the discretion of the nursing staff. They would consult the medical staff if they were in doubt, but in practice they seldom needed to do so. The sister said that she had not been given any special instructions by the medical staff about the daughter's supervision.

5. The sister stressed that when the daughter's condition stabilised it was her own decision whether or not she saw visitors. In regard to the young man who visited her whom she had known only as 'A', the sister said that she had been in a position to judge whether or not he was a suitable companion for the complainant's daughter. She made such decisions on the same basis as if an adolescent patient was her own daughter and she took into consideration the patient's medical condition and drug-taking pattern. The SW, the sister said, had visited the complainant's daughter occasionally but the nursing staff would not have discussed the daughter's activities with her as they expected liaison with social workers to be carried out through the medical staff. She said that she had not been on duty when the complainant's daughter went out with A on 27 March ; if she had been involved and had had any doubt about the proposal she would have got in touch with the medical staff or the parents or the warden of the hostel in preference to the SW. The sister stressed that a patient would not be allowed to leave the hospital grounds without permission from the nursing staff.

6. My officer interviewed a staff nurse who was on duty in the unit on 27 March. She said that A had visited the complainant's daughter frequently and that she had thought that he was her 'regular boy friend' of whom the parents were aware. On 27 March A had arrived some time before 0930 and he asked her if he could take the complainant's daughter out for the day. He had said he would take her to the hostel where she could have lunch while he made deliveries (the staff nurse believed he had worked for a cosmetic company) and that he would collect her and bring her back to the unit. The staff nurse said that she had given him permission on the understanding they returned by 1700 and that the daughter had been given the drugs she was required to take during the day. She had been aware that the daughter was in the care of the social services but she had had no hesitation in allowing her to go out; if she had had any doubts she would have got in touch with the medical staff or her parents; she herself had never seen or spoken to the SW. Another staff nurse confirmed that A had visited the complainant's daughter regularly and was regarded as her boy friend. She

said that they were able to form an opinion of him because he had sometimes stayed and talked with her in the unit.

7. The clinical assistant (the CA), who had been concerned with the daughter's treatment for a number of years said that she had seen her about twice a week during her stay in the unit. The senior nursing staff were aware that the daughter was in care but she had been thoroughly confident of their ability and she had not given them specific instructions about her supervision. She recalled that, when the complainant's daughter was first admitted and her condition required more restriction and supervision, she had told the sister to use her own discretion in deciding what activities the daughter could be allowed. The CA said that she would have expected the nursing staff to mention the daughter's boy friends to her only if they had doubts about allowing her to go out with them. It was her job to make decisions in regard to any restrictions proposed on patients' activities as such restrictions could have an adverse effect on their therapy.

8. The CA went on to say she had not known about A at the time but if she had been told about him (if the nursing staff had doubts) she would have wanted to know his full name and something about his personality and background. If a case arose where a person was considered by the medical and nursing staff to be an unsuitable companion for a patient she would discuss the situation first with the parents rather than the SW. As an example of the line of communication which applied in this case the CA instanced an occasion when the sister had suggested that the complainant's daughter should be prescribed an oral contraceptive. It had been the complainant's wife who had been first consulted on this matter and she had discussed it with the SW. The CA said that the SW had always been invited to attend case conferences concerning the complainant's daughter; she had seen the SW in the unit during the daughter's stay on one occasion.

9. The consultant psychiatrist (the consultant) who was responsible for the daughter's care said that the hospital had a duty of care towards adolescent inpatients to act as a parent but the fact that the patient was in the care of the local authority did not add further responsibility. He said that he would not have asked the parents' permission for the daughter to go out with A because he considered that the acceptance by the hospital of the role of parent obviated the need to do so. He thought that the hospital should keep the social services informed of any activities of an adolescent which were outside normal day to day events as they had the right to be advised as if they were parents; but, he said, the extent to which parents should be told about the activities of a 17-year-old girl was a 'grey area' particularly as she had been well enough to be discharged (see paragraph 23). He said it was wrong if the daughter had been allowed to go out with someone about whom little was known but he would have been more concerned if permission had been given when she had been medically unfit to do so. In a report he had made to the area medical officer shortly after the complainant's daughter disappeared the consultant said: 'during this period in hospital she had been out on several evenings with a boyfriend and these trips were very appropriate and successful'.

10. The SW (whose actions are outside my jurisdiction) had retired prior to my investigations but my officer saw senior officers of the social services. They told her that there was no transfer of legal responsibility when a child in their care was admitted to hospital and that they remained *in loco parentis*. Accordingly, they would have expected the unit's staff to have got in touch with the SW about a boyfriend but there was no reference to him in the SW's records. If the unit had asked her about A they thought she would have arranged tactfully to meet him to assess his suitability as a companion for the complainant's daughter. The SW, they said, had got in touch with the unit on 4, 6 and 13 March to discuss the case and she had taken her out for the day on 19 March; on 27 March she had been told that the daughter's condition was improving but no date had been fixed for her discharge; and on 29 March the warden of the hostel advised her that the daughter was to be discharged on 2 April when he would collect her; but she did not know that the daughter had left the unit without permission on 30 March until she was told by the warden on 2 April. The officers said that social workers should liaise with the medical staff as leaders of clinical teams and tell them the circumstances in which they should be consulted. There was no record in the SW's notes that she had been dissatisfied with the cooperation she received from the staff of the unit. (And the complainant and his wife told my officer that the SW had told them that their daughter's activities while she was an inpatient were at the discretion of the hospital).

Findings

11. It is clear from the evidence that the staff of the unit considered that they had assumed the role of parent and it was for them alone to decide who was a suitable companion for the complainant's daughter, although the consultant has said that, in the daughter's circumstances, this was a 'grey area'. I consider, first, that the hospital made a serious error of judgment in allowing a girl who was a minor to go out with a young man about whom they knew so little – not even his surname or where he came from. If, as the hospital claim, they were acting in the role of parent, I can only say, in company, I am sure, with most other parents that they interpreted their role in an unbelievably casual fashion. I believe, secondly, that the hospital staff had no right to take the decision they did without consulting the social services and I consider that the AHA should seek agreement with the social services as to the rights of the latter when *in loco parentis*. Moreover, I consider that they should issue guidance to the staff concerning their responsibilities *generally* towards the parents of minors in order to clarify the 'grey area' to which the consultant has referred.

(b) *The complaint that the complainant's daughter was able to leave the unit unobserved on 30 March*

12. The complainant, in correspondence with the AHA and when interviewed by my officer, said that although he had been told by the health authority that they could not accept any responsibility for his daughter's disappearance because she was an informal patient, he was not satisfied with the standard of supervision provided for her on the night of 30 March.

13. The senior nursing officer who was responsible for the night nursing staff at the unit, but was based at another hospital (the night SNO), told

my officer that the external doors of the unit were locked from about 2230 until 0630. The night nursing staff, who were responsible for the security of the building, checked all external doors and locked them where necessary with a master key. The windows, which were of the casement type, were fastened at night but they could be opened from the inside. Dormitory doors were not locked. The staff on duty on the night of 29/30 March was up to establishment and he considered that the staffing level was satisfactory. He said that there were no instructions about how often the patients in the 'low dependency' dormitory, where the complainant's daughter was, should be checked; the frequency of visits was left to the discretion of the nurse in charge and was not recorded. The night staff responsible for the female patients in the unit were based at a nursing station on the ground floor from which the door to the stairs leading to the dormitory was not visible.

14. My officer interviewed the staff nurse (the SN) who was the senior nurse responsible for the female patients on the night of 29/30 March; she had been assisted by a nursing assistant and a student nurse. The SN said that the layout of the unit was unsatisfactory and patients were moved closer to, or further away from, the nursing station according to their condition and need for nursing supervision. She confirmed that the complainant's daughter, whom she did not know well because night staff did not normally become much involved with patients, was in a dormitory for low-dependency patients, which was visited about hourly ; on the night in question she herself had checked the first floor where the dormitory was situated because she had been unhappy about another patient. The SN said that when not visiting or caring for patients the night staff remained at the nursing station, which was the sister's office ; the door leading to the dormitory was not visible from it and therefore it was possible for patients to leave this ward unobserved.

15. The SN said that at about 2300 on 29 March the complainant's daughter had refused her night medication but she had not insisted that it was taken because of the daughter's imminent discharge. Later the daughter had asked for the medication and the SN had seen her take it. She saw the daughter again when she visited the dormitory at about 0500 but on her next round some time after 0600 the daughter was missing. The SN said that she and other nurses searched the building and the grounds without success ; during the search they found a window open on the main passage on the ground floor ; this window was not visible from the sister's office. Entries concerning the daughter in the nursing report for 29 and 30 March, which I have seen, recorded: 'Requested night medication at 3.00 am Pt returned to bed. Found to be missing at 6.45 am last seen in bed at 5.15 am . . . Missing from the ward at 0645 hrs. Patients in upstairs dorm report her dressing at 06.15 hrs '.

16. In a letter to the complainant replying to his complaint the area medical officer of the AHA said: '——was, as you say, a voluntary patient. This means, of course, that the hospital had no legal right to prevent her leaving whenever she chose. It is difficult, indeed impossible, to prevent voluntary patients from leaving at any time, for without locking patients in [the ward] – which is not a good practice in such cases – it is really impossible to prevent

their going as they wish'. The area administrator of the AHA said in his written comments to me: 'It is freely to be admitted that at some time before 6.45 am on 30 March 1979 ——was able to leave the unit unobserved. Indeed, from information which is available she was seen to get up and get dressed and leave her dormitory at 6.15 am. It is perfectly possible for a patient to get dressed and leave a dormitory in the ——hospital without being seen by a member of the nursing staff. Patients in this hospital are not normally in a clinical condition which requires them to be under constant 24 hour observation by members of the nursing staff; although as I understand it the nursing staff on night duty make periodic 'rounds' of dormitories it is not the normal practice to have a member of staff sitting in each dormitory for the whole of the night hours'.

Findings

17. It is not disputed that the complainant's daughter left the unit unobserved and from the evidence it is clear why this was possible. My officer inspected the unit and I have seen plans of it which confirm to me that, as the SN said, the layout is unsatisfactory. Nevertheless it seems to me quite wrong that a patient who requires permission to leave the unit during the day can do so at will during the night (albeit not by the doors) without any counselling about the wisdom of her action. This, in my view, represents a failure in the service provided. I uphold this complaint and I urge the AHA to organise the night nursing staff in such a way as to ensure, so far as they can, that nobody who is free to leave can do so before the nursing staff have had the opportunity to dissuade them.

(c) and (d) *The complaints that the police were not informed promptly of the daughter's disappearance and were not told about her dependence on medication.*

18. The complainant and his wife said that they had first learned that their daughter was missing at about 1130 on Friday 30 March when the sister telephoned the wife. The sister had not seemed concerned and the wife had assumed that her daughter had only left shortly beforehand; it was not until later that they found out that she had been missing since 0600 that morning. The complainant said that he had assumed that the police had been informed but he learned afterwards that they had not been notified until that evening – which he considered was too late. When he himself had telephoned the police in the evening they were unaware of his daughter's dependence on her medication; and they told him that they would need confirmation of this from the medical staff. He therefore telephoned the hospital several times during the weekend but was told that neither the consultant nor the CA was available. The complainant spoke to the consultant on Monday 2 April and asked what would be the effect on the daughter of missing her medication. The consultant had replied that 'she could go through the roof'.

19. In a written statement made by the sister three days after the complainant's daughter took her discharge and when interviewed by my officer, the sister said that she had arrived on duty at 0700 on 30 March and had carried out the procedure required when a patient was missing. She completed

the 'report of missing person' form and between 0715 and 0730 she informed the duty medical officer, the senior nursing officer (the day SNO) the acting duty consultant and the hospital's family psychiatry unit which the daughter had attended as an outpatient. A little later she also got in touch with the hostel in case the daughter had decided to go there. She said that she had not been very concerned at the time because when the daughter had previously been a patient at the unit she had frequently left without permission and on these occasions she had 'surfaced' within a few hours.

20. At 0900 the sister tried to get in touch with the acting duty consultant, to whom she had spoken earlier, to obtain advice but the doctor had not arrived. At 1100 she again telephoned the hospital and spoke to the CA who, she said, had advised her to 'play a waiting game for a time' because of the daughter's previous history. They had discussed the circumstances in which the police should be informed, but not what they should be told. The sister explained that she had not telephoned the parents at the outset because she had had to wait until the complainant's wife arrived at her place of work as that was the only telephone number they knew; she had spoken to her shortly after 1100. Later at about 1500 she discussed the case with the day SNO who felt worried and had consulted the divisional nursing officer; the sister was then told to notify the police. The sister said she spoke to the police at about 1530 and officers came to the unit. They asked her whether there was any particular cause for concern; she replied that the complainant's daughter was under age, young for her years and very vulnerable, but that she was not suicidal at that time. She had not mentioned the medication as she did not consider that there was any immediate risk in its withdrawal. The sister said that the daughter had been due for discharge on 2 April and her condition was stable.

21. The day SNO told my officer that when he came on duty on 30 March he had been told that the complainant's daughter was missing. He had also learned that, as her condition was stabilising, there was no great urgency in notifying the police and that the CA shared this opinion. However, after several hours when nothing had been heard about her he had been concerned and discussed the situation with the divisional nursing officer who told him to speak to the CA and suggest that the police should be notified. He had obtained the CA's agreement and the sister notified the police. The day SNO said that normally when a 'report on missing person' form was completed the procedure for notifying the police followed soon afterwards (see paragraph 26); it was unusual for there to be as long a delay as there was in this case – which was due to the doctor's decision to wait and see if the complainant's daughter would return of her own accord.

22. The acting duty consultant on 30 March, told my officer that the sister had telephoned her to report that the complainant's daughter was missing. The sister told her that she had not been in touch with the police because the daughter had left the unit on other occasions without permission but had been located soon afterwards. She had discussed with the sister the procedure for missing patients and was told that the police would be informed about the daughter if she did not re-appear but no time was specified.

23. The CA said that when she and the sister had discussed the situation, the sister had assured her that there had been no change in the daughter's condition since she herself had last seen her; and she had not considered it necessary for the police to be notified then that the daughter was missing. Her condition had already stabilised sufficiently for her to be discharged but, as the warden of the hostel could not collect her until 2 April, she had decided to postpone discharge until after the weekend. She had thought it advisable that there should be only one change of environment for the complainant's daughter and that she should not go home to her parents for the interim period before going to the hostel. She said that the sister had asked her whether the police should be notified but she (the CA) had thought it likely that the daughter had gone to a friend's house or to her parents and was 'doing what she wanted to do' and that there was no reason why she should not be away for the weekend. She felt that calling in the police at that stage unnecessarily could damage the trusting relationship which existed with the daughter; she had asked the sister to telephone her again in mid-afternoon if there was no further news. The CA said that, although the sister had agreed with her views, the decision not to call the police at an earlier stage was hers and that it had been her clinical decision that notification was delayed until 15.30. I have seen an entry in the nursing notes for 28 March which provides contemporaneous evidence of her condition. It reads: 'the daughter may go back to ——[the hostel] Mon 2 April will be picked up at 11.30 Lith [Lithium] level to be done Friday. To go home on full medication'.

24. The CA told my officer that she had not considered that there was any immediate danger in the daughter missing her medication and that although it was unlikely that she would have stayed well for any length of time without any medication at all it would have been several days before the effects would have been felt. Moreover, in her opinion the daughter's condition at the time was not such as to make her either a danger to herself or others. But she had later agreed that the police should be notified because the daughter had been missing for longer than it could reasonably have been expected for her to reach her home or the hostel or to have got in touch with somebody – as she had often done in the past.

25. The consultant told my officer that he recalled speaking on 2 April to the complainant who had been very concerned about his daughter's medication. Although her condition could have deteriorated in time, especially if she was not taking her *regular* medication he had not mentioned any time scale in his discussion with the complainant and he had certainly not suggested that she 'would go through the roof'. He said that he himself had spoken to the police about her but that he did not think that her medication had been particularly emphasised. The consultant said that there was an arrangement at weekends whereby the hospital took messages and enquirers' telephone numbers and relayed them to him, but he had not received any messages during the weekend in question. The CA with whom there was a similar arrangement, also said that she did not receive any messages.

26. I have seen a copy of the procedure used in the unit for the notification to the police of missing patients. It says that the police are

to be notified immediately a patient is reported missing and that they should be given an indication of the classification of the patient concerned. Patients are put in three categories ; in respect of categories 1 and 2, where patients may be of danger to themselves or others, the procedure states that the police will initiate the full 'missing persons' procedure but in the case of category 3 patients those who are not considered to be immediately in danger, the police are to be notified again if the patient has not returned within 8 hours ; at that stage the full 'missing persons' procedure would be initiated.

Findings

27. It is clear from the evidence that because of the daughter's previous history the medical and nursing staff did not put into effect the usual procedure for missing patients. They clearly thought, albeit wrongly, that past history would repeat itself. Whatever their judgment, however, I can see no point in having a formal procedure if it can be discarded. Either it is the procedure or it is not. I think the procedure should have been followed.

28. Having said that, I do not find that this failure in any way influenced the course of events. The complainant's daughter was clearly not considered to be a danger either to herself or others and even if the police had been notified at the outset, they would not have instituted the 'missing persons' procedure for another eight hours and it was just about then that they were alerted and took action.

29. As to the complaint about the failure to tell the police initially about the daughter's dependence on her medication, the medical evidence, which I cannot question, is that she would not have been in any immediate danger because of lack of drugs. I think, however, that the hospital should have told the police that, in time, her condition would deteriorate without her drug administration ; but, sadly, she was not found and this lapse therefore had no practical effect.

Conclusions

30. I understand that nothing has been heard of the complainant's daughter since she left the unit in March 1979 and I have great sympathy with the complainant and his wife who must have suffered much anxiety. I have set out my findings in paragraphs 11, 17 and 27-29 of this report. The AHA have asked me to convey to the complainant and his wife their sincere regrets for the shortcomings to which I have drawn attention and have assured me that they will follow up the recommendations I have made.

31. Although it is not strictly my province I think it is only right for me to say, as a post-script, that, in case anyone should think otherwise, I have had no evidence to suggest that the daughter's association with the young man had any bearing on her disappearance from the hospital.

Case No. W.401/79-80—Accommodation and facilities provided for a private patient.

Background and complaint

1. A woman (Mrs. A) was admitted to a single-bedded room of the private ward (the ward) of a hospital (the hospital) on 10 September 1979 for a laparotomy and was discharged on 21 September. Mr. and Mrs. A. complained that:–

(*a*) when they first arrived on the ward they waited 10 to 15 minutes before anyone received them;

(*b*) the actions and attitude of a staff nurse were unreasonable;

(*c*) Mrs. A. was not seen by a doctor from noon on 14 September to 10.45 pm on 16 September;

(*d*) the room was in a filthy condition and was not cleaned properly during Mrs. A's stay; certain furniture and fittings were old and unsuitable and there was no television or radio; the ward had insufficient bathrooms and lavatories;

(*e*) the food was uneatable;

(*f*) the substantive reply to Mr. A's written complaints was unsatisfactory and they considered that a private patient should not be required to pay a large sum of money for the conditions and some of the nursing care Mrs. A had to tolerate.

Investigation

2. Mr A first put his complaints to me on 4 February 1980 but he had not then paid his account in full. In accordance with my normal practice, I explained that I could not undertake an investigation until the whole account was paid. Mr A consulted his solicitors and eventually decided to pay it but the start of my investigation was thereby delayed until August.

3. During the investigation I obtained the comments of the Area Health Authority concerned (the AHA) and saw the relevant correspondence and medical and nursing notes. One of my officers discussed the complaints with members of the hospital medical, nursing and administrative staff concerned. He also met the complainants.

(a) *Reception arrangements*

4. In discussion with my officer and in correspondence Mr and Mrs A said that when they arrived at the hospital on 10 September a man 'in a cubby hole' at the entrance directed them to the ward. There they waited 10 to 15 minutes before anyone appeared to receive them.

5. My officer confirmed Mr and Mrs A's description of the entrance to the hospital. None of the nurses interviewed by my officer could remember the incident described although one recalled 10 September as being a day when they were short of staff. The unit administrator explained that the nursing management of the eight bed ward was shared with another eight bed (NHS) ward on the floor above it. The senior nursing officer (the SNO)

responsible said that nurses would understandably have had to put clinical involvement first and might at the time have been deployed on the other ward. But neither she nor the nursing officer (the NO) denied that Mr. and Mrs A waited for the time they said and accepted that a patient might reasonably expect either the sister or a receptionist to receive them. Two of the nurses on the ward felt that the hospital reception point should in any case also have been involved.

Findings

6. When I first asked the AHA to give me their comments on the complaints they said that it was clear that arrangements for admitting patients to the ward were not entirely satisfactory. I certainly agree with that. They told me that the arrangements were being reviewed. I was later told that portering staff now telephone the ward to inform nursing staff that a patient has arrived and that the patient is accompanied to the ward when staff resources allow.

(b) *The attitude and action of the Staff Nurse*

7. In his letter of complaint to the AHA, Mr A said that three days after his wife's operation she requested some fresh orange juice. Eventually, the staff nurse grudgingly squeezed all her nine oranges into a jug rather than giving her the much smaller amount Mrs A needed. He added that the staff nurse said 'there is all your orange juice', banged the jug down in the blazing sun and left the room.

8. On a later occasion, Mrs A was given two suppositories to help her bowel movement. But the staff nurse made no arrangements for her to be accompanied along the corridor to the lavatory and when she needed to go there she was left to make her own way. When a bath was run for her immediately afterwards, the staff nurse told her to 'get on with it' and Mrs A was left in the bathroom on her own without medical supervision and without being informed of the whereabouts of the emergency bell. Mrs A subsequently found the bell to be on a window ledge some distance from the bath. She told my officer that the latter incident occurred on the first occasion she visited the bathroom while she was in hospital.

9. On yet another occasion, she asked for pain killing tablets and had to make three requests, one to an agency nurse and two to the staff nurse before they were given 45 minutes later.

10. I have had some difficulty in establishing when these incidents occurred. Mr A stressed that at the time of all the alleged incidents there was only one other patient on the ward and that there were three nurses on duty. In his letter to the AHA Mr A said that all the incidents happened three days after his wife's operation. Subsequently, Mrs A told my officer that the incidents about the lavatory and bath occurred on Thursday 13 September and the orange juice incident on Saturday 15 September. According to the duty roster however the staff nurse was not on duty on the ward on 13 September and there is no reference in the nursing notes

to Mrs A taking a bath that day. It is recorded that she had a kneeling bath on 14 September and a full bath on 15 September.

11. The staff nurse told my officer that she believed that a patient in Mrs A's condition might reasonably be expected to use the bathroom unaided by the fifth day after her operation and she said the whereabouts of the bell would be explained the first time a patient used the bathroom. The staff nurse could not specifically remember saying 'get on with it' but thought she might have done. She could remember nothing at all of significance about either the incident with the orange juice or the request for pain-killing tablets. She remembered Mrs A as being a patient who was very 'up and down' after her operation and with whom, she conceded, she might have been more tactful. She did not again nurse Mrs A after the incidents but remembered meeting her just before Mrs A's discharge when Mrs A was very friendly and put her arms round her. Mrs A did not recall this incident.

12. My officer also discussed these complaints with the sister normally in charge of the ward and a second staff nurse who frequently nursed Mrs A but neither of them was on duty when the incidents occurred. A nursing auxiliary who was on duty could remember nothing of significance. The agency nurse mentioned by Mrs A has returned home to an unknown address in Malaya and I have been unable to obtain any other first-hand evidence of the incidents. The NO agreed that Mr A complained on 15 September to her about the orange juice and about his wife being left in the bath and the NO recalled that at that time, the staff nurse admitted forgetting that the patient was in the bath and that she remembered the staff nurse apologising to Mrs A there and then. The NO told my officer that she had suggested to the staff Nurse that it might be better if she did not again become involved with nursing Mrs A, but the NO had taken no further action on the complaints which had seemed trivial to her at the time. The NO said that on the following morning, 16 September, Mrs A talked to her again about the orange juice incident and she remembered the duty doctor seeing her again that day. The nursing notes do not mention the incidents but the medical notes for 16 September include the entry 'V. upset concerning alleged insult from member of nursing staff; . . .'.

13. My officer saw that the bathroom, the only one on the ward, was some 10 yards along the corridor from the room Mrs A occupied. The call bell was a mechanical type, in a portable wooden frame, which sounded only within the bathroom.

Findings

14. I have no doubt that events occurred substantially as described by Mr and Mrs A. Although I cannot be certain about the date on which Mrs A was left unattended in the bathroom it could not have been later than Saturday 15 September, the fourth day after the operation. And even if it was not Mrs A's first visit to the bathroom, it was quite wrong that she should have experienced doubts about assistance from the nursing staff and that she was left unaware of the means of summoning their help. I hope too that the AHA will quickly arrange for the installation of a proper electric call-bell.

The bed occupancy figures show that there were only two patients on the private Ward on 15 September but the three staff on duty had also in their care the NHS patients in the ward above. I uphold the complaint that there were shortcomings in the nursing care Mrs A received, and that the attitude of the staff nurse did not reach the standard any patient, private or NHS, was entitled to expect.

(c) *Medical care*

15. Mrs A said that until Friday 14 September she was happy with the medical care she received because her doctor visited her every day. The senior house officer (the first SHO) of the consultant's 'firm' visited her at noon on 14 September and again at 10.45 pm on Sunday 16 September. She was concerned however that there was no attention in this interval since, by the time of the first SHO's second visit, her wound had become infected and this prolonged her stay in hospital. She believed the first SHO said 'What the hell has been going on over the weekend?' on his second visit. She did remember that a different doctor visited her on 15 September but he merely put his head round the door and did not medically examine her; she thought however that he had nothing to do with her case but was the on-duty doctor for the whole hospital.

16. My officer established that the latter doctor was also a senior house officer (the second SHO) and that he was the doctor on duty that weekend who was not then a member of the consultant gynaecologist's 'firm'. The second SHO said, in written evidence, that he first met Mrs A during his ward round covering the entire hospital. As she was not complaining of undue discomfort he did not deem it medically necessary to examine her at that time. But he recalled three further visits to her over the weekend; he said that they were not primarily of a medical nature but were prompted by Mrs A's dissatisfaction with non-medical aspects of her stay in hospital. He satisfied himself that there were no medical complaints and that the NO was dealing with the other matters. He said that when he saw Mrs A on 16 September he found her to be emotional and weeping and that she was considering taking her own discharge. He therefore telephoned her consultant gynaecologist (the consultant) who suggested that the wound clips be removed and that she be allowed home if that was her wish. The second SHO said that Mrs A was so informed but her husband thought that she should not leave until the consultant had seen her. The second SHO said the wound clips were removed the same day and it is recorded in the nursing notes that the wound was well healed except for a minute area in the centre from which there was very slight oozing. A saline bath was given that evening. The second SHO remembered discussing the case with the first SHO who examined her the same night. I have seen that all of this is supported by the entries in the contemporaneous medical notes.

17. The consultant said that he himself saw Mrs A every day during her stay in hospital except during the weekend. He recalled the second SHO telephoning him at home then. He said that the normal stay for Mrs A's type of operation was at least eight days and he warned her of possible infection before she entered hospital. Such infection was a known, though

uncommon, reaction to her operation. The first SHO could not remember the case when my officer approached him about it.

Findings

18. It was for the second SHO to decide, in the exercise of his clinical judgment, the extent to which he should examine Mrs A during that weekend. That is not a matter I can question. I suspect that the remark of the first SHO which Mrs A recalled, related to the incidents I have already dealt with in paragraphs 7-14. But in any event I am satisfied that both the nursing and medical staffs were fully aware of Mrs A's condition during the period.

(d) *The condition of the ward*

19. Mr A described his wife's room as filthy and disgusting and in need of repainting. He instanced certain items as being particularly in need of cleaning, namely the curtains, the globe type lamp shade, the wash-hand basin and the door and door frames. He remarked that the side table should have been discarded for firewood years ago and that there was no carpet on the wooden floor. There was no radio in the room and, unexpectedly, he had to pay for television hire. Mrs A said that cleaners visited every day but did little and she saw no signs of supervision. Two men did arrive on her final day in hospital to clean the lampshades but their overalls were filthy. Mr A also expressed his concern that there was only one bathroom and one lavatory for 'seven wards'.

209. The rooms were redecorated in early 1980. When my officer visited the rooms some of the furniture had been replaced but he gained the general impression that the furniture was unmatching and of a general utility type; only the bed looked relatively modern. The district domestic services manager strongly denied that the room would have been as dirty as Mr and Mrs A described although she said that because the fixtures and fittings were so old it was impossible to make them look clean however hard her staff tried ; there was also the problem caused by the dirty atmosphere in the locality. She remembered specifically that her deputy cleaned the light shades – although technically the job was one for the maintenance staff – and denied that he ever wore dirty overalls.

21. The consultant said that he used the room for his patients quite a lot and had had complaints about the furniture and fittings previously ; but that they had not been made as strongly as Mr and Mrs A had put them. Mrs A believed that the conditions might in some way have caused the infection to her wound but the consultant told my officer that this was not the case. There had been no problems with infection in other patients which he could specifically relate to the conditions in the ward.

22. The then unit administrator in an internal minute which formed the basis of the AHA's substantive reply dated 25 January 1980 to Mr A said that the toilet and bathroom facilities were for seven *rooms* not wards and that radio headsets were one of several electrical improvements which one would wish to see incorporated in an upgrading scheme. I was informed that financial constraints prevented that upgrading at present although the present unit administrator told my officer that some NHS wards had been

upgraded and that it was accepted that the conditions there were better than in the private ward. The SNO too thought that upgrading was necessary in the private ward. I have seen that the leaflet 'Notes for the information of private patients' which I was assured was handed to all private patients at the hospital, made it clear that the patients were themselves responsible for settling hire charges for television sets and I know from other investigations that this is usual.

Findings

23. The lampshade did require cleaning and it has been admitted that the age of some of the fittings had the effect of preventing the room from looking clean and tidy. I believe however that Mr and Mrs A were overstating their case in describing the room as filthy and disgusting. The ward was dearly in need of redecoration since this was done four months after Mrs A's stay. It is also clear from the consultant's evidence that Mr and Mrs A were not alone in complaining about the furniture and fittings. The AHA accept that the ward needs to be upgraded but they have explained that financial constraints have prevented this. I am pleased to record however that the AHA have recently told me that it has been possible to allocate £1,200 for the purchase of replacement furniture on the ward during the current financial year. I think it entirely reasonable for a private patient to expect a headset for radio (and I understand that many NHS beds at the hospital *are* so provided) but I do not uphold the complaint of failure to provide a television set. I now hope however that Mrs A will accept the consultant's considered view that the condition of the room did not in any way cause the infection to her wound.

(e) *Food*

24. Mrs A said that the food was so appalling that she ate almost nothing other than cheese and biscuits and food brought in from outside. She told my officer she believed it was the cooking rather than the distribution that was at fault and recalled shrivelled chops and side salads served on paper plates. She complained direct to the catering manager whom she met by chance when he visited the ward on another matter approximately ten days after her operation, but noticed no subsequent improvement.

25. The catering manager said that he visited the ward to see Mrs A at the sister's request and not by chance. But he felt, after speaking with the patient, that her complaints related not to the cooking – which was his responsibility – but to the presentation of the food by the nursing staff. As Mrs A mentioned to him other problems unrelated to food, he decided that they were for the sister rather than himself and accordingly told her about them. He maintained to my officer his view that the cooking was not at fault; the food was certainly not uneatable when it left the kitchen. He said that he had every confidence in his chef and that he had received no other complaints of this nature. The duty doctor recalled that Mrs A had complained about the standard of food which he found to be surprising since in his experience it reached fairly high standards.

26. In the AHA's substantive reply to Mr A they said that they had recently carried out a detailed investigation into the catering service at the hospital which revealed that although the quality of food prepared in the kitchens was of a good standard there were problems in distributing it to the wards. The food was not always warm and was sometimes poorly presented when it reached the patient's bedside. The catering manager accepted that the present system of distribution to the wards was inadequate and had planned the introduction of a plated meals service to all wards in the hospital.

Findings

27. I believe that the complaint about the food was the result of inadequate distribution and presentation rather than of the cooking itself, but in any case I uphold it. I note that the plated meals service was implemented in the Spring of this year and that distribution and presentation is now the responsibility of the catering department. I trust that this has resulted in an improvement of the service in this respect.

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

28. Mr A said that on 15 September, while his wife was still in hospital, he met the NO and the second SHO together on the ward and he complained then about the lack of medical attention, the indifference of the staff nurse and the condition of the room. He felt the answers he was given were evasive and that the staff knew that what he was saying was correct. The staff nurse was called in to the meeting and said something to the effect that she had tried her best. Mr A subsequently put these points together with the other complaints I have investigated, in writing to the AHA on 25 October. He also withheld payment on his account for some £821 in respect of accommodation and service and, unwittingly, a further £60 for a minor part of the medical expenses. The AHA replied on 25 January 1980. But Mr A remained dissatisfied and wrote to me saying that the payment requested was excessive.

29. The NO remembered meeting Mr A on the ward on 15 September. She said that she had had difficulty in identifying the problem but the main issue seemed to relate to the staff nurse and she had suggested that the staff nurse should not again nurse Mrs A. The second SHO could not remember whether or not he was present at the ward meeting but he has confirmed that he was certainly aware, that weekend, that Mrs A had complained about the way the staff nurse had treated her and he had concluded that there had been a clash of personalities.

30. I have seen that when the AHA received Mr A's written complaint the then unit administrator obtained comments from the consulant, the SNO, and the domestic services and catering managers, and that in their reply the AHA admitted the deficiencies to the degree I have myself identified. In their substantive reply the AHA made no reference to the reception facilities but they accepted that the physical state of the ward left 'much to be desired'. They said that prior to painting, the state of redecoration was 'certainly poor', that some of the furniture 'ought to be replaced' and

that they intended to introduce radio headsets and to increase the provision of sanitary facilities as part of the upgrading scheme. As for cleanliness, they made the point that some of the surfaces *appeared* dirty and instanced the wash-hand basin which was cleaned regularly but was discoloured due to cracks in the glazing. Their reply referred also to the intention to introduce a plated meal service and accepted that there were grounds for criticism for the way certain members of the nursing staff had treated Mrs A. The letter referred to the financial constraints which prevented remedying immediately the shortcomings in the fixtures and fittings and offered to Mrs A sincere apologies for those facilities and elements of nursing care which were unsatisfactory.

Findings

31. Mr A was right to raise his complaints while his wife was still on the ward. I am satisfied that the NO and the second SHO were concerned primarily to help Mrs A there and then. I have seen that the consultant offered to discharge Mrs A on 16 September but in the event she decided to remain. I think that the problems regarding the staff nurse were sensibly resolved. It is less satisfactory that Mrs A found there was no improvement in what she felt were serious inadequacies in the cleaning of her room and in the catering. I have seen that the catering manager was himself involved (paragraph 25) but the domestic services manager told my officer that it was a pity Mrs A did not bring the problems to her attention at the time. Rather, I think, the NO should have done this when Mr A had raised the complaints on the ward.

32. When Mr. A's written complaint was subsequently received the AHA's investigation was thorough and the reply was full and contained an apology for frankly admitted shortcomings. However, as regards nursing staff attitudes, the reply stated that the senior nursing officer had pointed out in no uncertain terms to the individuals concerned that there were grounds for criticism and added that the nursing staff had been reminded about the importance of informing patients of the location of the emergency bell. The evidence my officer obtained shows that the senior nursing staff in fact took the incidents rather less seriously than the AHA's letter implied, in that there was no follow-up action after the meeting on the ward. There was an obvious misunderstanding on this point. The AHA's reply also implied that nurses other than the Staff Nurse were involved but I have found no evidence that this was the case.

Conclusions

33. With the exception of the complaint about medical care (paragraphs 15-18), Mr and Mrs A were justified in complaining to me. I have been critical of the staff nurse and I record that she has now retired. They thought that the conditions of the ward should have been reflected in the accommodation and services charges they were asked to pay but I know that private patients' charges for National Health Service (NHS) hospital accommodation are designed to reflect the full cost of providing hospital in-patient services and are determined nationally by the Secretary of State.

The relevant legislation provides no basis for the widely-held belief that a higher standard of hospital facilities and accommodation should be provided for private patients than for NHS patients. I quite see the desirability of that arrangement. But it presupposes that a certain standard of private accommodation and service will be maintained by hospitals offering admission as a private patient and that that standard will match more or less the payment demanded for it. When, as I here find, the mismatch between the accommodation and service offered and the payment demanded is too great to be tolerated, it verges on the dishonourable to offer admission as a private patient in the first place: one is offering a service which one knows one cannot deliver. I make no observation one way or the other about the desirability of private practice within the NHS, since that is none of my business. What I do say is that it is morally wrong to offer for sale goods which one has not got.

34. It follows that I am disturbed about this case. It has not been denied that Mrs A's private room needed to be upgraded and that the facilities were less than those on some public wards. I am glad to note that the AHA have already given full apologies for these shortcomings but I do not think that is enough. This is an appropriate case for the AHA to make a reasonable payment to Mr A in respect of the failure in service provided for his wife and for the modest solicitors' charges which he incurred. I am glad to say that the AHA have told me that, exceptionally, on the basis of the facts of the case, they accept that they should make a payment to the complainants. They have said that they will be getting in touch with Mr and Mrs A about this on the near future. I hope that they will, as I do, regard this as a satisfactory outcome to my investigation.

Case No. W.153/80–81—Care and treatment following fall and subsequent hip replacement operation.

Complaint and background

1. The complainant's mother, aged 84, was admitted to a ward (the ward) of a hospital (the hospital) on 21 October 1979 following a fall at her home and on 23 October she had a hip replacement operation. She remained an in-patient until her death on 28 December, the main cause of which was stated in the *post mortem* (PM) report to have been 'Septicaemia due to (or as a consequence) of infected bed sores, due to (or as a consequence of) fracture neck of the left femur' and that 'acute-on-chronic bronchitis' was another significant condition contributing to death; furthermore that 'the fracture of the neck of femur was a factor in death'.

2. The complainant complained on behalf of herself and her sister to the Area Health Authority (the AHA) and, being dissatisfied with the outcome, she then complained to me. She was told that I could not investigate matters which in my opinion arose solely from the exercise of clinical judgment but that I would investigate her complaints that:—

(*a*) the patient was not adequately observed or attended to, in that bed sores which developed became infected and contributed to her death,

and that the development of bronchitis and ulceration of the operation wound were not noticed or treated;

(*b*) nursing staff failed to keep medical staff properly informed of her mother's condition and, in particular, did not notify a doctor when she vomited blood on 23 December;

(*c*) her mother became under-nourished because nursing staff took no action to help her to eat or drink;

(*d*) throughout the period that her mother was an in-patient neither nursing nor medical staff provided the complainant with adequate information about her condition and treatment and, in particular, she was not advised of the severe deterioration in her mother's state of health; and that

(*e*) the AHA failed to deal with her complaints satisfactorily.

Investigation

3. I have examined relevant documents from the AHA including the medical and nursing notes. My officer interviewed the medical, nursing and administrative staff concerned and she also met the complainant and her sister. The complaints made to the AHA and to my officer are summarised in the opening paragraphs of each section of my report.

(a) *The complaint that the patient was inadequately observed and cared for*

4. The complainant felt that the PM report showed that there had been neglect in the patient's care and she expressed the opinion that had it not been for the infected bed sores, some of which were deep and had exposed the bone, her mother would have lived. She said that about three weeks after operation the patient had been nursed on a water bed for about a week and had then gone back to an ordinary bed as she was active, and that it was not until 23 December, that her mother was nursed on a 'ripple' bed.

5. The complainant said that about half way through her mother's period in hospital she had helped to nurse her and the operation scar had then been perfectly healed and she wondered whether the ulceration referred to in the PM report had been reported to medical staff. She also wondered whether the acute-on-chronic bronchitis had been recorded in the case notes. Finally she expressed her concern that the standard of care on the ward had been affected by the employment of high numbers of nursing auxiliaries and agency staff. She stressed to my officer that she was not saying that her mother should not have died, but that the manner of her death was wrong. She also said that the nurses had always been very kind to her and her sister.

6. When putting her complaint to the AHA, the complainant asked (i) when the bed sores had started to develop ; (ii) when they began to deteriorate and (iii) when they became infected. In his reply the area administrator (the AA) said that the nursing records indicated the development of pressure sores on 28 October but that it was difficult to say when deterioration began as body tissue was known to devitalise from the time of an injury and the period during which the patient was lying at home had to be considered as a con-

tributory factor. The AA said that the consultant orthopaedic surgeon responsible for the patient's care (the surgeon) had advised him that pressure areas began to develop soon after surgery but he had also stated that on 19 December they were clean with no apparent deep-seated infection and that he had approved the orthodox therapy which the patient had received. She had been placed on a water bed but as she had been improving and was able to walk this was later considered unnecessary. The AA further said that when on or about 23 December it had become obvious that she was deteriorating, she was moved into a side ward and placed on a 'ripple' bed. The advice of the consultant pathologist (the pathologist) (who had conducted the post-mortem) was that the onset of septicaemia would have been very rapid and was likely to have been part of the terminal stage of the patient's illness. The pathologist had also advised him that acute-on-chronic bronchitis meant chronic bronchitis exacerbated by acute bronchitis and that the latter condition, like septicaemia, appeared to be a terminal phenomenon.

7. The AA told the complainant that neither of the ward sisters could recall an infection and no opening of the wound had been recorded by nursing staff when dressing the pressure sores during the days preceding the patient's death. The AA said that, on average, there were about 8 trained nursing staff and 6 auxiliaries on the ward and that because of recruitment problems between 6 and 8 agency nurses had to be used. These nurses, he said, provided some continuity in that they often worked for the same hours on the same ward but as their hours differed from those of hospital staff it would have seemed to the complainant that in the evenings and at visiting times there were more auxiliary than trained staff. The AA said that the previous complaints about bed sores had not gone unnoticed and effective measures had been taken to monitor the level of the problem within all wards of the hospital.

8. In his interview with my officer the surgeon confirmed his statements to the AA (paragraph 6) and added that he had also seen the patient on 24 December and had not then thought that she was deteriorating. He said that although deep, the sores were clean. The bone was visible but this was not in itself unusual as the patient had been a thin person. With regard to the bronchitis he said that he had not gained the impression that she was particularly 'chesty', and neither had the physiotherapy staff to whom he spoke after the PM. He said that he could not explain the reference to an ulceration of the operation wound, as he would have expected an infection to have occurred within two weeks of the operation and it had been intact on 21 December.

9. The pathologist confirmed to my officer that he had given the advice to the AA mentioned in paragraph 6 and that although he had carried out about a thousand post-mortems a year this was the only one in three and a half years in which he had given septicaemia due to an infected bed sore as a direct cause of death. He described the septicaemia as a terminal phenomenon and emphasised that in the elderly the onset could be extremely rapid. He told my officer that bed sores were fairly common but it did not make sense to say that they indicated a lack of care because when someone was bedridden it was very difficult to prevent sores.

10. The patient was also examined by a consultant physician geriatrician (the physician) who told my officer that he undertook a weekly ward round to advise junior doctors on the medical care of orthopaedic patients, and that he also took part in the weekly case conferences which had been introduced in November. He said that he had first seen the patient on 19 November and that although she was walking with the help of a physiotherapist she did not seem to have the will to regain her previous physical state. I have seen that it was agreed at a case conference on 4 December that 'we ought to be able to get her home', but that a further entry in the case notes on 11 December reads:– 'Can walk on her own [with] Zimmer but refuses for most part.... We seem to be losing the battle'. The physician said that the patient was apathetic and resigned and by 18 December she could not be discharged as her nursing problems required professional care.

11. In his comments on the bed sores the physician pointed out that there had been a period of 36 hours between the patient's accident and her admission. She was dehydrated and her operation had been deferred for two days whilst her condition improved. The physician added that the patient's sacral sore should have begun to heal but it was inhibited because she was refusing to eat and had no motivation for physiotherapy. He said that it was difficult to comment on the onset of infection but added that there was nothing in the PM report to indicate long-standing septicaemia. It was clear, he said, that when the process of death began some time after 24 December, the patient suffered a rapid deterioration, and he regarded the bronchitis as part of the process of dying and the ulceration of the operation wound as a *post mortem* change.

12. The senior ward sister (sister A) told my officer that the pressure sore first recorded on 28 October was treated in the orthodox way. She said that when she had last seen the sores, on 21 December, they were clean and the operation wound healed. She added that she would not have thought the patient had had bronchitis; her chest was x-rayed on admission and the physician had examined her thoroughly. The junior ward sister (sister B) told my officer that the patient had been incontinent and she thought that the pressure sore may have developed because she moved about wet in bed. She said the patient had been put on an air ring to relieve the pressure but she kept throwing this out of the bed and that she had then been transferred to the water bed. Sister B recalled that 3 or 4 weeks after the operation the patient's pressure sore, although very deep, had started to heal but her mood changed and the sore deteriorated. She said that she had ordered a 'ripple' bed on 24 December and that she did not think the sore was infected when she examined it that day. She had not considered the patient to be bronchitic, and as she had been nursed on alternate sides this might have made the operation wound red and the PM could have discoloured it further.

13. A staff nurse (staff nurse A) told my officer that initially the patient's sores were treated by a saline bath in the morning and dressings morning and evening. She had been turned 4-hourly, then 2-hourly and the sores were dressed at the same frequency, but when she became incontinent they were changed more frequently. Staff nurse A thought that the incontinence probably caused the infection; in her view the cure for bed sores depended on a good

nutritional state, regular turning and a feeling of well-being. She thought that everything possible had been done for the patient but her only response was 'Leave me alone. I want to die'.

14. My officer interviewed fifteen other members of the ward nursing staff. Their evidence was that the patient's pressure sores were bad but had been treated regularly and when she became incontinent the dressings had been changed and that she had become depressed and had lost the will to live. Both the day and night nursing officers told my officer that they had examined the patient and had been satisfied that the bed sores were clean and that appropriate treatment was being given. None of the staff interviewed could recall an ulceration of the operation wound nor could they remember the patient developing a serious chest infection. I have seen from the nursing records and the ward dressing book that nursing staff were fully aware of the sores and that directions for regular treatment were given.

15. In response to the complaint the AHA chairman (the chairman) asked the area nursing officer (the ANO) to visit and assess the ward. I have seen that her report of her visit on 5 February, refers to visits which she had made over the previous three months and says that she was particularly disturbed because on a visit in October she had enquired into the incidence of bed sores following an earlier complaint and had discussed ward record keeping and management with the local senior nursing staff, but that since then the position had obviously deteriorated. She said that with the regional nursing officer she had also paid a night visit to the hospital on 18 January ; when they had then asked about pressure areas they had been told that it was not a cause for concern and on this and on another occasion on 21 January, she had accepted similar misleading assurances and had not made a personal inspection. The ANO told my officer that on her visit on 5 February however she had made a personal examination of all patients' pressure areas, and she said that she felt that the philosophy of the ward, which was that pressure sores had to be accepted as a fact of life, had been wrong. In her report she had said that she had visited a comparable ward in another hospital within the AHA and found that the incidence of pressure sores there was neglible. The ANO said that the nurses in the ward were submerged under a workload which was far too large to manage. She did not believe that the patient had been neglected and she believed what was said by the ward sisters about her care. But she said that she was dissatisfied with the nursing records kept for the patient because they gave little idea of her true condition. She told my officer that since this complaint the whole philosophy of nursing management at the hospital had been changed and that bed sores were no longer accepted as inevitable and that they had 'gone to town' on record keeping and patients' care charts. She was of the opinion that the complaint had brought the need for changes at the hospital sharply into focus and had precipitated the changes required.

16. The chairman told my officer that when he received the ANO's report he decided that he and another member of the AHA should make a personal investigation. On 21 February they issued their interim findings in the form of a press release which, after referring to this particular case, said that they had visited the ward and talked to the ward sisters who

without doubt had many problems. They said that there was no balanced nursing team owing to difficulties of recruiting nursing staff and that the ward had maintained an adequate number of nurses in the daytime only by the employment of agency nurses. They recommended that the number of beds in the ward should be reduced. Their statement added that the nursing sisters and staff were coping as best they could in the difficult circumstances but that the number of patients suffering from pressure sores had from time to time reached unacceptable levels. They considered that changes in nursing planning were also necessary. A copy of this press release was sent to the complainant.

Findings

17. I am in no doubt that the nursing staff on the ward were overwhelmed by the load of work confronting them and its management left much to be desired. The regime for the prevention of bed sores was inadequate in that their inevitability was passively accepted. To that extent I must find that there could have been a failure in care. But I believe that the patient was properly observed and otherwise reasonably cared for within the limits of available resources. I welcome the very necessary steps taken by the AHA to remedy the unsatisfactory situation revealed on this ward. Nevertheless, all medical evidence given to me confirms that the onset of septicaemia was very rapid and would be a terminal phenomenon, as was the acute bronchitis. The PM report should be viewed in the light of this evidence.

(b) *The complaint that medical staff were not kept properly informed of the patient's condition*

18. The complainant's sister said that when she visited her mother on Sunday 23 December she found her in a very distressed condition, vomiting blood and that although this incident was not apparently reported to a doctor they assumed that this had led to her being moved into the side ward and on to a 'ripple' bed. The AHA interpreted this complaint as being solely about the move into the side ward and the AA replied that 'the case sheet, nursing [record] and nursing statements give no indication that the move was reported to medical staff, however, a change of location would have been self-evident to any examining doctor.'

19. The physician told my officer that there was ample opportunity for medical staff to keep themselves properly informed. The surgeon said that his ward round took place on Wednesdays, those of his senior house officer on Mondays and Fridays, and that the house officer (the HO) was available on the ward all the time. The surgeon agreed that if the patient had vomited blood on 23 December it would have indicated a fresh development which should have been investigated but he said he was sure that if there had been a considerable quantity the nurses would have called a doctor. He pointed out that no rupture of a major blood vessel had been noted on the PM report. The senior nursing officer (the SNO) told my officer that there was a good relationship and frequent communication between the nursing and medical staff and that the HO, who was on the ward each day, would have kept the senior house officer and the consultant

informed. Sister B, who was on duty that afternoon said that she had been called to see the patient but she did not remember her having vomited or being told that she had and she thought that the patient had probably been wet or needed turning. She said that as the patient did not look well she had decided to move her to the side ward. She added that, in her opinion, it was not always necessary to call a doctor if a patient vomited but if there was somehting unusual one would be summoned straight away. None of the other nurses interviewed could recall what happened that afternoon. Both ward sisters confirmed that the patient's condition had been discussed frequently with medical staff and at case conferences.

20. I have seen that the medical and nursing records of 23 December contain nothing about this incident but they do confirm that the surgeon examined the patient on 24 December. Sister B's entry in the nursing record for 23 December reads 'poor day, condition deteriorating: relatives informed. Please continue 2 hourly turns'.

Findings

21. I have no doubt that the patient was found by her daughter on 23 December in the distressed condition that she described, and that she called attention to it. Sister B in deciding whether or not to call a doctor and what to record in the notes, was exercising her professional judgment which I may not question. However, I am satisfied that the doctors were aware of the patient's condition from their own observations and from the nurses' reports and I do not uphold the complaint that they were not kept informed.

(c) *The complaint that nursing staff did not help the patient to eat or drink, which led to her becoming under-nourished*

22. The complainant and her sister felt that their mother had lost much weight whilst an in-patient and they were concerned that the PM report described her as poorly nourished. They said that they had never seen nurses attempting to feed their mother (or other elderly patients who could not help themselves): they would just put the food in front of the patients and leave. The complainant said that even towards the end of her mother's life, when her teeth were loose due to loss of weight, no help was offered. The AA told the complainant that some loss of weight would have been normal after the operation but that the patient's continued loss had been due mainly to her reluctance to eat and drink. This reluctance had been well documented in the nursing records and had also been noted by other patients.

23. The physician told my officer that every effort had been made to feed the patient and that he was quite sure that had she wanted to get better she would have been eating and drinking. The doctors were aware that her protein level was falling and of the problems that this might cause with her pressure sores but none of them was prepared to force feed a patient of her age. The surgeon also confirmed that nursing staff had done their best to encourage the patient to eat and drink. The HO told my officer that in his opinion had there been more trained staff on the ward more time might have been available to encourage the patient. But he stressed that she could not have been

forced to eat and that it was his impression that she had lost the will to live; he vividly remembered remonstrating with her about her failure to co-operate in her treatment.

24. Sister A told my officer that all the nurses had encouraged the patient to eat and drink as much as possible; sometimes she would take a semi-solid diet but if she did not then a proprietary food drink or egg and milk would be prepared. Sister B told the AHA that the patient had had periods of considerable confusion after her operation and fluids were given intravenously, although she had pulled out the cannula a number of times. She told my officer that although the complainant's mother was a difficult patient who spat out food and fluids and hit the nurses who tried to feed her, she clearly remembered nurses sitting with her for between 30 minutes and an hour trying to encouraging her to drink. She remarked that because patients tend to take fluids and food better from relatives the nurses would leave it to them when they were present. Both staff nurses confirmed that great pains were taken to encourage the patient to eat and drink but said that nurses could not force her to do so. The other ward staff interviewed also said that the patient had been encouraged and had even been asked whether there was anything in particular she would like them to prepare but there had been no response. The nursing records and the statements made by the nurses during the AHA's investigation indicate that throughout the patient's stay the staff were conscious of the importance of her fluid intake but had encountered reluctance on her part to co-operate.

Findings

25. The records and the clear recollections of the staff leave me in no doubt that the patient was encouraged to eat and drink but that she had little desire to do so. I do not uphold the complaint that she was undernourished because of any failure by the nurses.

(d) *The complaint that adequate information about the patient's condition, treatment and deterioration was not provided*

26. The complainant and her sister said that they had not known the nature of their mother's illness until the inquest and they felt strongly that they had not been properly informed. Although one of them saw her each visiting time, and also at lunch time when she was particularly ill, the nursing staff had not approached them or volunteered any information other than that she was making no effort to walk and should try to eat and drink more. The nurses had never indicated that she was seriously ill, not even on the evening of her death. The complainant said that they had received no information from the doctors until she made an appointment to see the surgeon and that at the interview with him on 21 December, he had said that the operation had been a complete success and that the patient had been walking. They had discussed the pressure sores but the complainant gained the impression that he did not regard them as of any consequence. Possible arrangements for hospital discharge were also discussed and there was no hint that she would not make a full recovery. The complainant and her

sister were also concerned that they had not been advised in detail of the need for, and outcome of, the physician's assessment which had been made.

27. The AA told the complainant that although the surgeon agreed that he had told her that the operation had been successful he was sure he had not given the impression that the pressure sores were of no consequence. The AA said that the surgeon had not felt very optimistic about the patient returning home and in discussing her discharge arrangements had suggested that the most likely alternative was long-stay accommodation in another hospital. The AA said that the surgeon had told him that it was normally impossible to make dogmatic statements about life expectancy but that, although he had considered that the patient had been deteriorating progressively, up to 21 December there was no indication that death was imminent. The AA said that the recollections of the staff and the notes made in the nursing record indicated that the nurses had kept them informed and in particular that the complainant had been informed of her mother's deterioration on 23 and 26 December. He said he was advised that signs of ultimate deterioration might not have been apparent prior to her arrival during the evening of 28 December but it continued while she was present. The AA said that information from the physician would have been included in discussions between other medical staff and herself.

28. The surgeon told my officer that although he tended to leave liaison with relatives to the ward sisters he was always happy to interview them on request. He said that so far as he was aware prior to 21 December the relatives had been kept informed about her condition and he thought that the interview had been requested then because the complainant thought that her mother was going home. That had not been suggested and he said that he told the complainant that a period in a local authority home was probably appropriate. He had explained that the patient had not maintained her initial progress and that her condition was static. He had not tried to hide the fact that she had pressure sores or that he was not happy about them. He told my officer that he had certainly not expected the patient to die during the following week. The HO told my officer that although he could not recall speaking to the complainant in any detail about her mother he thought that he had explained that she was not walking, eating or drinking and that it would help if the complainant could talk to her, and encourage her to take nourishment. The HO said that medical staff tended to rely on the nurses to communicate with relatives but he stressed that any of the doctors would have spoken to the complainant and her sister if they had been asked.

29. Sister A told my officer that she and her staff were always available on the ward to answer relatives' enquiries and would on request arrange interviews with medical staff. She said that whenever the complainant or her sister visited they went to the sister's office to talk about the patient and they also telephoned the hospital regularly to ask about her. She said that she remembered the patient being very ill after the operation and, thinking that she might die, she had contacted the relatives and asked them to come to the hospital. She also recalled seeing them after the surgeon had completed his first ward round when she explained why the physician was

involved. She had talked in detail about the patient's unwillingness to do anything, or to eat and drink, and about her deteriorating mental condition. Sister A said she felt sure that she had discussed the pressure sores with the relatives but would have been unable to prepare them for the patient's death as, when she went off duty on 21 December, she had not expected her to die.

30. Sister B told my officer that normally when a patient was admitted the nurse in charge would explain to relatives the nature of the operation, that an elderly patient would be likely to be confused, and the probable length of the recovery period. (Neither sister could recall this explanation being given to the complainant or her sister.) Sister B continued that if a patient deteriorated the nursing staff would try to see the relatives. As the patient was confused for longer than was usual after the operation, would not eat or drink, and had taken a lot of persuasion to walk, she was sure that several nurses would have seen the complainant and her sister, particularly as the complainant regularly visited at lunch times to help feed the patient. Sister B was certain that she herself had discussed the patient's problems with her relatives but she could not recall discussing the pressure sores. She remembered telling the complainant's sister on 23 December that the patient was deteriorating and that they would move her into a side ward where it would be more peaceful and where it would be easier for her and her sister to stay night and day. On 24 December she thought that the complainant and her sister had asked how long their mother was expected to live and she had explained that she could not say but her mental condition was not improving and, until it did, her physical condition would not improve either. Sister B said that she could not remember seeing the relatives on 27 December but that it would have been very difficult for the nurse in charge that evening to assess whether the patient was dying as her condition fluctuated so much. She said that there had been occasions when she thought the patient would not last many hours and the next day she had been bright and alert.

31. Staff nurse A told my officer that she was surprised at the suggestion that the relatives had not been properly informed about her condition as she had found the complainant to be very enquiring and that she always tried to be honest with her and her sister. She said that the nurses were faced with the sensitive problem of how to explain that the patient was not trying, and had no desire to get better but had told her relatives that she was not well and it did not look as though she would improve.

Findings

32. I can well understand that on seeing the PM report the complainant may have doubted whether she had been told the truth about her mother's condition. However I am satisfied that the nursing staff kept her as fully informed as they could and that she had ready contact with junior doctors. When she asked to see the surgeon arrangements were promptly made and I am sure that any other similar requests would have been met. It is clear that the rapidity of the patient's final decline surprised those looking after her. Accordingly I do not uphold these complaints.

(c) *The dissatisfaction about the way in which the complaint was dealt with*

33. From the documents supplied to me by the complainant and the AHA I have seen that following the PM and on her solicitor's advice the complainant expressed on 1 February to the local evening paper her dissatisfaction with her mother's care. When the AHA were told this by the newspaper they immediately arranged for the hospital's assistant sector administrator (the ASA) to visit the complainant and her sister on 4 February. The ASA drew up a draft statement of complaint which was sent on 6 February to the complainant who, after consulting her solicitor, approved it with some slight amendments. This agreed statement specified 21 items of concern to the complainants which were sent to the surgeon, the physician and the division nursing officer (the Div NO) for their comments. The surgeon and the SNO wrote in reply to the ASA, while the physician discussed the complaints with the chairman. The chairman arranged to discuss with the Area team of officers the form of reply to the complainant and he asked the ANO to visit and assess the ward.

34. In the meantime the complainant had also complained to her Member of Parliament who wrote to the AA and to the Minister of Health. The regional administrator (the RA) of the Regional Health Authority, having seen the report in the press and because of enquiries from the Department of Health and Social Security (the Department), also enquired of the AHA. In addition the chairman and one of his member colleagues conducted their own investigation. The chairman told my officer that he and his colleague had been concerned about whether the case was symptomatic of the standards of nursing care in the hospital or was an isolated case.

35. The chairman sent the Member of Parliament a copy of the press release about his report (see paragraph 16) and a copy was sent to the complainant and to the RA who informed the Department. The complainant took exception to some of the comments made in the chairman's press release about her mother and her care and as a consequence raised four more questions with the AHA. On 26 March the chairman and his colleague presented a substantive report of their investigation to the AHA ; this gave an assessment of the difficulties faced by the hospital and made recommendations which would help to resolve them. I have seen from the minutes of AHA meetings and from the evidence given by senior nursing and administrative staff that those recommendations were subsequently put into effect and that the number of beds on the ward have been reduced, staffing levels have been improved, and changes in ward management have taken place.

36. A meeting attended by senior members of the medical, nursing and administrative staff took place on 1 April to formulate a reply to the complainant and on the basis of that meeting, and of the enquiries made by the ASA and the chairman, the AA sent a comprehensive reply to the complainant on 2 April. Copies were sent to the RA and the Department, and the chairman sent a copy to the Member of Parliament.

37. That reply of 2 April, to which I have referred in paragraphs 6, 7, 18, 22 and 27 contained detailed answers to the complainant's questions and suggested that if she required clarification or further information a

meeting with hospital medical and nursing staff would be arranged. She had wanted her solicitor and a representative of the local press to be present at such a meeting, but the AA said that he could not agree to the press being present. No meeting was held and the complainant referred her complaints to me, saying that in doing so she wished to 'preserve and protect [the NHS] in which I have every faith despite my mother's awful death'.

Findings

38. When the AHA became aware of the complainant's concern they took prompt action. Their investigations into the complaints were thorough and conscientiously carried out. After careful consideration of the outcome a detailed reply was sent to the complainant. I do not therefore uphold this aspect of her complaint.

Conclusions

39. I have set out my findings in paragraphs 17, 21, 25, 32 and 38 of my report. The complainant had some reason for her concern and I hope that she will derive some consolation from what subsequently happened. As a direct result of her complaint impetus was given to improvements in the management, staffing and conditions of the ward. She thus achieved her main aim and other patients will have gained the benefit.

40. But there were known deficiencies before this particular complaint was made and I cannot escape the conclusions that they could, and should, have been tackled at an earlier date with the vigour require to remedy such an unsatisfactory state of affairs. I am pleased to record now that I have received an assurance that close monitoring of patients' care is being maintained.

Case No. W.173/80–81—Delay in attending to a patient suffering from a subarachnoid-haemorrhage.

Background and complaint

1. The complainant's wife was taken by ambulance to the Accident and Emergency Department of a hospital (the A and E department) during the evening of Sunday 20 January 1980 after collapsing at home. Later the same evening she was transferred to another hospital (the second hospital) where she died on 22 January as a result of a subarachnoid haemorrhage.

2. The complainant said that:

(*a*) the duty casualty officer in the A and E Department (the casualty officer) did not attend the complainant's wife for 30 to 45 minutes after her admission and did very little for her in the four hours before her transfer to the second hospital; and

(*b*) the nursing care his wife received in the A and E Department was inadequate.

He complained to the district administrator of the health district (the DA) of the Area Health Authority (the AHA) and pursued his complaints with

the assistance of the Community Health Council for the area. But he was dissatisfied with the AHA's investigation and asked me to make enquiries.

Jurisdiction

3. At the outset the complainant regarded the failure to treat his wife as gross negligence but he assured me that he was not going to take any legal action arising out of the events of which he complained and on that basis I agreed to exercise the discretion given me under section 116(1) of the National Health Service Act and investigate his complaints.

Investigation

4. During the investigation I have obtained the AHA's comments on the complaints and seen their papers, including the clinical notes. One of my officers, sometimes in the company of another, met and discussed the case with members of the medical, nursing, administrative and ambulance service staff concerned. He also met the complainant and the secretary of the Community Health Council.

(a) *Medical care*

5. The complainant wrote to the DA on 12 February setting down the facts of his wife's treatment in the A and E department and asking for a full investigation so that no other patient or relative would suffer a similar experience. In his letter and a statement made to one of the DA's staff, which he confirmed in discussion with my officer, he said that he arrived at the Department shortly after the ambulance and gave his wife's details to a nurse in the reception area. He waited with his wife for about half an hour in a corridor, where she was left without treatment before being moved into a cubicle and examined by the casualty officer some 15 minutes later. During the four hours or so that she remained in the A and E department, she was seen about four times by the casualty officer and given two injections; after the second she was again left. The casualty officer asked her how she was and she said she was all right. But the complainant believed that she was not fully conscious during this time and that the seriousness of her condition was not recognised and treated; he commented that other patients who arrived after his wife were given treatment while she waited. He thought that the casualty officer was trying to call in the consultant in charge of the A and E department (the A and E consultant) but he did not come and that the transfer to the second hospital was primarily for diagnostic purposes. He could not understand why it was necessary to transfer her to another hospital some four or five miles away since, unlike the first one, it was not equipped for neurological cases. The complainant said that if his wife had received treatment while she was at the first hospital she might have been alive today. He wanted to ensure that no one else ever went so long without treatment.

6. In a formal reply of 6 August to the complainant the DA told him that the complainant's wife died of a subarachnoid haemorrhage and that there was no known treatment that could have prevented her death once

she had collapsed in the early evening. The casualty officer correctly sought to make her comfortable by the injections and arranged for the medical unit doctor (the medical SHO) to see her. The DA said that there was no record kept of the time the casualty officer saw her but she was booked in at 7.32 pm. one of three patients within ten minutes, and the first injection was recorded as given at 8.10 pm. The DA apologised that there was any delay at all when a patient was admitted to the A and E department. He did not think much could be done to obviate all delays but said that there was always a minimum of one qualified doctor on duty although in the evenings the demand varied greatly; even if money was available, recruiting enough doctors to ensure that there were two on duty in the evenings would be difficult.

7. The ambulance records which I have seen show that the ambulance which was called to take the complainant's wife to hospital as an emergency arrived at the hospital at 7.21 pm. The ambulance taking her to the second hospital is recorded as arriving at the first hospital at 10.17 pm and reaching the second at 10.34 pm. I have confirmed that the A and E department's history sheet records the patient's time of arrival as 7.32 pm. The time that the casualty officer examined her is not recorded, but it is noted that she was given an injection of glucose at 8.10 pm and an injection of Stemetil at 8.30 pm. The casualty officer recorded, without stating the time, that he had spoked to the medical SHO asking him to see the patient and advise; and a note signed by the medical SHO is timed to 10.00 pm. A summary compiled from the A and E department's records shows that between 7.32 and 10.10 pm there were nine other cases dealt with in the department, four of whom were atended to by the casualty officer treating the complainant's wife.

8. The ambulancemen who first took the complainant's wife to hospital confirmed in discussion with my officers the time of their arrival at the hospital and said that they were reasonably certain that the patient was taken into the examination bay in the A and E department and there transferred to a hospital trolley. They spoke to one of the nurses giving her the details of the case and their observations of the patient. The complainant thought that they had described his wife as 'rigid' when they took her from home into the ambulance but they had no recollection of using the term. The receptionist on duty in the A and E department at the time of the patient's arrival remembered nothing about the case but she told my officers that normally she would allow a patient a few minutes to settle before going to obtain details for the history sheet. The time taken to book in a non-emergency stretcher case was usually about five minutes from the time of arrival in the A and E department but, she said, eleven minutes (i.e. from 7.21 pm to 7.32 pm) was not excessive.

9. In a statement responding to the original complaint the casualty officer said that after the complainant's wife had been booked in with a history of headache, vomiting and collapse, he examined her at the earliest opportunity and found her to be conscious. Her general condition was found to be satisfactory and there were no signs of any neurological deficit, nor did systemic examination reveal any abnormalities. Following the second injection, in view of the symptomatology, the casualty officer said, he contacted the

medical SHO who examined her and arranged for her admission and transfer to the second hospital for investigation and treatment, as he thought she was fit to travel. The casualty officer added that the complainant's statement that his wife was left in the corridor for half an hour was not accurate. He said that it was out of the question to do anything for her until a firm medical diagnosis was made and that the complainant was wrong in thinking that active treatment at that stage would have changed the course of her illness.

10. The casualty officer told my officers that he could not remember the time at which he examined the complainant's wife. Based on the recorded time of the first injection, however, he estimated that he would have seen her probably between 7.50 and 7.55 pm and that this would have been some two or three minutes after being called; he remembered having to deal with four other patients around that time, all of whom required admission to hospital. The casualty officer thought that he called the medical SHO between 8.45 and 9.00 pm, having waited 15 to 20 minutes to observe the effect on the complainant's wife of the second injection. Had he regarded the situation as urgent he would have hastened the medical SHO's attendance, but he expected the nurses to observe the patient and to call him if her condition deteriorated. The casualty officer did not consider it necessary to call in the A and E consultant from home since the complainant's wife was conscious each time he saw her, which he thought was on three occasions at least.

11. The medical SHO made a written statement to the sector administrator at the end of March, saying that he saw the complainant's wife at the earliest possible opportunity and in view of her symptomatology thought it appropriate to observe her and investigate. Accordingly he arranged her transfer to the hospital 'on-take' in medicine that day (i.e. the one scheduled to admit patients from A and E departments to the medical speciality). In discussion with my officers he said he thought that he received a telephone call from the A and E department at about 9.00 pm and was told that the complainant's wife was fully conscious, having been admitted after collapsing and vomiting. He did not consider that the situation was very serious and his attendance was not hastened by the A and E department ; in those circumstances, he said, his normal response time would have been within 15-30 minutes. Based on the time he recorded in the notes, however, he thought that he must have arrived between 9.30 and 9.40 pm although he could not recall why it took him 30 to 40 minutes to respond. The medical SHO told my officers that he did not himself form a diagnosis of the patient's condition but, bearing in mind her previous medical history, he decided that she should be admitted to the hospital 'on-take' for further observation ; had there been any doubtful symptoms, he said, he would have arranged her admission to the first hospital. But she was fully conscious and there were no indications of anything seriously wrong.

12. The A and E consultant told my officers that he had eight senior house officers working as casualty officers in the A and E department on six month appointments ; at least two were, in fact, on duty each evening until 11.00 pm and I have seen from the A and E records that at different

times between 5.00 and 11.00 pm on 20 January 1980 no fewer than four different doctors attended patients in the A and E department. He said that a senior registrar was appointed to the department in November 1980 and a second consultant post had been approved but was not yet filled ; these changes were unconnected with this complaint. The consultant added that on appointment the casualty officers were given a booklet of information and instruction on the work of the department and were told that if they were in any doubt about a case they should call him or the appropriate specialist consultant on call.

13. The A and E consultant said that on the evening of 20 January there were two reasonably experienced casualty officers on duty. He himself was on call that night but the casualty officer did not call him. The consultant explained that it was extremely difficult to diagnose a subarachnoid haemorrhage in its early stages and a migraine could mimic its symptoms, even to the extent of causing low blood pressure. He considered that the casualty officer had acted correctly in examining the complainant's wife, making his own tentative diagnosis and calling the medical SHO. The A and E consultant did not feel that more could have been done for the complainant's wife even if the casualty officer had called him. He sympathised with the complainant over the sad loss of his wife but added that he could never guarantee immediate treatment to all patients coming into the A and E department although, of course, the staff make every effort to get their priorities right.

14. The consultant physician at the second hospital into whose care the complainant's wife was transferred (the consultant physician) told the DA that he had explained to the complaintant that the early diagnosis of subarachnoid haemorrhage could be very difficult and that hours of observation might be necessary with repeated re-estimation of the patient's clinical condition. She was among the one third of cases dying in the acute event and no known treatment would have helped her in the A and E department or subsequently, even if the diagnosis had been made earlier. Investigation by angiography and operation could not have been performed without increasing her peril, well attested experience having shown that such treatment in the early phase led to disastrous results. For progressive, massive subarachnoid haemorrhage, little could be done.

15. My officers discussed the complaints with all the nursing staff on duty in the A and E Department at the time of the patient's arrival. The staff nurse in charge (the staff nurse) thought that the casualty officer arrived soon after 7.30 pm, although in an earlier written statement she said that it was shortly after 7.40 pm. A student nurse remembered that the complainant's wife was very distressed on arrival and talked wildly for about ten minutes before the casualty officer arrived, which she thought was between 7.45 and 8.00 pm. The nurse who called the casualty officer did not remember any times at all. The staff nurse mentioned that the casualty officer took at least ten to fifteen minutes over the examination. The nursing staff thought that the patient waited in the trolley bay area off the main corridor.

16. The DA explained to my officers that there was a shortage of medical beds at the hospital where the complainant's wife was first taken and that a bed bureau system involving four local hospitals was in operation in the district. Patients adjudged on examination clinically fit to travel would be transferred to the hospital 'on-take', irrespective of the medical bed state at the hospital.

Findings

17. I have established that the complainant's wife reached the A and E Department at 7.21 pm and was transferred to the second hospital shortly after 10.17 pm. The evidence I have suggests that she waited some 30 to 35 minutes to be seen by the casualty officer and a further 30 to 40 minutes after the medical SHO had been called before she was seen by him. Both doctors have said that they attended her as soon as they possibly could. There is no evidence of undue delay by the casualty officer on being called but there was delay in calling him. The medical SHO took longer than usual to respond to the call to the A and E deparment, but there was no indication given to him of any urgency and no hastening calls were made to him. Action taken solely in consequence of the exercise of clinical judgment is excluded from my jurisdiction and the absence of any indication of urgency rested on the clinical judgment of the casualty officer. In these circumstances I make no criticism of the actions of these two doctors.

18. I also make no comment on the doctors' assessments of the patient's condition – including her fitness to travel, on the treatment they prescribed or on the decision not to call in the A and E consultant since again these were matters of clinical judgment. But I have recorded earlier (paragraphs 13 and 14) the consultants' clinical opinions about the difficulty of diagnosing subarachnoid haemorrhage in the early stages and that no known treatment would have helped the complainant's wife in the A and E department or subsequently, even if the diagnosis had been made earlier ; I have received similar medical evidence in another similar case which I have investigated.

(b) *Nursing care*

19. The complainant told the DA that he was unable to leave his wife in order to make a telephone call while she waited, unattended, in the corridor, for fear that she would fall from the trolley. After she was moved into a cubicle, he said, she had four bowel motions which he cleaned up himself, having been given material to do so by a nurse whom he told about it. During the time that his wife was in the A and E department, he said, nurses were standing in the corridor talking about wages and conditions in the hospital. The complainant told my officer that, although there were nurses around, he did not like to call them to position the sides of the trolley ; he tried to calm down his wife but could see that he was 'not getting through to her'. He said that she vomited constantly after her collapse and that he attended to this as well as to her incontinence. On the first occasion a nurse asked him if his wife had used a bedpan and he replied that she was not capable of doing so ; he tried, unsuccessfully, on the second occasion to get her onto a bedpan. Afterwards a nurse gave him a bowl of water and some

cotton wool, saying only, 'There you are'. He tried to explain the seriousness of the situation but was told that often such problems arose through constipation. He told my officer that he was not so much complaining about the nurses' failure to help, for he would willingly have done anything himself for his wife, but he thought that had they observed her they might from previous experience have recognised what was wrong. He added that he was certain no nurse was in attendance outside the cubicle while he was with his wife.

20. In reply to the complainant the DA said that there were seven nurses on duty when the complainant's wife arrived in the A and E Department (I believe the correct number was six) but his enquiries had not shown clearly what happened during the period she was there. He said that the complainant certainly should have been able to leave his wife to go to the telephone and there should have been a nurse available if his wife needed a bedpan. As the DA understood it, she was kept in the trolley bay area just off the corridor and there was a nurse in that general area during the evening when there were patients there. The staff nurse remembered talking to him about his wife's condition, her medical examination and treatment and subsequently explaining about the medical SHO. Other nurses remembered other particular incidents and the nurse in the trolley bay area recalled talking to the patient to reassure her, although she deliberately left the complainant and his wife alone so that they could have some privacy. The DA accepted that the complaint clearly showed that the A and E Department did not have the level of staff available to give the attention that the complainant and his wife felt they needed that night and for that he apologised.

21. I have seen the statements made by nursing staff during the DA's investigation as well as the record of evidence given orally to my officers by the six nursing staff on duty until 09.00 pm and the two state enrolled nurses (the night SENs) who came on duty at that time. The staff nurse said that it was a quiet evening in the A and E department and the complainant's wife was never left alone at all. She heard screaming after the complainant's wife arrived and went to investigate, finding the nurse from the trolley bay area on her way to fetch the casualty officer. She spent two minutes trying to calm the patient by which time the casualty officer had arrived; during his examination the patient asked twice for a bedpan. The staff nurse said that she talked to the complainant and later she returned to the patient who again asked for a bedpan but would not use it because she wanted to go to the lavatory. The staff nurse added that she saw the night staff coming on duty, talking about the recent pay award as they were making their way down the corridor.

22. Other nurses on duty until 9.00 pm said that the complainant's wife would have been transferred from the ambulance trolley to a hospital trolley in one of the examination cubicles; that the sides of the trolley were up the whole time except during the casualty officer's examination of the patient; and that two of them believed that they were in the immediate vicinity of the cubicle except for brief intervals. One of the nurses thought that she might have chatted to the night staff about a recent pay award as they came on duty, although this was denied by one of the night SENs.

23. The night SENs told my officers that they were extremely busy immediately after coming on duty, with several serious cases requiring attention. One of the night SENs recalled seeing the complainant's wife in a cubicle on a trolley with the sides up when she received the report from the staff nurse; she also remembered going into the cubicle twice, once to apologise for the waiting time and once to give the complainant a bowl of water. But she was so busy attending to other patients that she did not hear the medical SHO arrive to examine the patient. The other night SEN said that she overheard the complainant's wife say that she wanted to go to the lavatory; she went to the cubicle to explain that the patient should use the bedpan but was called away by the casualty officer to another patient.

24. The night SENs said that earlier in the week one of the night sisters in the A and E Department had informed the sister deputising for the Night Nursing Officer that there would only be two SENs on duty overnight on 20/21 January. One of the night sisters confirmed this to my officer. The night SENs added that when they came on duty at 9.00 pm on 20 January the sister deputising for the night nursing officer told them that she was seeking assistance for them but in the event no help arrived until after 11 pm.

25. The night nursing officer (the NNO) gave my officer details of the night staffing levels in the A and E Department and said that she aimed to have on duty a minimum of three qualified nurses and if possible a sister or staff nurse in charge. She confirmed that back-up was normally available to the Department from the theatre or the intensive therapy unit teams. It was her practice, she said, to check duty rotas weekly in advance and if there appeared to be a shortage of staff to ask the district nursing officer for 'bank' nurses, that is nurses who were prepared to work occasional nights. The NNO said that she no longer had details of her request for bank nurses for 20 January but in the absence on holiday of a sister and staff nurse she was expecting one bank staff nurse to be on duty that night. For reasons unknown to her the nurse did not report for duty. The NNO said that she herself was not on duty on 20/21 January and was informed of the complaint after it was lodged. She understood that support was promised from the theatre team but did not know why it was not given at 9.00 pm. The NNO told my officers that in addition to the bank scheme she now had a number of nurses experienced in casualty work on whom she could call at short notice.

26. My officer also spoke to the sister who deputised for the NNO on the night of 20/21 January. She said that she would have learned that there were only two SENs in the A and E department when the night staff came on duty. It was difficult to recollect what she did about it but she thought she would have told them to telephone her if they needed help; she did not say that she would immediately send someone to the department. She thought that she would have visited the A and E department probably between 9.15 and 9.30 pm but could not remember when she sent staff there, although it was probably at the usual time of 11.00 pm to enable the night SENs to take a meal break; had they telephoned for help, however, she would have

sent staff across. She thought that the theatre nursing staff were working in the intensive therapy unit at the time.

Findings

27 I have no doubt that the nursing care of the complainant's wife in the A and E Department fell far below an acceptable standard both before and after the shifts change. I do not believe the day nursing staff were hard pressed at the time and I am not impressed by their evidence. I believe that events happened substantially as the complainant described them. It is clear that the level of staffing of the night shift was inadequate and that the normal back-up arrangements failed to reinforce the department. I uphold this complaint.

(c) *The investigation of the complaints*

28. The complainant said he felt that a proper investigation of his complaints had not been carried out. He was told that the record of a statement he made to one of the DA's officials had been destroyed—although I have seen a copy of it. He expressed dissatisfaction over the attitude of the senior nursing officer (the SNO) at an interview because the latter did not seem to think that there was anyhing wrong in the A and E department and said that the situation would not change because he could not do anything about it. The complainant also complained that inaccurate statements about his wife's treatment at the A and E department were made to him by the consultant physican when they met on 18 July.

29. I have ascertained that following receipt of the complaint the DA referred it to the sector administrator at the hospital (the SA) saying that the complainant would welcome a personal meeting with a senior member of the medical staff and possibly the SNO ; the DA also spoke to the SNO who initiated an investigation. The SA obtained and forwarded to the DA comments from the A and E consultant, the casualty officer and the medical SHO.

30. The SNO told my officers that during his investigation of the complaints he saw the A and E department's history sheet, confirmed the ambulance timings, interviewed all day nursing staff concerned, asking for statements where necessary and asked the NNO to speak to the night staff concerned. Although he was assured that there was always someone within earshot of the cubicle, the SNO said that he let it be known to staff that he was alarmed and very disturbed about the incidents. He also drew to the attention of all the hospital's nursing sisters in August 1980 the apparently increasing number of complaints arising out of attitudes and complacency of staff, asking the sisters to emphasise to all nursing staff the need for discretion and for following set procedures. The SNO said that when he met the complainant the latter emphasised his concern about the lack of medical treatment and in discussing nursing care asked for an absolute guarantee that the type of incidents of which he complained would never happen again ; but the SNO said he could not give such a guarantee. He accepted that he may have sounded unsympathetic in replying to one of the complainants points but was disappointed to learn of his dissatisfaction.

31. The consultant physician told my officers that he had with him during the interview with the complainant the A and E consultant's statement on the complaints. He gave the complainant information based on the contents of that statement, but he already seemed to be aware of it; he took exception to a statement that a drip had been set up. The A and E consultant said that his statement was based on information from the clinical notes and from the medical and nursing staff. I have seen from the clinical notes that there is no mention of a drip being set up and I have noted other minor inaccuracies in, and inconsistencies between, the notes and the statement made by the A and E consultant.

32. In general comment on the case the DA said that considerable time and involvement had been given to the complaints; the complainant suddenly lost a young wife when there had been an apparent lack of treatment. The approach to the complaints was by personal interview to seek to convince him that the death of his wife was nobody's fault and that whatever had been done could not have saved her. Interviews for the complainant were arranged with the A and E consultant, the SNO and assistant sector administrator and the consultant physican at the second hospital; further interviews were offered. The DA said in discussion with my officers that he did not consider that the statements obtained from nursing staff were sufficiently comprehensive and accepted that the delay in sending a detailed written reply to the complainant was unsatisfactory, although he thought it was right to have placed emphasis on personal interviews. The DA added that he had discussed the nursing side of the case with the district nursing officer. I am also pleased to report that the procedures for the investigation of complaints within the District have been revised and codified.

Findings

33. I have found that there was a lack of rapport between the SNO and the complainant at one point in their interview and that was unfortunate. I have also found that in some respects the A and E consultant's statement on the complaints was inaccurate but I have no doubt that the consultant physician used it in good faith and I do not criticise him for that. Nor do I criticise the DA's approach to the complaints in this case, although I think that an earlier written reply should have been sent. In other respects the DA identified a number of shortcomings in the investigation procedure and I am pleased to note that he has taken steps to effect improvements and to introduce a formalised procedure for the handling of complaints. Part of the complainant's dissatisfaction with the DA's investigation stemmed from his in-ability to secure the absolute guarantees he sought. But I do not consider that the staff could honestly give such guarantees and I do not criticise them on that score.

Conclusions

4. Matters of diagnosis and treatment are outside my jurisdiction. However I have recorded earlier the clinical opinion that once the complainant's wife collapsed no known treatment would have helped her in the A and E department or subsequently. Nevertheless I have found some delay in the

procedures on her arrival in the A and E department as an emergency case and a failure in the provision of adequate nursing care for her. I invited the AHA to remind nursing staff in the department of their responsibility to obtain medical attention for patients as quickly as possible. I also invited the AHA to review the arrangements for providing support to the night nursing staff when necessary and to ensure that clear procedural instructions are available to all those concerned. I am pleased to record that the AHA have told me that the SNO is currently regularising the procedures for the deployment of staff to areas of concern and stress. Discussion about the problems of medical cover and response has taken place and the operational policy of the A and E Department is to be appraised. The AHA have also asked me to convey in my report their apologies to the complainant for the shortcomings which I have found during my investigation and this I gladly do.

Case No. W.216/80–81—Payment for replacement contact lens

Complaint

1. A man complained that a contact lens, which was a replacement for one he had lost, was withheld from him for six months by a hospital (the hospital), in an attempt to enforce payment for a lens which had been previously supplied.

Investigation

2. In the course of the investigation I obtained the comments of the Area Health Authority (the AHA) and saw the relevant correspondence and clinical notes. My officers met and discussed the complaint with the complainant, the consultant ophthalmologist who had been responsible for the complainant's care from 1970 to 1972 (the retired consultant), the consultant ophthalmologist who has been responsible since then (the consultant) and members of the ophthalmic and administrative staff at the hospital.

3. The complainant explained that he suffered from the complications of high myopia and that he attributed the extent to which he had delayed the onset of the final stage of the condition to the fact that he had worn contact lenses rather than spectacles for nearly thirty years. He had developed a considerable interest in myopia and had written articles on the subject. The retired consultant had been sympathetic to his views and he had travelled a good distance to the hospital for that reason. He said that prior to the incidents which are the subject of this complaint, he had been fortunate in being able to obtain lenses from practitioners who were sufficiently sympathetic to the views he held on the condition to allow him to use his own judgment in arriving at 'the most probably satisfactory prescription' as regards power and curvature.

4. The complainant said that the necessity for a contact lens for the left eye of an entirely different prescription arose after he underwent an operation for the extraction of a cataract in May 1979. His judgment on the prescription was on this occasion overruled. He said that the lens proved unsatisfactory. Two separate modifications—one to curvature and the other to power, were subsequently made. He found the third lens acceptable but

unfortunately he broke it when a branch whipped against his eye and he lost its replacement. The complainant said that it was the second replacement (the fifth lens) which in late January 1980 the hospital had refused to release until accounts for that and a previous lens had been paid. He said that he had paid for the original lens and the first modification but contended that his liability should not extend to the cost of lenses whose detailed prescription he had disputed and which in the event he had found unsatisfactory. He claimed that 'medicaments had been withheld against the payment of an account'.

5. The complainant had not retained an exact record of the transactions but I have established from the clinical records that after the extraction of a cataract from the complainant's left eye on 1 May 1979, he was again admitted to the hospital on 4/5 June for a left capsulotomy. He attended out-patient consultations on 27 June, 18 July, 12 September, 28 November and 19 December 1979 before any contact lens was withheld. And accounts were raised for one contact lens on each of the following dates, 21 August and 19 September 1979 and 7 and 30 January 1980. He paid the second and third of these on 30 October and 28 January respectively.

6. The district finance office (the DFO) reminded the complainant on 9 October 1979 that the first account remained unpaid and in a letter of 31 January 1980 informed him that the optician had asked the DFO to let the complainant know that the lens which had been most recently ordered would be sent as soon as she knew that the outstanding account had been paid. On 3 April the DFO wrote again to say that he understood that the complainant was in receipt of social security benefits and he enclosed Form HES1 on which a claim for exemption from NHS charges could be made. He invited the complainant to complete it and return it so that the optician could send on the contact lens ; he added that there would then be no question of any further payments being required from him.

7. On 28 April 1980 the complainant complained to the hospital secretary about the evident passing of false information by the optician to the finance department, 'presumably to conceal their own clinical incompetence' with the result that at that stage, a replacement lens had been withheld for about four months. He said that the action amounted to extorting a charge which was not due and which should not have been made in the first instance. The sector administrator (the SA) told my officer that she treated the complainant's letter as a formal complaint and discussed it with the finance department and the opticians. She learnt of the decision that the complainant should not receive the lens which had been most recently ordered until outstanding accounts had been paid. The SA replied to the complainant on 8 May referring to the statutory charge of £6.15 for a contact lens supplied under the NHS. She also mentioned that exemption from the charges could be claimed by patients receiving supplementary benefit, family income allowance or by those who were exempt from prescription charges on income grounds. The SA enclosed a further form HES1 for completion in the event of any of those circumstances applying. If they did not, the SA invited the complainant to send £12.30 for the

original and replacement lens which would then be sent to him. The complainant replied on 17 May that he had paid for one contact lens plus replacement yet he was not allowed to have the replacement. On 22 May the SA acknowledged that they had received two payments but pointed out that two invoices remained unpaid. She again mentioned exemption and that if the complainant was so entitled, then she would be pleased to receive form HES1 duly completed. On 28 May the complainant reminded the SA that they were discussing one eye and not 'x number invoices'. He asked why it was necessary to alter the original prescription on two subsequent occasions if it had been correct, and contended that he could not be liable for what was wrongly prescribed. His letter also indicated that he was registered blind and lived on a weekly supplementary benefit income of £21. But he did not enclose form HES1.

8. The SA told my officer that she seized on the complainant's reference to supplementary benefit as a way out of the impasse and agreed with the finance department that it was sufficient evidence to waive the outstanding charges. She wrote to the complainant on 10 June enclosing the contact lens and informing him that the charge had been waived. In fact two outstanding accounts were cancelled. On 23 July the complainant wrote again to the SA contending that her letter of 10 June was tantamount to an admission that the contact lens 'for which I may be said to have paid in advance' had been withheld from him for six months. He said that whether or not he lived on supplementary benefit was irrelevant. After a further exchange of correspondence, it was suggested that if he considered that there had been maladministration he should approach me.

9. The optician told my officer that the decision to withhold the lens until the invoice was cleared had been reached by the finance department and herself jointly. The assistant treasurer said that it was the hospital's policy not to send 'goods' to patients where there were bills outstanding. But he added that in a case of overriding clinical need, the lens would have been released. The assistant treasurer said that he would expect the consultant to approach the finance department in such a case. The consultant told my officer that he was aware that the lens had been withheld although the complainant himself had not complained to him about it. Indeed I have seen no evidence in the complainant's correspondence that he required the immediate release of the lens on grounds of clinical need.

10. I know that in cases of non-tolerance of a lens, the charge may be waived. But the optician and the consultant told me that this was not a case of non-tolerance. That is a matter for the clinical judgment of the optician and consultant and not one that I can question. But in this connection I have noted that after the complainant complained to me, additional lenses were supplied to him to different prescriptions when, the consultant told my officer, he continued to try to satisfy his wishes.

Findings and conclusions

11. The burden of this complaint was that 'the replacement lens was withheld for six months in an attempt to enforce payment of the amount

claimed . . .'. The decision to withold the lens was communicated to the complainant on 31 January 1980 but as the lens was sent to him on 10 June it with withheld for a little over four months rather than six. And I do not think that a complaint that the hospital tried to enforce payment can be upheld when the administrative staff there made frequent references to the possibility of claiming exemption.

12. As a general rule it is not unreasonable to withhold 'goods' when previous invoices are outstanding but because a lens was involved in this case, I was concerned to establish that the administration had not acted in isolation. I am satisfied that they did not; both the optician and the consultant were aware of the situation and I have concluded that the decision to withhold the lens was taken with the full knowledge of those professionally concerned with the complainant's treatment.

13. The complainant declined to pay for more than two lenses when the original and first modified lens had to be further modified because of alleged clinical incompetence. But I have found nothing to support that allegation. There is no evidence to show that the consultant found that the lenses which were dispensed were other than in accordance with the prescriptions which he, in his clinical judgment, had considered appropriate. The consultant told me that he had gone to excessive lengths to try to accommodate the complainant's wishes as regards prescriptions and the evidence overwhelmingly supports this.

14. Although there was delay in the complainant receiving a lens, the remedy rested in his hands. He had the option to pay or to claim exemption from the standard National Health Service charge of £6·15. He did neither. I am satisfied that the administrative staff decided on the unorthodox step of treating his letter of 28 May as the equivalent to a completed form HES1 in order to get the lens to him. In no way was the decision to send the lens, as explained in the SA's letter of 10 June, tantamount to an admission that the hospital had withheld a lens for which he had paid in advance. I dismiss this complaint.

Case No. W. 221/80-81 - Notification of in-patient's death to coroner:

Background and complaint

1. On 28 February 1980 the complainant's wife, aged 60, was vaccinated by a local family practitioner. She became ill and during the evening of 29 February was admitted to hospital (the hospital) where she died the following morning. When the complainant attended the hospital on 3 March he was asked to sign a form which permitted the hospital to carry out a post-mortem examination. A community relations consultant from the local Race and Community Unit, acting on the complainant's behalf, wrote to the hospital to obtain a copy of the *post-mortem* report. When this was not forthcoming the community relations consultant wrote to the Department of Health and Social Security (the DHSS); the correspondence was passed to the Area Health Authority (the AHA) and the consultant physician who had been responsible for the complainant's wife's care (the physician)

sent an invitation direct to the complainant to attend the chest clinic at an appointed time. The complainant complained to me that:—

(*a*) in the period immediately following his wife's death, the cause of it was not explained to him by any doctor at the hospital and information about it was not conveyed to the family practitioner; moreover the sudden death of his wife was not immediately reported by the hospital to the coroner;

(*b*) the purpose of the form he signed on 3 March was not explained to him nor were the implications of signing it;

(*c*) the consultant pathologist at the hospital (the pathologist) obstructed the community relations consultant's request for a copy of the *post-mortem* report;

(*d*) he was not told that the purpose of the appointment with the physician was to discuss his wife's death, nor was the community relations consultant invited to accompany him; and

(*e*) he did not understand the explanation of his wife's death given to him by the physician and a request for a written statement was refused.

Jurisdiction

2. The legislation defining my jurisdiction as Health Service Commissioner and Parliamentary Commissioner for Administration precludes me from investigating the actions of a coroner who is an independent judicial officer soley responsible for the conduct of his (or her) duties according to law. The actions of a registrar of births and deaths are also outside my jurisdiction. Under Section 116 (2) (*b*) of the National Health Service Act 1977 I may not investigate any action taken in connection with the provision of general medical services and it follows that I have not investigated the actions of the locum family practitioner who injected the complainant's wife.

Duties of coroners and registrars of births and deaths

3. The coroner has a statutory duty under section 3 of the Coroners Act 1887, as amended by Section 21 of the Coroners (Amendment) Act 1926, to enquire into a death if he or she is informed that a body is lying within the geographical area for which he or she has responsibility and there is reasonable cause to suspect that it is a violent or unnatural death, or a sudden death the cause of which is unknown, or that it occured in other specific circumstances not relevant here.

4. The registrar of births and deaths is required in certain circumstances specified in Regulation 51 of the Registration of Births, Deaths and Marriages Regulations 1968 to report a death to the coroner. This requirement applies in cases where the cause of death is unknown, or where the registrar has reason to believe that it was unnatural or caused by neglect or attended by suspicious circumstances. It is also established practice for medical staff to advise the coroner direct of cases where he or she is likely to have an interest.

Investigation

5. During the investigation I obtained the written comments of the AHA and saw the relevant correspondence and medical notes. My officers discussed the complaint with members of the medical and administrative staff of the hospital and AHA and also discussed the case with the coroner, the coroner's officer, the registrar of births and deaths who registered the wife's death and her family practitioner (the FP). One of my officers also met the complainant and the community relations consultant.

(a) *The information given about the cause of death and the failure to approach the coroner immediately*

6. In discussion with my officer and in correspondence sent on his behalf by the community relations consultant, the complainant said that on Thursday, 28 February 1980, a locum family practitioner 'vaccinated' his wife against smallpox. She became ill, fell into a coma and during the evening of 29 February was admitted to the hospital. The complainant said that a doctor there asked him whether his wife was diabetic or addicted to drugs. On the following morning, he learned in the course of a telephone conversation that his wife's condition had deteriorated and when he arrived at the hospital he was told that she was dead. He said that the doctor who had seen him the previous night explained to him that there would have to be an investigation into the death and suggested that he return to the hospital after the weekend. On Monday, 3 March, he saw a different doctor at the hospital but was given no information about the cause of his wife's death. When the complainant went to collect a death certificate he asked the registrar of births and deaths why nobody had talked to him about the death. He was referred back to the hospital doctor. The complainant said that the doctor was called and according to the complainant was standing in the doorway when he asked the complainant what he wanted. He said he asked the doctor whether there was to be an inquest and he was told to telephone two days later. Because nobody wanted to speak to him about his wife's death, his personnel manager telephoned the hospital but was unable to obtain any further information.

7. The complainant said that he went to the FP, who had been away when the complainant's wife was given her injection, on two occasions after his wife's death, once in the company of the community relations consultant. The FP told them that the hospital authorities had not explained the cause of death to her. However, she understood there had been a meeting at the hospital to discuss the death, and a report was to be sent to the Committee on the Safety of Medicines. He added that the FP said it would be ten days before she could tell them more. The community relations consultant thought that the referral to the Committee on the Safety of Medicines indicated that there was an element of uncertainty about the cause of death.

8. The community relations consultant said that, accordingly, on 11 March he wrote to the coroner to ask for an inquest but the coroner's office subsequently informed him by telephone that this could not be arranged because the complainant had signed a form giving permission for the hospital to perform the *post-mortem* and the registrar of births and deaths had not

indicated to the coroner's office that there was anything unusual in the wife's death. It was suggested to the community relations consultant that he telephone the registrar of births and deaths for further information; when he did so the registrar said that she had written on the death certificate what she was informed had been the cause of death and had no reason to disbelieve the details given to her.

9. A Registrar of the physician's 'firm' (the medical registrar) remembered examining the complainant's wife on her arrival at the hospital on 28 February. She told my officers that she spoke to the complainant on three occasions; twice in the accident & emergency department waiting room when she first talked to him about what might have caused his wife's illness and later clarified a few points and explained that his wife was seriously ill when she returned after tests had been carried out. The next morning she saw the complainant on a third occasion just after his wife's death. She said how sorry she was and that they could not explain the cause of death but that there would have to be a *post-mortem*. She recalled the complainant asking if he would know the outcome and she had assured him that he would. But the medical registrar told my officer that she did not regard this as a request for her to arrange for him to see the report, although had she realised that was what he wanted, it could have been arranged. The medical registrar could not remember who decided on a hospital *post-mortem* and said she did not know why there had not been a referral to the coroner because of the standing rule at the hospital that all deaths within 24 hours of admission should be so referred. She made the point that she thought that a *post-mortem* conducted in the hospital might well be more thorough than one conducted at the request of a coroner.

10. The House Physician (the HP), who was the doctor the complainant recalled seeing on 3 March, said that he remembered the medical registrar telling him on the night the complainant's wife was admitted that she had seen her and would follow the case up. On his arrival on the ward the next morning, he learned of her death and discussed the case again with the medical registrar who said there would need to be a post-mortem. I have noted that it was he who completed the cause of death certificate dated 3 March. He inserted ' lactic acidosis' as the cause of death but made no entry in the box on the reverse side of the 'cause of death' certificate in which a doctor indicates that the death is to be referred to the coroner. He explained that he knew the case had to be referred to the coroner but that he had left this blank until it was confirmed whether the coroner wished to proceed with a *post-mortem*. The HP did however indicate elsewhere on the certificate that further information about the cause of death might become available from a *post-mortem*. The HP could not recall exactly what happened after he had completed the certificate but he thought it likely that he gave the certificate to the clerk who dealt with matters arising from a patient's death. He said that he understood that a death within 24 hours of admission was automatically referred to the coroner's office. However he did not regard it as his responsibility to do this and he thought it the responsibility of the clerk to refer it. He admitted to my officer that at the time of the wife's death he did not know whether a hospital *post-mortem* would prevent a subsequent coroner's *post-mortem*.

Returning to the events of 3 March he said he thought that the clerk telephoned him later in the morning to say that the complainant had arrived. He recalled meeting the complainant once only in the corridor and that they spoke for about five minutes. He recognised that it was not usual to discuss a sensitive matter such as the cause of death with a relative in the corridor; he told me that it was with no disrespect that he did so but that he just happened to meet him there. The HP recalled that the complainant was confused about his wife's death, and in the circumstances, he thought this was understandable. He tried to explain acidosis as well as he could; however, he remembered being asked several times by the complainant what 'acid in the blood' meant. Because the HP thought that the coroner had already decided to take no action on the death, he obtained the complainant's agreement to a *post-mortem* carried out by the hospital. He believed that the medical staff at the hospital preferred it when the post-mortem was undertaken there because they would receive less information about the cause of death from a *post-mortem* performed on the coroner's instruction.

11. The clerk who dealt with the administrative matters arising from the death of all patients at the hospital described her duties to my officer. She said that the medical notes and property of the patient were sent to her and she examined the notes to see whether there should be a referral to the coroner. She suggested referral when there had been an unnatural death or the patient had died within 24 hours of admission. In these cases she telephoned the junior medical officer who in turn contacted the coroner. When referral to the coroner was not appropriate she passed the cause of death certificate signed by a junior doctor to the relatives who took it to the registrar of births and deaths to obtain a death certificate. In this particular case the clerk said that she could recall passing the certificate to the complainant who was quiet and seemed to be in a state of shock. He had had to wait a short time while she telephoned the HP in order to obtain the cause of death certificate. But the clerk thought that the HP would probably have seen the complainant because it was his practice to speak to relatives about the hospital *post-mortem* and to seek their agreement rather than leaving this for her to do as some other doctors did. But she was unable to remember the complainant returning from the office of the registrar of births and deaths to seek clarification about his wife's death.

12. The registrar of births and deaths who was on duty at the hospital at the relevant time explained that she would be presented with the cause of death certificate by a relative and would examine it to see whether or not the death could be registered. This was an important part of her work, but in practice doctors were expected, when completing the 'cause of death' certificate, to assess whether the death should be referred to the coroner. In her opinion, doctors were quite good at this but she said that in this case had she known that the death followed so soon after the injection, she would have got in touch with the coroner at the time. In her opinion if the hospital doctor had known that situation, he should have referred the death to the coroner immediately. The registrar remembered the com-

plainant visiting her with the cause of death certificate; he seemed bewildered and upset and asked for information about the cause of his wife's death. The registrar told him he would have to enquire of the hospital doctor. The registrar recalled that on the following afternoon she received a telephone call from one of the coroner's officers. He said that a doctor, who she assumed was the FP, had telephoned him and mentioned that the complainant's wife died following an injection. He asked her to read the details given on the cause of death certificate. This she did but she said she left it to the coroner to decide whether to take the matter any further. The registrar also recalled the community relations consultant telephoning her and she referred him to the wife's doctors; the HP remembered receiving such a call.

13. The physician explained to my officers that junior doctors followed a set procedure when certifying a death. If they were clear as to the cause of death and were satisfied that there were no unnatural circumstances, then a 'cause of death' certificate could be completed and signed by the doctor. When there was no obvious cause of death the coroner was informed. If there was no need for a coroner's *post-mortem* a hospital *post-mortem* might still be performed if the case was 'medically interesting' and provided the agreement of the relatives was obtained. 'Lactic acidosis' had been inserted on the cause of death certificate and the physician acknowledged that the hospital would have been happier with more information than this. He said that 'lactic acidosis' as a description was incomplete, but it was as complete as it could be at that time and this was the reason for he hospital *post-mortem*. The physician added that when this provided no further information the death was reported to the coroner. The physician also said that he had been puzzled by the death and it had been discussed at a clinical meeting at the hospital subsequently. I know that medical practitioners are requested to avoid using vague or ill-defined terms on a cause of death certificate and that 'acidosis' is included in the list of indefinite or undesirable terms. In a paper entitled Notes and Suggestions to Certifying Medical Practitioners, it is recommended that it is as well to insert on the certificate 'Cause Unknown' in a case where an indefinite term has to be employed because more definite information is lacking.

14. The pathologist confirmed to my officers that a coroner's *post-mortem* was intended to establish cause of death while one undertaken by the hospital was for its own purposes. He did not personally perform the *post-mortem* on the complainant's wife on 3 March but was present and examined the results. The report of the examination concluded that the cause of death was metabolic acidosis. Following the examination he decided that a referral should be made to the coroner's office and one of his housemen, he could not remember which, telephoned direct from the mortuary. The pathologist said that a telephone call was received later from the coroner's office to say that no further *post-mortem* was required. The pathologist confirmed that the case had been discussed at the regular Wednesday meeting of medical staff.

15. The coroner and the coroner's officer were both unable to recall any contact from the hospital about the death. They could not recall receiving the community relations consultant's letter of 11 March or the subsequent telephone conversation about that letter (paragraph 8). The coroner told my

officers that had a call come to her office from the hospital reporting the death it would have been passed to her personally. No record of telephone calls was kept. She confirmed to my officer however that because the patient died within 24 hours of admission to hospital, the death should have been reported and she said she would certainly have taken over the case. She regarded 'lactic acidosis' as 'totally unacceptable' for the purposes of certification of death and said that she thought it was a case for an inquest. The coroner denied that a hospital *post-mortem* was more thorough than a coroner's autopsy ; she pointed out that she had a panel of seven pathologists, three of whom were Professors in pathology and that hospital doctors were always informed when a *post-mortem* was to be carried out and invited to attend.

16. The FP told my officer that it was recorded in the wife's notes that she had been given a cholera vaccination. She recalled that after his wife's death the complainant went to see her and that she had spoken on the telephone to the medical registrar about the death. She was told that the complainant's wife died of metabolic acidosis but that it had not been established why this had happened. The FP said she explained this to the complainant and as far as she was aware, he went away satisfied, although she acknowledged that it was very difficult for a layman to understand such a complicated medical matter. Later she remembered that the complainant returned with the community relations consultant and that she explained the position again. The FP said she was certain she had not mentioned a meeting at the hospital or a referral to the Committee on the Safety of Medicines and she had no recollection of saying to them that they should get in touch with her again after ten days. She received a written statement dated 18 March from the medical registrar about the wife's admission to hospital and subsequent death. The FP said that she believed that she did all that she could to explain what had happened to the complainant's wife.

Findings

17. The complainant saw the medical registrar very soon after his wife's death and she explained that there would have to be a *post-mortem*. When the HP saw the complainant on 3 March that *post-mortem* had not been undertaken and he was not able to give any more information. Undoubtedly the complainant was in a state of shock when he visited the hospital on 1 and 3 March and would have had difficulty in understanding such explanations as were given to him on those occasions; but in any event I think it was most regrettable that the HP should have discussed such a sensitive and distressing subject in the corridor of a hospital. The HP has expressed his regret for this incident in a written communication to me. After the *post-mortem* had been undertaken, the FP explained to the complainant as well as she was able to, the cause of the death. I can well understand that the complanant remained dissatisfied with the explanation he was given. I do not believe, though, that this was the fault of those who tried to explain the position to him. I believe it arose from the failure of the *post-mortem* examination fully to explain the death and that it is not a matter on which I can comment.

18. The FP was sure that she did not mention the Committee on Safety of Medicines and the physician and pathologist told my officer that, to their knowledge, no referral to that Committee was made. I have established that in the circumstances pertaining here, it is not mandatory for members of the medical profession to refer a case to that Committee and this would explain why the complainant never saw a report from the Committee as he expected.

19. As for the matter of referring the death to the coroner I find that there were some serious failures in this respect. First the HP indicated on the cause of death certificate dated two days after her death, that he had last seen the complainant's wife alive on 29 February 1980 when in fact he had never done so. Moreover the HP requested the complainant's permission for a *post-mortem* to be carried out at the hospital believing that the coroner had decided against one when, at that stage, no approach had been made to the coroner. Such a misunderstanding is indefensible. The clerk has said that the medical records were passed to her and she should have realised that the complainant's wife had been admitted to the hospital less than 24 hours before her death. This should have prompted the clerk to get in touch with the HP to refer the case to the coroner. But this hospital procedure failed. Although the coroner said at first that she had no recollection or record of a telephone conversation the pathologist has said that the coroner's office was informed of the wife's death after the hospital *post-mortem* had been unable to establish 'a plausible cause of death based on the anatomical changes'. Subsequently the coroner thought she had a vague recollection of a telephone conversation between one of her officers and a hospital pathologist; she added that from the information given it was assumed that the matter did not warrant her intervention. The registrar of births and deaths recalled too a telephone conversation with the coroner's office and I have seen a copy of the letter of 11 March addressed to the coroner by the community relations consultant (paragraph 8). On the evidence I have obtained I believe that the coroner's office were informed of the death after the *post-mortem*. But in view of the grave doubts that continued to exist about the cause of death I am surprised that the communication from the pathologist's department was only by way of telephone. I have already explained that the actions of the registrar of births and deaths and the coroner are outside my jurisdiction and accordingly I make no comment on them.

20. I am satisfied that the wife's death was a sudden one and that it should have been *immediately* referred to the coroner for her consideration. I uphold this aspect of the complaint. Reference is the responsibility of the medical staff and there was clearly uncertainty in the mind of the HP about responsibility for referring the death to the coroner and the correct procedure to be followed in completing the cause of death certificate. I therefore examined the notes for guidance issued to junior medical staff at the hospital on the subject and consider the information given to be deplorably inadequate. There is no reference to the procedure to be followed in the cause of a sudden death. However such guidance as there is does indicate the 'death certificates' should not be issued without the consent of a senior member of the medical staff if any doubt arises, for example, where it might be necessary

to report the death to the coroner. I have found no evidence that such consultation took place in this case and I therefore recommend that the AHA review their guidance in this respect to ensure that junior medical officers are fully aware of the correct procedures and in the hope of preventing recurrences of this unfortunate incident.

(b) *Consent to a post-mortem undertaken by the hospital*

21. The complainant said that when the HP asked him to sign a form on 3 March he did not explain to him that it was for a hospital *post-mortem*, that the coroner would not be involved and that there would be no inquest. He said that he signed the form but that he was in too great a state of shock to understand what he was doing.

22. I have seen the certificate the complainant signed on 3 March. It reads 'I hereby consent to an examination to be held after death in respect of my late wife as above named'. The HP told my officer that he informed the complainant that the hospital would like to carry out a *post-mortem* examination and explained that he needed to have the complainant's agreement. The complainant considered this for a moment before agreeing. The coroner told my officer that the fact that a hospital *post-mortem* had been performed did not then automatically preclude or discourage her from taking further action. In such a case she would call for the hospital post-mortem report and it would be used as an aid to any *post-mortem* undertaken on her instructions. A representative of a medical defence organisation said that it was their view that agreement to a *post-mortem* carried out by a hospital did not prevent a coroner's *post-mortem* or inquest.

Findings

23. The complainant has said that he was in a state of shock when he saw the HP and I think it is likely that he may not have understood all that was said to him about the *post-mortem*. In any event I am satisfied that his agreement to a hospital *post-mortem* did not have the implications he and the community relations consultant believed and I do not uphold this complaint.

(c) *Request for the post-mortem report*

24. The community relations consultant said that after his unsuccessful attempt to persuade the coroner to hold an inquest he tried to obtain a copy of the *post-mortem* report from the hospital. He wrote to 'The Secretary' at the hospital on 21 March, explaining that he was acting for the complainant and asking for a copy of the report. He received a reply not from the administrative staff but from the pathologist, saying merely that *post-mortem* reports were not usually sent to relatives and suggesting that the FP could ask for information from the physician. As the community relations consultant had already been with the complainant to see the FP he wrote again on 28 March to the pathologist questioning the logic of such a decision and asking again for the report. The pathologist replied on 3 April that the community relations consultant had not mentioned why the report was wanted and that no

written authority from the complainant had been received. He added that post-mortem reports were confidential and open to misinterpretation by even the most intelligent of lay people. On 18 April the community relations consultant sent a letter signed by the complainant requesting the release of the report but he received no response from the pathologist. The community relations consultant told my officer that he thought the tone of the pathologist's replies was impolite and that the pathologist was unco-operative.

25. In a written statement to me the pathologist said that it was not his practice to give *post-mortem* reports to anyone, but he invariably suggested that relatives discussed the case with the clinicians involved. He said that it was the duty of the clinicians involved in a case to communicate as necessary with the family practitioner. As regards the community relations consultant's first letter the pathologist told my officer that he had taken it as indicating that legal action was being contemplated against the family practitioner who gave the vaccination. He thought that the community relations consultant was 'out for trouble' and he therefore felt justified in replying as he did. He said that when he replied he had taken into account the difficulty which had been experienced in diagnosing the cause of death. When he received the second letter, which suggested that he was being unhelpful, he contacted his defence organisation. He did not recall seeing the third letter signed by the complainant.

Findings

26. I do not think that the terms of the community relations consultant's first letter should have led the pathologist to conclude that the former was 'out for trouble'. But as he did, his proper course in my judgment was to ask whether the administrative staff so interpreted it and if so, to seek legal advice. The pathologist's normal practice was to suggest to relatives that they discuss the matter with the clinician and it is unfortunate that he did not do so in this case. The physician told my officers that had the complainant asked him for a copy of the *post-mortem* report he would have sent one to him since this was his policy and I have noted that when the complainant sought the assistance of solicitors a copy of the report was sent to them by the physician. The pathologist's replies had the effect of delaying the release of the report and I uphold this complaint.

(d) *Visit to the physician*

27. On 25 May the community relations consultant referred to the Secretary of State for Social Services the correspondence to which I have referred in paragraph 24. A Departmental official replied to the community relations consultant on 9 June and said that the papers had been referred to the area administrator who would reply direct. But it was the complainant who received a letter dated 3 July from the physician; he was asked to go to the chest clinic on 8 July but there was no reference in the letter to his wife. After the meeting, the community relations consultant received a letter dated 9 July from the area general administrator (the AGA) notifying him that arrangements had been made for the complainant to meet the physician to discuss the cause of his wife's death.

28. The physician said that he first learned on 3 March of the wife's admission to hospital and her death but he had not realised that there was a complaint until 20 June when he was sent all the papers by the AHA with the request that he see the complainant. The physician said that he wrote informally to the complainant saying that he would appreciate it if the complainant would go along to the chest clinic on 8 July at 2 pm to see him. He told my officer that he believed that the complainant would understand the meaning of the note. He had not realised that the complainant wanted to bring the community relations consultant with him and the complainant had not mentioned the point at the meeting.

29. The AGA told my officer that, normally, the AHA dealt with a complaint by seeking the comments of those concerned in the hospital and then replying to the complainant; but they also encouraged consultants to arrange to meet the complainant in suitable cases. The letter from DHSS was dealt with by one of his staff, although he thought that at some stage the matter would have been discussed with him and he accepted full responsibility for the way the complaint was handled. The AGA recognised that the AHA did not deal with the complaint well; it disturbed him that the community relations consultant had not been invited to the meeting with the physician and was only informed of it after it took place. He also acknowledged that the AHA had not written to the complainant after the meeting with the physician and that this was discourteous. Furthermore DHSS were told nothing more.

Findings

30. I accept that the physician's letter was intended to have consideration for the complainant's feelings and was a discreet invitation to go to discuss his wife's death but the complainant did not read it as such. This was unfortunate. The community relations consultant could also be forgiven for thinking that he was deliberately excluded from the meeting. Moreover the overall handling of the complaint by the AHA fell well below an acceptable standard and, on their own admission, it was badly managed. I uphold this complaint.

(e) *The discussion with the physician*

31. The complainant said that he found the physician sympathetic but he did not really understand the reasons the physician gave for his wife's death and he was not convinced by the explanation for so little information being given in the first instance. He left the meeting dissatisfied although he agreed that he knew that the consultant was willing to see him again if he wished. The community relations consultant added that the complainant said he wanted a written statement but that the physician would not give him one.

32. The physician said that he spent about half an hour with the complainant on 8 July. The physician realised that it was difficult for him to understand such a complicated matter as a metabolic death for which no exact cause had been found. The physician said that the complainant had

ample time to question him fully about it and he had hoped that the complainant understood the situation. The physician thought that the complainant seemed reasonably satisfied when he left. This account is supported by his contemporaneous entry in the clinical notes. He also recorded in the notes that the complainant 'left with the knowledge that should he so wish I would be prepared to see him again'. The physician said that if the complainant asked him for a copy of the *post-mortem* report he would have let him have it since this was his policy; but so far as he could recall the complainant had not asked for a statement in writing. The physician had received a request for a copy of the *post-mortem* report from the complainant's solicitors and this was sent to them nine days after he met the complainant.

Findings

33. I am satisfied that the physician explained as best he could the difficult concept of a metabolic death. He was unable to say what caused the condition of acidosis which led to the wife's death and I can well understand that the complainant felt that he received an incomplete answer. But the physician could do no more than pass on the information that was obtained from the *post-mortem* and therefore I do not uphold this complaint.

Conclusions

34. The complainant asked me to persuade the AHA to provide a written report of the circumstances of his wife's death. I am satisfied that a copy of the *post-mortem* report was sent to his solicitors and that he has seen a copy of it. I do not think that the AHA should do more in this respect. The complainant also asked for the findings of the Committee on Safety of Medicines but I have found no evidence that this case was referred to that Committee.

35. The AHA have admitted that they did not handle the correspondence well and I have criticised the pathologist for responding as he did. I have concluded that the circumstances attending the wife's death, namely its suddenness and the imprecise knowledge of its cause, should have led to immediate referral to the coroner. I have been critical of the actions of the HP and the clerk in this connection. I have also concluded that the wife's death was subsequently brought to the notice of the coroner's office. But because communication by the hospital was by way of telephone, I cannot say whether the fact that it occurred within 24 hours of admission to hospital, and so shortly after the vaccination, was brought to notice. The copy of the community relations consultant's letter of 11 March which I have seen makes no mention of these specific points The AHA may be surprised that no record of telephone calls is maintained by the coroner's office and I hope that they will accept therefore not only the importance of keeping such a record themselves but also the necessity for confirming details in writing.

36. The failures which my investigation has brought to light are serious ones and I think it would be appropriate for the chairman of the AHA to write personally to the complainant to convey the apologies of the AHA

to him. I am pleased to report that he has agreed to do so. I am also pleased to report that the AHA have agreed to review their guidance to junior medical officers in an attempt to prevent other relatives suffering unnecessary distress as did the complainant in the period immediately following his wife's death. They have also agreed to the recommendations I have included in the final sentence of the previous paragraph. I consider their response to be an appropriate outcome to my investigation.

Case No. W.248/80–81—Accommodation and facilities provided for a private patient.

Background and complaint

1. On 3 June 1980 the complainant was admitted as a private patient to a hospital (the hospital) for a minor operation. He occupied a room in one of three private wards in the hospital (the ward) until his discharge on 7 June. He complained that the accommodation and facilities were unsatisfactory and in particular that:

(*a*) his room was dirty, the bed unsuitable and the bathrooms unusable;

(*b*) the food was insufficient and of poor quality;

(*c*) he was left unattended when he called for service.

2. He complained to the district administrator responsible for the hospital (the DA) seeking a reduction in his bill but was told that the regulations covering the admission of private patients to National Health Service (NHS) hospitals did not allow the health authority to provide the complainant with a higher standard of service than that offered to non-paying patients and that there was no means to agree a reduction in the charges. He asked me to investigate but in accordance with my normal practice, I explained that I could not do so until the account was fully paid. In January 1981 the complainant informed me that he no longer owed any sum to the Area Health Authority (the AHA) and I began my enquiries.

Investigation

3. In the course of my investigation I obtained the written comments of the AHA and examined the relevant documents. One of my officers met and discussed the complaints with members of the medical, nursing and administrative staff involved and also the complainant.

(a) *The accommodation*

4. In a letter of 22 July to the DA the complainant said that his room was dirty and there was fungus growing in one corner, the bathrooms were full of rubbish and unusable, the television did not work, the curtains were torn and dirty and the bed was completely unsuitable. He said that he had brought the deficiencies to the notice of the consultant in charge of his care (the consultant), the ward sister and an assistant administrator (the administrator); they had all agreed with the complaints and the latter told him that some consideration would be given when the account was prepared.

5. In reply the DA apologised to the complainant for the fact that he found his stay in the hospital unsatisfactory. The DA said he understood that the room had not been cleaned satisfactorily although it was not fungus in the corner but probably excess carpet cleaner, which was promptly removed. He agreed that furniture was stored in one bathroom at times because there were no adequate storage facilities elsewhere and he said that he would raise the matter again with the hospital. The DA was sorry if the complainant thought the curtains were dirty and he commented that the curtain changing programme was being re-examined. He added that no charge had been made for the television and that the bed was of the older type rather than the better type in some rooms but there was no money available for new beds for the ward. He invited the complainant to call and discuss his complaints with the hospital administrator (the HA).

6. In their comments to me the AHA said that every effort had been made to deal with the complaints at the time they were made by the complainant and that the AHA had taken the opportunity to apologise for a number of shortcomings. The AHA accepted that in some respects the private accommodation at the hospital had been unsatisfactory and compared very unfavourably with standards in some new private hospitals. The AHA added that NHS accommodation at the hospital was in a similar condition as a result of the severe financial constraints of recent years, which had prevented the operation of normal programmes for replacement of furniture and carpeting, redecoration etc; local management were very conscious of these matters and regretted that they had been unable to maintain the environment of the hospital to a high standard. The nursing staff agreed that the bed used by the complainant was not ideal for their purposes.

7. The complainant told my officer that on arrival at the hospital on 3 June he signed a form undertaking to pay charges but was given no information about the accommodation or services to be provided. After a delay of two to three hours caused by the late departure of the previous occupant, he was shown to his room which he found to be in an appalling condition, nothing having been attended to apart from a change of bed linen. He said that there was dust on the tables, the water jug had not been changed and the previous patient's mouth rinsing tablets were still on the table by the bed. When my officer pressed him about the condition of the carpet he said that he could not be absolutely certain that it was fungus in the corner. He said that he drew to the ward sister's attention immediately the deficiencies of the room, yet by the third day of his stay, 5 June, nothing appeared to have been done. He complained again to the ward sister and she arranged for the administrator to see him. He also complained to his consultant who expressed disgust at the condition of the room and apologised for it. The complainant said that the administrator also apologised and asked the ward sister why nothing had been done when the complaint was first made. The administrator promised to look into the complaints and shortly after he left, the carpet was cleaned. Someone else looked at the curtains but nothing was done to them; however, one of the bathrooms was almost cleared of furniture. The following day, 6 June, the consultant

advised him to stay a few more days but he refused because of the conditions. The ward sister and the administrator offered to change his room but he declined because he had had enough of the hospital. As a result, however, he subsequently had to attend the consultant's clinic in London about six times, with all the personal expense and inconvenience that that entailed. He added that he was so annoyed about the unsatisfactory facilities that he invited a Sunday newspaper to photograph his room, but no one responded.

8. The ward sister explained to my officer that literature, which I have seen, about the private wards was normally sent to prospective patients by consultants' secretaries and on arrival in reception the patient was given information about the facilities and signed the appropriate forms. Normally, she said, she met patients on arrival on the wards, having first ensured that their rooms had been cleaned and tidied. But she did not remember the complainant's arrival or him complaining when he first occupied the room and her first recollection of him was on the third day of his stay when he complained about conditions. The ward sister said that she apologised and called the administrator who, she recalled, discussed the complaints with him. She thought that she had offered to change the complainant's room during his stay but he declined. The ward sister added that the complainant was not the first person to complain about the room and in her opinion it was probably the worst accommodation on the ward because it was small and its standard of furnishing was poor; no amount of cleaning, she said, would have made much difference to the carpet because of its appalling condition. Nursing staff had themselves been depressed about the conditions patients had to endure.

9. The consultant told my officer that he recalled the complaint being made to him, on the day after the complainant's operation, about the condition of the room and the bathroom and asking why he had recommended the hospital. He said that the complainant had justification for complaining and, having ascertained that his patient had no complaint about the medical or nursing care, he spoke to the ward sister about the conditions; she told him that she had informed the administrative staff of the complaints. The consultant said that he and his fellow consultants had been concerned about the number of complaints at the time relating to the 'hotel' facilities and some consultants had been reluctant to recommend patients to the hospital despite its excellent medical and surgical facilities; the consultants' staff council had made known their concern to the administrative staff. The consultant added that, although it was understandable that the complainant should attribute to his early discharge his subsequent visits to the clinic, that was not the case. The complainant was in fact in hospital longer than normal for the operation he underwent, having suffered more pain than usual. The consultant said that the complainant would have had to visit his clinic whenever he was discharged and that he did so more frequently than he might have expected because there was a slight delay in the healing process.

10. The administrator confirmed to my officer the details of his discussion

with the complainant on 5 June. He said that he apologised to the complainant, agreed that most of his complaints were probably justified and promised to look into them; he also agreed to take into account in the bill the faulty television set but emphasised that he would have to approach his superiors about a more general reduction in charges and was not optimistic about the outcome. However the nursing officer (the NO) told my officer that when the complainant complained to her on the morning of his departure, she apologised and said that all the points would be taken into account when the bill was sent to him. The administrator said that the cleaners were called immediately and furniture was removed from the bathroom. A curtain changing programme at nine weekly intervals was also introduced. The possibility of transferring the complainant to another room was also considered, especially as he requested a replacement television set or a move to a room with a set that worked. But the administrator thought that the ward was full at the time and, although some of the rooms were occupied by NHS patients, a transfer would have created too much of an upheaval for the patients concerned.

11. The administrator said that there had been a general decrease in the number of private patients taking private beds in NHS hospitals but at the same time there was a great demand for NHS beds at the hospital. During the time that the complainant was a patient 75 per cent of the beds in the private wards were occupied by private patients and the remainder by NHS patients. Facilities throughout the hospital had suffered through lack of funds, although a newer type of bed was in use in the other private wards and in NHS accommodation in the intensive therapy unit, the coronary care unit and the orthopaedic ward where there were also two separate rooms equipped with such beds. Furniture, however, was no better on the NHS side and there was less of it. The administrator pointed out that under the legislation governing the provision of private beds in NHS hospitals, authorities could not offer appreciably higher standards for private patients than for NHS patients.

12. The HA told my officer that he thought the complaints were probably justified but they did not warrant a reduction in the bill. During the past year a number of similar complaints and requests for reductions in charges had been received but all had been resolved by discussion with the patients ; only in exceptionally serious cases, he thought, might a reduction in charges be considered. The HA admitted that there had been particular difficulties in the private wards in 1980, especially in view of the building programme on the floor above and said that, with hindsight, perhaps more consideration should have been given to closing parts of the wards. He told my officer that an increase in the number of complaints received and a drop in income from the private wards had led to the allocation at the beginning of 1981 of £50,000 for improvements ; each private room now had the new type of bed, new furniture and new floor covering.

13. At the end of my investigation the area administrator said that in his experience patients did not complain immediately they arrived on a ward and that on the balance of probability the complainant did not complain until the third day. I take the view that a patient would complain

immediately about a water jug and mouth rinsing tablets used by the previous patient being left in the room when a new patient occupied it and about dust and something which the complainant thought might be fungus.

Findings

14. Hospitals are not required to set aside particular accommodation for private patients but in this hospital there are three private wards. At the relevant time only three of every four beds in these wards were occupied by a patient who, like the complainant, had agreed to pay some £95 per day for accommodation and service. I find it surprising therefore that the complainant as a private patient should have been allocated the room which the ward sister thought was probably the worst on the ward. The consultant, the NO, the ward sister and the administrative staff have all expressed the view that the complainant had justification for complaining and so do I. Some effort was made to improve the situation but for the most part not until the third day and the effect was limited. It has not been denied that deficiencies existed when the complainant arrived and I uphold this complaint. I am pleased to learn that improvements have now been made to the accommodation. But I do not find that the date of discharge caused the complainant to have to make additional journeys to his consultant's clinic.

(b) *The food*

15. In his letter to the DA and in discussion with my officer the complainant said that the food was totally disgusting, and of poor quality and quantity. The DA replied that the catering officer had explained to the complainant that the hospital was not geared for individual cooking but that if he had any particular wishes the catering officer would do all he could to meet them ; he said that the catering officer had offered to see the complainant again if there were any further problems but that the offer had not been taken up. The complainant agreed that the catering officer saw him on 5 June and explained what he could and could not do, which the complainant accepted. But he told the catering officer that he found both the quality and quantity of food to be extremely poor. He said that there was some improvement after this meeting ; nevertheless, although the catering officer was obviously doing his best, the food was still not very satisfactory.

16. The catering officer explained to my officer that since 1979 he had provided for all patients a choice of five main dishes at lunchtime and four at supper plus two additional choices and a cooked breakfast for private patients ; patients ordered their meals a day in advance. As far as the catering officer could recall, the complaint related to the standard of one particular meal. He discussed with him the difficulties of catering for large numbers of people while providing for individual tastes. The catering officer apologised to the complainant and invited him to call him again if there was any further problem, but he heard no more. He said that the catering service received far more compliments than complaints and he doubted if more than two or three written complaints were received in a year. From

his diary he noted that he dealt with no more than four minor grumbles in a period of five months in 1981. The administrator referred to a spot check on catering in the private wing some time after this complaint and said that only two of the 38 patients had any critical comments at all on the meal in question or on the standard of the food generally.

Findings

17. The catering officer believed that the complainant was complaining about one meal in particular but I believe his complaint about the food was based on more than one meal. However I have found no evidence of patients' dissatisfaction with the standard of catering at the hospital generally, nor can I now ascertain whether any particular meal was unsatisfactory. I am pleased to see that the catering officer apologised and offered to do what he could to satisfy the complainant's particular wishes ; I do not think he could have done more in the accomplishment of a notoriously difficult task.

(c) *The lack of response to calls*

18. In his letter to the DA the complainant said that no one answered his calls for service. He told my officer that frequently he had to wait fifteen minutes before anyone responded to his bell and on one occasion when his visitor left an hour after a nurse had been called, there had still been no response. The ward sister to whom he complained told him that some of the lights on the indicator board in her office were not working and she would have them checked, but the problem remained.

19. The ward sister was unable to recall any complaint about lack of response to the call bell; she was certain that the complainant made no complaint to her about any aspect of nursing care, although she thought he could have mentioned it to the NO. The sister assured my officer that she was insistent that staff answered calls as quickly as possible and they were well aware of this requirement. The time taken to answer varied according to the workload but there were always three nurses on duty to care for a maximum of 16 patients and that was usually adequate. The NO told my officer that she saw the complainant on the day of his discharge home when he made known that he had telephoned the Press. She asked him quite specifically if he had any complaints about the nursing care and attention he had received and he replied that he had not, although she said he did mention that there were occasions when things were not attended to quickly. The staff nurse in charge in the ward sister's absence also told my officer that the complainant stressed to her on the day he left the hospital that he had no complaints about the nursing staff themselves. I have examined the nursing notes and found no reference to any complaints until 7 June when it was recorded that he had complained about his room etc and was seen by the NO about the 'hotel' facilities.

Findings

20. The nursing staff have no recollection of any specific complaint about lack of response to the complainants calls for attention. In my opinion, however, there probably were some small delays in responding at times.

Had there been serious delays I would have expected the complainant to impress his views on the staff more forcefully, but the recollection of the nursing staff directly concerned, which I accept, is that he had no complaints about nursing care. I do not find this complaint made out.

Conclusions

21. The complainant was justified in complaining to the hospital staff and to me about his room. He thought that its size and condition should have been reflected in the accommodation and services charge of £95·60 a day that he was asked to pay, but I know that charges to private patients for NHS hospital accommodation are designed to reflect the full cost of providing hospital in-patient services and are determined nationally by the Secretary of State. The relevant legislation provides no basis for the widely-held belief that a higher standard of hospital facilities and accommodation should be provided for private patients than for NHS patients. But I think the HA conveyed the wrong impression in his letter to the complainant when he said that the regulations did not *allow* the health authority to provide the complainant with a higher standard of service than that offered to non-paying patients (paragraph 2). In any event, as I have remarked in another similar case which I have recently investigated in this Area, the arrangement whereby private patients can be treated in NHS hospitals presupposes that a certain standard of private accommodation and service will be maintained by hospitals offering admission as a private patient and that that standard will match more or less the payment demanded for it. I have concluded that that was not the case here.

22. As I have already indicated, this is not the first case I have investigated this year about deficiencies in accommodation and services offered to a private patient. The allocation of additional funds for improving facilities in the private ward (paragraph 12) has been prompted in part by the complaints of those using the ward. I hope the complainant will get some satisfaction from the reflection that his action has played a part in improving conditions for future private patients. I am pleased to note that the AHA have already apologised for the shortcomings in this case but I do not think that that is enough. I find it disturbing that the Authority have been reluctant to make concessions in financial terms for the shortcomings they have admitted. In my judgment the complainant is entitled to be repaid some of what he has already paid to the AHA for accommodation and services which I find to be worth far less than £95 a day. I therefore invited the AHA to review the particular circumstances of this case and to consider making a repayment to him. After they had undertaken the review they concluded that they could not agree to make such a payment. They recognised that they had done so in an earlier case but they said that they were satisfied in that case the whole episode was so completely outside any normal range of tolerance that they were justified in treating it as wholly exceptional. They did not consider the complainant's experience to come into this category. But in my judgment, it did. They admitted that the accommodation was 'below standard' but not 'wholly unsatisfactory' and considered that the whole of the patient's stay had not been marred in the way it had for the

patient in the earlier case. They considered that by making a repayment to the complainant they would in effect be operating a sliding scale of charges.

23. While I recognised that there were differences between this and the previous case where the AHA had agreed to make a repayment, I thought that such differences as there were should be reflected in the quantum of the refund. I did not accept that by acting in this way the AHA would be operating a sliding scale of charges. I informed the AHA of my views, reiterating my judgment that the accommodation provided to the complainant was far below the value placed on it. The AHA replied that their fear in the future was that if one of their services to a patient were to fall short of what was reasonable, then they 'might be faced with claims for deductions and thence in effect a sliding scale'. They added that although there were some very unsatisfactory aspects in this complaint for which an apology was undoubtedly necessary, they still did not feel after very careful reflection, that it was in the same category as the earlier case.

24. I conclude that the complainant complained at the outset, that he had reason to do so and that the standard of accommodation and services in no way justified a charge of £95 a day. I also bear in mind the fact that he occupied what the sister regarded as probably the worst room of the private ward when other patients were occupying better rooms in that ward at no charge. I have concluded that this complaint was justified and has not been remedied.

Case No. W.287/80–81 – Nursing care and hospital discharge arrangements of elderly patient.

Background and complaint

1. The complainant's husband, aged 73 years, was an in-patient at a hospital (hospital A) from 22 August to 24 September, from 28 September to 3 October and from 18 to 19 October 1979. He was taken by ambulance to a second hospital (hospital B) on 12 November and re-admitted to hospital A. On 14 December he was transferred to a third hospital (hospital C). He died there on 6 January 1980.

2. The complainant contends that:—

(*a*) during her husband's first stay in a ward (ward X) at hospital A his personal cleanliness was neglected and on one occasion he was placed in the bath only on condition that the complainant bathed him because the nurses were so busy ;

(*b*) during that stay no one noticed that he was losing the sight of his right eye ;

(*c*) when her husband was discharged on 24 September he was unshaven and had vomit stains on his clothes ;

(*d*) when she bathed him on that day she found he was covered with bruises ;

(*e*) on 19 October he was discharged from hospital A and left alone on the doorstep of their home although he was unable to stand unaided ;

(*f*) on 11/12 November her husband was obliged to travel to hospital B by ambulance four times before the duty doctor accepted that his condition warranted admission and, even then, he was re-admitted to hospital A ;

(*g*) following her husband's admission to a second ward (ward Y) at hospital A on 12 November his cleanliness was again neglected and he was regularly left in a chair for five or six hours soaking wet because of his incontinence ;

(*h*) although her husband was unable to chew his food the nursing staff refused to have it pureed ;

(*i*) on one occasion because he was unable to swallow his tablets her husband spat them out on the floor where she found them at visiting time ;

(*j*) on the only occasion she was allowed to bath her husband after 12 November she found he had bleeding sores.

The complainant wrote to the Area Health Authority (the AHA) but was dissatisfied with their incomplete replies.

Investigation

3. During the investigation I obtained the written comments of the AHA and examined the relevant documents including the clinical and nursing notes and the correspondence on the complaint. One of my officers met members of the medical, nursing, voluntary and administrative staff of the hospitals concerned and of the AHA. She also met the complainant and members of the Social Services Department of the area where the couple lived (the social services department).

(a) *Nursing care on ward X*

4. In her complaint to the AHA and in discussion with my officer the complainant said that in August 1979 her husband was suffering from vomiting and rectal bleeding and, following a domiciliary visit from the consultant physician in geriatric medicine (the consultant), he was admitted on 22 August to ward X at hospital A. His wife complained that her husband's personal cleanliness was neglected; she gave the following account. She said he was unkempt and about a week after admission she found he was beginning to smell. He had to wash himself in a bowl of water placed by his bed but no soap was provided. During the second week of his stay she noticed that his face was blotchy and there was thick scurf in his hair. She said he had not been bathed since his admission. The complainant asked the nurses whether he could have a bath but they said she must ask the ward sister. The sister agreed that he could but said the complainant must bath him herself because the nurses did not have enough time. The following day the complainant took some toiletries to the hospital and bathed her husband after some nurses had carried him to the bathroom. She bathed her husband

on one other occasion during his stay on ward X and would have liked to have done so more often but the nursing staff would not allow it. The complainant said that, although she was often told the ward was short of staff and this was given as a reason for not bathing her husband, there always seemed to be plenty of nurses.

5. The sister in charge of ward X (the ward sister) told my officer that all patients were bathed at least once a week but often more frequently. Baths were normally given between 1 pm and 4 pm when there were most staff on duty. She said that the complainant sometimes wanted to bath her husband and wash his hair herself and she was encouraged to do so; nurses would lift him in and out of the bath and she would wash him. The ward sister remembered that the complainant's husband had greasy skin and his wife brought in special cream to use on his scalp. She said that on days when patients did not have baths they were washed twice daily and incontinent patients more often. The complainant's husband was able to wash himself during the latter part of his stay in hospital and would have been encouraged to look after himself. She said most patients preferred to have their own soap but, if they did not, it was always available on the ward. The ward sister did not remember the husband's face being blotchy or his hair having scurf in it. The consultant told my officer that he considered the nursing care on ward X to be quite adequate and confirmed that relatives were encouraged to help.

6. The contemporary nursing notes and the ward bath book show that during the period from 22 August to 24 September the complainant's husband had nine baths and four of these were given between 22 and 30 August. The records also show that the complainant twice helped nurses bath her husband and that on the second occasion she cut and shampooed his hair. The nursing notes indicate that she liked to help in this way.

Findings

7. The complainant's husband would have been washed routinely when he was not bathed. The complainant is wrong in thinking that her husband was not bathed until the second week of his stay in ward X. During the latter part of his stay he had fewer baths but this was when, according to the ward sister, he was able to wash himself. The ward policy is to encourage relatives to help patients and it is recorded that on two occasions the complainant helped bath her husband. I do not uphold the complaint that the husband's cleanliness was neglected.

(b) *The husband's eyesight*

8. The complainant said that in May 1979 her husband had suffered a stroke and afterwards she noticed that he did not seem to be focusing well although previously his eyesight was normal with glasses. While he was in ward X he told her his vision was blurred and fuzzy in his right eye and she noticed he often pulled at that eye although he did not rub it. In the past he had been an avid reader but in the ward he lost interest in books and television. The complainant had assumed that the blurring was caused by the stroke. After he was discharged from hospital he continued to com-

plain about his vision until he was seen by a doctor at home on 19 October. She said the doctor examined him and said he was blind in the right eye (but see paragraph 27). The complainant suspected that no one had noticed earlier that he was going blind.

9. The clinical notes show that the husband's sight was fair when he was admitted. The consultant told my officer that it would not have been tested as a matter of routine during his stay unless the complainant's husband made a complaint about it or the nursing staff noticed any problems. He said that the report made by the doctor who visited the husband at home (the senior registrar) showed that he was suffering from retinopathy which was the result of high blood pressure. This would have developed over a period as would the cataracts which were also present.

10. The senior house officer who attended the complainant's husband during August and September (the first SHO) and the senior registrar confirmed the consultant's statements. The senior registrar added that the husband had some vision in his right eye but was unable to focus properly. The ward sister told my officer that she did not notice any change in the husband's sight while he was on the ward and the nursing notes do not show that he made any complaint about his sight to the nursing staff.

Findings

11. I find it surprising that there is no record that the husband complained to the nursing or medical staff of loss of vision during this particular stay if there was any foundation in the complainant's fear that her husband had gone blind in his right eye while he was in hospital. The senior registrar who examined him took the view that the deterioration in his eyesight happened over a long period and the consultant was of the same opinion. These views are matters for the clinical judgment of the doctors concerned and I cannot question them. There is no evidence to substantiate this complaint.

(c) *Discharge from hospital on 24 September*

12. The complainant told my officer that when her husband arrived home after his discharge from hospital on 24 September he was unshaven and had vomit stains on his jacket and trousers. She said the ambulancemen told her that he had vomited in the ambulance and that they would report this to the ward sister. The complainant thought her husband looked as if he had not been shaved for about three days. As far as she knew the nurses did not shave patients; a barber called to do this but only infrequently.

13. The ward sister in discussion with my officer explained that a barber visited ward X on Monday, Wednesday and Friday of each week to shave the male patients. If necessary male nurses would shave the patients between his visits. She did not remember the complainant's husband vomiting while on the ward and thought that had he done so regularly, drugs would have been prescribed. She did not recall receiving a report that he vomited on the way home.

14. A state enrolled nurse on ward X who was on duty on 24 September said that those patients who were able were encouraged to shave themselves. I have seen that the occupational therapist's report of 7 September suggested that the husband's shaving gear might be brought in from home for him to practice daily.

15. The attendant in the ambulance in which the complainant's husband was taken home has left the Ambulance Service and no report of the husband vomiting was made on the journey record. However the ambulance driver recalled that the husband vomited slightly during the journey but was cleaned up before arriving home. The driver added that he had conveyed the husband to and from hospital on other occasions and each time he had vomited during the journey.

Findings

16. It is not disputed that the husband's clothes were vomit stained when he arrived home on 24 September but this occurred during the journey. It was unfortunate but I make no criticism of the health authority for this. He was discharged on a Monday and he may well not have shaved or been shaved that day. But I make no criticism of the general arrangements that were in existence for shaving male patients in ward X.

(d) *The bruising*

17. The complainant bathed her husband almost as soon as he arrived home on 24 September. She said that while doing so she found he was covered with bruises which he said were caused by falling on the ward. She recalled that on one occasion when she was helping her husband to the hospital bathroom and he was using his walking frame she was warned by a nurse to watch him because he might fall.

18. The contemporary nursing notes record that the complainant's husband fell on 5 September when he got out of bed and that on 20 September he slipped on to the floor. On each occasion an accident report form was completed. The description of the accident on the second form said he was found sitting on the floor. He was trying to walk without his frame, lost his balance and went on the floor. He was examined by the first SHO who recorded that he had sustained no injury.

19. The ward sister said that accident report forms were always completed when patients fell. She did not remember whether the complainant's husband was bruised when he went home but said that elderly people bruised easily and healed very slowly. The state enrolled nurse who completed the accident form on September 20 was unable to remember the incident or any other occasion on which the husband fell. The consultant thought the complainant's husband may have been bruised when he fell but he doubted if he was covered in bruises. He added that one purpose on the ward was to mobilise geriatric patients and it was inevitable that sometimes, in trying to walk again, patients would fall. The first SHO said that the husband was unsteady on his feet, although he could walk with a frame. He might have fallen but the first SHO was not aware that he was bruised.

Findings

20. One of the hazards of encouraging patients to walk again is that they are liable to fall but it is nevertheless the duty of the nursing staff to encourage them. When the compainant's husband fell the correct procedure was followed and no injury was found. I accept that bruises may have developed later and therefore I do not doubt that when he arrived home he had some bruises from his fall four days earlier. But I believe the complainant was overstating the position in saying that her husband was 'covered in bruises' and I do not uphold the complaint in these terms.

(e) *Discharge from hospital on 19 October*

21. The complainant said that on 18 October she could no longer cope with her husband at home and because they were not registered with a family practitioner, she called an ambulance to take her husband to hospital. He was admitted but the following morning she received a telephone call from a nurse to say her husband was being sent home. She told the nurse that he was not fit to be at home and that he needed hospital care, but to no purpose. She gave this account of succeeding events. She telephoned her former family practitioner's partner who suggested that when her husband was brought home she should not answer the door so that he would be taken back to hospital. When the ambulance arrived she did as had been suggested and her husband was taken back to the ambulance. The driver spoke to the estate warden and said he was going to leave the husband outside his door. The complainant looked out of her window and saw a group of people below. Her husband was brought to the door of the flat and left leaning against the wall. She heard him call, opened the door and he collapsed into her arms. She telephoned the social services department and two social workers arrived ; later there followed a doctor from the hospital who introduced himself as the senior registrar. He explained that he had been off duty and that the husband had been left on the doorstep without his authority. She went on to say that he examined the husband and said that he was blind in the right eye but that there was no necessity for immediate readmission to hospital A. Later that day the husband was taken by the social workers to an old peoples' home (the home) in order to give the complainant a rest. She thought that the senior registrar called only to justify the action in discharging her husband and leaving him at her front door.

22. The community service volunteer who took the complainant's husband home on 19 October (the volunteer) said in his statement and in discussion with my officer that he did not normally take patients home when they were discharged but he had sometimes taken out-patients home. When he collected the husband from ward X he was told that the complainant was expecting her husband. The volunteer drove the husband to the block of flats where he lived and then transported him to his flat on the eighth floor in a wheelchair. There was no reply and he returned with him to his vehicle. He established that there was no warden who could provide access to the flat. But the volunteer then saw someone looking out of the window of the flat. He telephoned the senior house officer who arranged the husband's discharge (the second SHO) from a family practitioner's surgery nearby and was

told to leave the husband outside the front door of the flat. The volunteer tried to telephone the complainant but received no reply and the family practitioner's receptionist suggested getting in touch with a community worker on the estate. The community worker advised against leaving the husband on the dorstep and said that he should telephone the area specialist in community medicine (the ASCM). But before he did so the volunteer again saw someone looking out of the window of the flat and so went up to it again. He said that the complainant came to the door and behaved in a threatening manner when he told her he was taking her husband up to the flat. (The complainant later denied that she spoke to the volunteer at any time on 19 October). The volunteer took the husband from the vehicle and left him standing outside the flat. He then telephoned the ASCM to report what had happened.

23. The hospital voluntary services organiser (the VSO) told my officer that it was not normal for volunteers to take patients home when they were discharged. On this occasion her assistant understood from the second SHO that the complainant's husband was not an in-patient but had been brought to the hospital that morning and therefore agreed to a volunteer taking him home.

24. In his account of events that day and in discussion with my officer, the second SHO said that it was the husband's third recent admission and each time the patient himself had no complaint apart from constipation. On 18 October the complainant had sent a note with her husband when he was admitted saying that he had become more incontinent, was unsteady on his feet and very aggressive. On examination the second SHO found that the husband was cheerful and well orientated and had no complaints. In the absence of the consultant, he discussed the case with his registrar. They agreed that the husband did not need hospital care and he made arrangements for his discharge. The second SHO decided to ask for a voluntary worker to take the husband home because he anticipated that there would be difficulties in arranging, at short notice, transport by way of the Ambulance Service. A member of the nursing staff telephoned the complainant to inform her that her husband would be home shortly. Later that morning the volunteer telephoned the second SHO and told him he could see the complainant in the flat but she refused to answer the door. The second SHO gave the volunteer the complainant's telephone number and understood that he was going to try to get in touch with her.

25. The second SHO denied suggesting to the volunteer that he should leave the complainant's husband outside his front door. However he said that since the husband was fit and his wife was inside, there could be no real objection to leaving him in this way. He said that as far as he was aware the normal support services were arranged with the social services department after the husband's previous discharge although in retrospect he thought he probably should have got in touch with the social workers himself to let them know of this discharge. But the complainant had anyway promptly called her social worker. The second SHO also made the point that since the husband was fit enough to be admitted to local

authority Part III accommodation later the same day, he could not have been in need of hospital care because the home would not have accepted him in those circumstances.

26. The two social workers who visited the complainant and her husband on 19 October at home told my officer that earlier that day they had tried to arrange for the husband to be kept in hospital A by speaking to the doctor concerned and by asking the ASCM to intervene but it had not been possible. They provisionally arranged a temporary place in an old peoples' home for the complainant's husband but this was dependent upon his condition meeting the normal requirements for such accommodation. They therefore went to see him and found he was able to walk around the flat. They satisfied themselves that the other criteria for admission to the home were met i.e. that he was able to wash, dress and feed himself. And once the senior registrar had decided not to re-admit him to hospital they persuaded the complainant that it would be best if her husband went to the home so that she could rest. When they took him out to the car they found he was scarcely able to walk outside the flat even with his frame. Despite his limited mobility the matron of the home agreed to accept him temporarily. The social workers described the husband's condition as 'pretty groggy' and said he was not as well as patients normally were when discharged from hospital A.

27. The senior registrar told my officer that because the consultant was on leave he was asked to go to see the complainant's husband at home. When he arrived the complainant was unwilling to allow him to examine her husband but she was persuaded to do so by a social worker who was present. He examined the husband and considered he was well enough to be at home and that admission to hospital was not immediately necessary. His examination showed that the husband had some vision in his right eye but could not focus.

28. The consultant told my officer that his registrar and the second SHO were aware that he did not consider the complainant's husband was in need of hospital care following his previous admissions and because there was no change in his condition they were correct in discharging him. He did not however condone the action of leaving him outside the front door and said that normally in-patients were taken home by the ambulance service who, if they could not gain admission, would take the patient back to hospital. In his comments on the complaint the ASCM said he had made it clear to the staff at hospital A that the decision to discharge in a case such as this should be taken by a consultant in conjunction with the social services department.

29. The complainant was concerned that the senior registrar asked her during his visit on 19 October whether her husband had had a stroke before and I can understand why this should raise doubts in her mind. However I have seen the clinical note made by the senior registrar that day and there is no reference to a second stroke in it. In discussion with my officer the senior registrar said that although he had not seen the complainant's husband before and had not seen his detailed clinical notes before his visit, he was

aware that he had had a stroke previously. He could not positively say whether the husband had had another minor stroke but he confirmed that it was his view that the husband's condition did not warrant re-admission.

Findings

30. I think that it was an error of judgment to have called on a member of the voluntary service to transport the complainant's husband home on 19 October. There can be little doubt that he would not have been left at his front door had the ambulance service been summoned. And however anxious the second SHO was to get him back to his home after he had concluded that the patient's condition did not warrant admission, it should have been apparent from the recent history that there was also a social problem and I think greater thought should have been given to it. As it was, a domiciliary visit and a second transfer to the home were necessary the same day. The chairman of the AHA sent a written apology to the complainant for this incident and I support the ASCM's views expressed in paragraph 28. I know that the complainant hopes that others may benefit as a result of her complaint and on this important aspect, I believe they will.

(f) *The re-admission to hospital on 12 November*

31. The complainant told my officer that between 11 and 12 November her husband's speech deteriorated and he could only grunt ; in addition he could not stand even with his walking frame. She said on 12 November she called an ambulance to take her husband to hospital but on arrival at hospital B he was refused admission and returned home. She called an ambulance on two further occasions but each time the result was the same. She asked the ambulance crew why this was happening and they said the doctor at the hospital could find nothing wrong with him and that her husband did not say anything. The complainant called an ambulance a fourth time and on this occasion the crew suggested that she accompanied her husband to hospital B. The doctor on duty agreed to admit him but said that there were no beds available at that hospital and he would have to be admitted to hospital A. When she objected to this, the complainant was told the alternative was to have him home again and be responsible for him herself, so she had to agree to the admission.

32. I have examined the records of the Ambulance Service (the AS) relating to calls from the complainant on 12 November. Emergency calls were made at 12.51 am and 1.54 am and the caller said on each occasion that the complainant's husband had fallen on the floor. The ambulance crew went to the flat and merely put him back to bed each time ; their records show that they did not take him to hospital B and there is no indication in the register of the accident and emergency department (the A and E department) that he was taken there on those occasions. However following a further call at 2.40 am he was taken to the A and E department.

33. The clinical note made in the A and E department shows that the ambulance crews had not detected any injury when they had been called three times but on the third call took the complainant's husband to hospital so that

the complainant would not continue to call them throughout the night. On examination the duty doctor found no signs of injury but decided to keep the husband in hospital until the morning when he could go home. He recorded in the notes that the complainant said on the telephone that she could not cope with her husband at home and the duty doctor made a note that a social worker should be asked to visit. A second doctor in the A and E department wrote in the notes later on the morning of 12 November, that the husband wanted to go home and agreed that he should be discharged. The duty doctor told my officer that he allowed the husband to stay in the A and E department until morning but did not admit him because there was nothing wrong with him and he had no complaints himself.

34. The social services department records for 12 November show that at 9.00 am a member of the hospital staff telephoned to say they wanted to send the complainant's husband home but could not get in touch with his wife and thought she might not accept him back. A social worker telephoned the complainant who said she was waiting for her husband to return home. The social worker notified the hospital. The AS provided an ambulance to take the husband and at 11.25 am the crew reported that the complainant did not want to let her husband in. They were told that a social worker would visit and finally they left the husband in the flat with his wife. A further emergency call was made by the complainant at 3.52 pm and her husband was again taken to the A and E department where it was arranged that he should be admitted to hospital A.

Findings

35. It is clear from the hospital and ambulance service records that the complainant's husband was taken to hospital B twice on 12 November. On the first occasion he was kept there for several hours until his wife told the social worker she was waiting for his return. On the second he was transferred and admitted to hospital A which provides all long-stay geriatric care in the district. The complainant is therefore wrong about the number of times her husband was taken to hospital and I dismiss this aspect of her complaint. Furthermore by 12 November her husband had been allocated to a family practitioner and the complainant would have been better advised to have approached the family practitioner on call than make numerous emergency calls for an ambulance.

(g) *Nursing care on ward Y*

36. The complainant's husband was admitted to ward Y at hospital A on 12 November. The complainant told my officer that she visited him every day from 2 pm to 7 pm and he was often left sitting in his chair with his clothes wet and puddles of urine under his chair. When she asked the nurses to clean him they always said they had no time. After the first week in hospital her husband's eye became bloodshot and later 'a ball of fire', very red and running with tears. When she pointed out to the nurses that her husband's eye was becoming red they said they would bathe it in the evening. She thought the care her husband received on ward Y compared very unfavourably with that given subsequently at hospital C.

37. The nursing notes record that the complainant's husband was frequently incontinent of urine particularly at night. They also indicate that on 7 December his eye was very inflamed and the doctors were to be informed. An entry in the clinical notes for 12 December simply said 'eye swab'. On 13 December another registrar (the second registrar) asked for a specialist opinion about the eye. The following day the second registrar recorded in the notes that the husband was not complaining about any eye problems and was not in pain. However he made a provisional diagnosis of glaucoma and the husband was transferred to hospital C the same day so that his eye could be examined quickly by a specialist.

38. The charge nurse and a staff nurse in ward Y (the charge nurse and the staff nurse) told my officer at separate interviews that they thought it impossible that the complainant's husband was left wet for five or six hours or with puddles of urine under his chair. The charge nurse said that the complainant spent a great deal of time with her husband and if he was incontinent she would have asked a member of staff to clean him at once. He added that on many occasions when she thought her husband needed something she would ask the nurses even if they were attending to another patient at the time. The staff nurse thought the complainant was demanding and expected the staff to pay a disproportionate amount of attention to her husband. The charge nurse explained that there was always a domestic on the ward who would clean up puddles of urine and pointed out that it would be unpleasant for the staff if urine was left on the floor for any length of time. In his written statement the charge nurse said that the complainant did not want her husband to be catheterised ; but the complainant says this was never discussed. He also explained that they were not able to fit the husband with an incontinence sheath. The consultant said that the nursing care on ward Y was very good and he was more than satisfied with it.

39. The charge nurse said that junior doctors did daily rounds of their wards and he was sure a doctor would have seen the husband's red eye before 12 December. The second registrar told my officer that he did not remember the complainant's husband but the house officer must have called him to see the husband when the red eye did not clear up. His first thought was that the husband had an infection and he therefore ordered an eye swab and asked for an appointment for a specialist opinion. However before that could be arranged the second registrar decided on 14 December that there was a possibility of glaucoma and the husband was transferred to hospital C to be examined there.

Findings

40. I have no doubt that the complainant was particularly vigilant about her husband's eyes after the senior registrar had mentioned his sight on 19 October (paragraph 27). Understandably, she expressed concern to the nurses but the treatment of his eye was a matter for their professional judgment and the house officer's clinical judgment and I do not question this. There are inevitably times when the nursing staff are not able to attend to patients at once and I do not doubt that the complainant's husband was

sometimes wet as a result of his incontinence. But I do not believe he was left for hours in that condition. I do not uphold this complaint.

(h) *The diet*

41. The complainant said that her husband was unable to chew or swallow his food properly while on ward Y and was losing weight as a result. She asked the charge nurse if food puree could be provided but he said it was not necessary. Her husband was sent what was called a liquidised diet on one occasion but it was simply gravy from the meat and juice from tinned peas. When the complainant offered to bring him some Complan from home she was told his diet was ordered by the consultant and could not be interfered with.

42. The consultant told my officer that he had not ordered any special diet for the complainant's husband because it was not necessary. The charge nurse said that when the complainant was not there, her husband managed to eat quite well. However because the complainant was unhappy about the food, on one occasion he ordered a soft diet for him. His wife was not satisfied with this because it was like liquid and she described it in an offensive manner. He said soft food could always be ordered if necessary and there was almost always at least one patient on the ward who needed it. The charge nurse said the reason he told the complainant not to bring Complan from home was because it was always available from the ward.

43. The staff nurse recalled that the complainant's husband ate quite well but that his wife would not believe it. He generally managed to eat on his own but on one occasion when the complainant was present, the staff nurse helped her husband to eat a normal dinner to show her that he could swallow it. The nursing notes include numerous entries to the effect that he took his food well or fairly well but they also indicate that on occasion he had a soft diet.

Findings

44. I believe that the complainant's husband was able to eat and was not regularly in need of a soft diet while on ward Y. When he needed it I have no doubt it was provided. I do not uphold this complaint.

(i) *The tablets*

45. The complainant said that because her husband could not swallow he was often unable to take his tablets and he sometimes spat them out. She arrived on the ward at visiting time and had found them on the floor on one occasion. However when she asked the nurses to crush the tablets for her husband they said they did not have enough time. When he was transferred to hospital C his tablets were regularly crushed by the nurses.

46. The charge nurse told my officer that the complainant's husband could chew and swallow his tablets and it was not necessary to crush them. They were crushed for patients who found swallowing difficult. If they were unsuitable for crushing the doctor would be informed to see whether the drug could be administered in an alternative form.

Findings

47. The complainant may well have found her husband's tablets on the floor on one occasion but that does not demonstrate that he could not swallow. The nurses believed, in their professional judgment, that he could swallow them and I do not question that judgment.

(j) *The bedsores*

48. The complainant said that she was allowed to bath her husband on only one occasion after his admission to ward Y. This was about a fortnight after his admission and he had not had a bath previously and his hair and ears were filthy. She found that the skin on his buttocks, elbows and ankles was shrivelled and sore and that he had bleeding sores on his buttocks. She called the charge nurse but was told everyone had sores because they were lying in bed all day. She pointed out that her husband was sitting out in a chair most of the time and felt that the sores were caused by the urine which was not cleaned up regularly. She said that because she complained to a medical social worker about her husband's condition it was arranged that as soon as a bed became available he would be transferred to another ward where the charge nurse was more caring. However before a bed was available he was transferred to hospital C for the treatment of his eye.

49. In the nursing notes it is recorded that on 4 December the complainant's husband had broken skin on the sacrum and on 6 December a superficial sore on the sacrum. Throughout the period when the husband was on ward Y there were regular notes that his pressure areas were treated and after 6 December the treatment given and dressing applied were noted. The nursing notes relating to the husband's stay in hospital C showed that on admission on 14 December he had bedsores on his buttocks. On 17 December it was recorded in the clinical notes that he had pressure sores on his hips, ankles and buttocks and on 2 January that the complainant constantly remarked on the neglect of her husband both there and at hospital A.

50. The charge nurse said that all patients were bathed at least once a week and washed every day. In addition they were washed or medi-bathed after any episode of incontinence. He remembered the complainant helping him to bath her husband on two occasions and said she may well have helped other staff as well. To prevent sores developing incontinent patients were dried carefully after washing, nursed on ripple beds and turned regularly. Despite being nursed on a ripple bed the complainant's husband developed a superficial sore on his back. The charge nurse and the staff nurse had no recollection of any bleeding sores.

51. The consultant told my officer that it was inconceivable that the husband could have had bleeding bedsores without them being mentioned in the notes. The nurses always looked out for sores and recorded them in the notes and if they were bleeding might well report them to the medical staff who would normally mention them in the clinical notes. The hospital medical social worker (the MSW) told my officer that the medical staff decided that the husband would not be discharged again and he would

therefore be transferred from ward Y, an acute ward, to a continuing care ward (ward Z). Since the MSW knew the complainant was unhappy about the care her husband was receiving on ward Y he showed her ward Z and introduced the staff. He told her that they were very caring so that she would not be depressed at the thought of her husband having to stay in the hospital.

Findings

52. The complainant's husband developed a superficial sore on his sacrum while a patient in ward Y but the observations made when he was admitted to hospital C do not confirm the complaint about sores on his elbows and ankles and bleeding sores on his buttocks. He was to be transferred to another ward because he had been reclassified as a long-stay patient and not because of any shortcomings in the care he received. I do not uphold this complaint.

The handling of the complaint

53. After the incident on 19 October the complainant approached her local councillor who in turn got in touch with the area officer of the social services department. On 9 November the latter wrote to the ASCM describing the events of 19 October. He said that he did not consider that there was justification for depositing a frail elderly man in the hallway of a block of flats. The ASCM replied on 11 December and said it appeared that one of the junior doctors was rather over anxious to get the complainant's husband out of hospital on 19 October. He also explained that the procedure to be followed in future, in cases where it was proposed to discharge a patient in circumstances similar to those of the complainant's husband, had been revised (paragraph 28).

54. Copies of this correspondence were passed to the councillor who, on 11 January 1980, wrote to the AHA chairman asking for a full investigation of the incident on 19 October by members of the AHA. The AHA chairman obtained comments from the staff and copies of statements made by those involved in the husband's discharge from hospital and on 15 February replied to the councillor. The chairman gave more detail to the councillor about the events of 19 October as described by the volunteer and answered some specific questions put by the councillor.

55. On 4 March the councillor wrote to the AHA chairman enclosing a copy of a long statement made by the complainant about her husband's care. He added that there were still some points about the events of 19 October which the AHA chairman had not dealt with and that he would like an investigation of these. Further comments were obtained from those involved by a member of the AHA and in August he prepared a report on the complaints. The AHA chairman wrote to the complainant on 10 September and said that one of the AHA members had investigated her complaints about hospital A. She apologised that the complainant's husband was left outside his home without attention on 19 October. As for the other complaints the chairman recognised the complainant's understandable con-

cern about her husband's condition but concluded that the nursing staff did their best in the circumstances.

56. In discussion with my officer the AHA chairman said that it had been quite wrong that the complainant's husband had been left outside his door on 19 October. She explained that although the AHA member had prepared a full report she deliberately kept her letter to the complainant brief because she thought that detail would provoke further queries as had happened after her first letter to the councillor. She tried to make it clear to the complainant that a full enquiry had taken place and that the AHA had concluded that members of staff were doing their best in an imperfect world. A copy of the full report was shown to the local councillor to reassure him that a full investigation had in fact taken place.

Findings

57. The enquiries that were made were very thorough and I have no criticism on that score. But while I appreciate the AHA chairman's reason for sending a brief reply to the complainant, I do not consider that a two paragraph letter constituted an adequate reply to a five page statement of complaint. I think that the AHA chairman should have given the complainant some explanation of the care her husband received without necessarily setting out all the details which had been included in the personal confidential report prepared by the member.

Conclusions

58. The AHA chairman has told me that she is sorry if the complainant felt that she was unsympathetic in her reply and that if she gave that impression she wished to apologise wholeheartedly to the complainant. The chairman assured me that the AHA prided itself that it is a caring Authority and that she was personally much concerned about the content of the letters of complaint. I think the investigation the AHA undertook shows this to be the case. Many of the complaints in this case were concerned with the nursing care in two wards of hospital A. It is clear that when the complainant was unable to provide her husband with adequate care, she expected a standard in the hospital which would have required for substantial periods the sole services of a member of the nursing staff. The husband's condition did not warrant this and consequently his wife was dissatisfied. I have not found the complaints about nursing care to be made out. However, it is not disputed that the discharge arrangements on 19 October were badly handled and the chairman has already apologised for them. The procedures have been revised and I believe that the revision will prevent a repetition of the experience suffered by the complainant's husband.

Case No. W.340/80–81 – Care and treatment provided for paralysed patient at home.

Complaint and background

1. The complainant's husband became paralysed from the waist down and was admitted to hospital (the hospital) on 17 March 1980. On 9 April a hospital occupational therapist (the OT) and a medical social worker (the

MSW) visited his home to assess its suitability and the adaptations which would be necessary if he was to return to it. He was discharged home on 21 April. He died on 17 June.

2. The complainant complained through her Member of Parliament (the Member) that:

(*a*) the Area Health Authority (the AHA) and the County Council Social Services Department (the SSD) failed to liaise effectively to provide adequate service, care and equipment both before and after her husband's discharge from hospital;

(*b*) the hospital provided a helping-hand pick-up stick for which she paid £3·78 but which proved to be useless;

(*c*) the hospital failed to advise her husband's family practitioner (the FP) promptly about his discharge; and that

(*d*) a satisfactory domiciliary nursing service was not provided for her husband.

Jurisdiction and investigation

3. The actions taken by SSD staff which are included in complaint (*a*) are the subject of a separate but concurrent investigation and report by the Commission for Local Administration. During my investigation I obtained the comments of the AHA and have examined relevant documents including the medical and nursing notes. One of my officers and an officer of the Commission for Local Administration interviewed the AHA and SSD staff concerned.

(a) *The complaint about the lack of liaison*

4. In her letter of complaint to the Member and in her interview with my officer, the complainant said that shortly after her husband's admission to the hospital a nurse had told her that his prognosis was poor and this was later confirmed to her by the consultant orthopaedic surgeon (the consultant). However her husband continued to visit the occupational therapy department (the OT department) and she said that she had joined him there on two occasions when they had practised using a hoist, and her husband had also demonstrated to her his ability to use a sliding board which helped him to move from his wheelchair to a bed. She said that she met the senior occupational therapist (the senior OT) who told her that they were not used to dealing with a paralysed person and just gave her a catalogue of available aids and equipment. The complainant said that the medical and nursing staff had given no indication of a date of discharge for her husband but on 9 April the OT and the MSW (a SSD officer) visited her home to judge its suitability for her husband. She said that although they discussed the provision of ramps and minor adaptations the advice they gave was very vague. They gave the impression that everything necessary would be put in hand in readiness for her husband's discharge. A few days before he was due home a bed was delivered but it was dirty and too high for her husband's wheelchair. Some other items including a hoist and a commode were also delivered but these too she found to be unsuitable and dirty. The day before her husband's discharge she said that she had asked the senior OT where she could obtain more suitable equipment but she could not tell her.

5. The complainant said that on 30 April she and her husband had complained to a social worker at the hospital about the equipment provided and the officer in charge of community nursing aids (the equipment manager) (a NHS officer) visited them almost immediately and was helpful. However, the complainant said that no one seemed to have overall responsibility for liaison or for offering advice or providing information about aids and equipment.

6. The Member referred the letter of complaint to the Minister of Health who asked the AHA for a report. In their reply the AHA said that while the complainant's husband was in hospital, physiotherapy and occupational therapy were provided to help him adapt to the routine of life as a paraplegic. On two of his visits to the OT department he was accompanied by his wife and she learned how to transfer him from a wheelchair to a bed. The AHA said that the complainant had been lent three books about caring for the disabled at home and was also given information about the Disabled Living Foundation and a private appliance supplier. The visit of 9 April was made in preparation for the husband's discharge on 21 April and arising from it the OT and the MSW made several recommendations including the use of a more accessible bedroom, the supply of a hospital bed with overhead lifting grip and a mobile hoist, the provision of ramps, and daily visits from a district nurse. The AHA said that later that day the SSD were requested by telephone and on the following day in writing, to provide ramps and also to arrange supervision and support after the husband's discharge.

7. The AHA said that various aids and equipment were delivered on 18 April and although a suitable commode was not available at first an alternative model was supplied which was replaced by a mobile commode on 22 April. The wheelchair which had been used by the complainant's husband in hospital was also delivered, with a suitable headrest, but the OT department had not recommended a sliding board. The AHA said that no adjustable height beds were available at the time and an old-style hospital bed had been provided. It was higher than the wheelchair but it was common practice in such cases to lower it by removing the wheels. More equipment was delivered as other needs and difficulties were identified. The AHA said that the nursing aids provided for patients were not new but they were checked before delivery.

8. The AHA said that the ward charge nurse had visited the husband's home before he was discharged and had strongly recommended that he remain in hospital, but the complainant insisted that she could manage. The AHA said that other staff they had interviewed had commented that because she was impatient for her husband's return home she had failed to appreciate the difficulties of caring for him there, and that both the OT and the charge nurse had recommended that he should go home for a weekend as a trial.

9. The senior OT told my officer that it was possible to provide some nursing aids for immediate use quickly but other aids for daily living had to be ordered through the SSD and this took time. She said that she ordered various nursing aids on 9 April but had not realised how old the bed would be or that it would be of a different height to that on which her husband had practised in hospital. The OT told my officer that she and the MSW

had discussed with the complainant on their visit on 9 April details of her husband's immediate and basic needs on discharge. On her return to the OT department she had telephoned the community OT (the community OT) (a SSD officer) to discuss what equipment the SSD could provide. I have seen that she wrote the next day requesting ramps and other items and suggesting a home visit by the community OT.

10. The equipment manager's records show that he visited the complainant's home on 22 April when he delivered the mobile commode and discussed their immediate problems with them and additional equipment was delivered next day. He recorded that he had visited on 1 May to assess the complainant's husband for bath aids and the following day a bath hoist was fitted. The equipment manager told my officer that he thought some of the problems could have been overcome if he had attended the home visit on 9 April but he felt that too much equipment had been needed in too short a time. He agreed that the bed was unsuitable but said that the complainant had not wanted to have the wheels removed until an adjustable bed was available. He said that no equipment was issued unless it was in a clean and respectable condition. The van driver confirmed to my officer that he always checked that equipment was clean and in working order before it was delivered.

11. I have seen that the husband's OT notes record that although he spent two days at home before discharge a trial weekend was strongly recommended. He returned to the physiotherapy department on 30 April and was referred from there to the OT department. The OT notes indicate that he and his wife were in a distraught condition because of the problems at home and that the senior OT contacted the SSD to inform them of this, as it was then apparent that the community OT had not visited.

12. In a statement to the AHA and in an interview with my officer the charge nurse said that discharge arrangements normally followed a 'phased' pattern, with patients going home at first during the day, and then for a weekend, as this arrangement identified home nursing problems. He said that as the complainant had pressed to have her husband home the phased period had not been as long as he would have liked. He said that he had not been in favour of discharge and had told the complainant and her husband that the consultant, who was kept informed of the situation, was very willing for the husband to remain an inpatient. The consultant confirmed to my officer that he was aware of the charge nurse's advice to the complainant and her husband but considered that it would have been unreasonable to keep the husband in hospital against his will. However the complainant told my officer that she had not insisted upon her husband's discharge.

13. I have seen that following this complaint a series of meetings took place between the NHS and SSD staff to discuss the future coordination of discharge arrangements. The divisional nursing officer, community services (the Div NO) and the assistant district administrator told my officer that this complaint had highlighted deficiencies in their organisation and that as a result posts at the hospital for two liaison nurses had been established. They would work closely with all the social workers whose traditional role was to coordinate discharge arrangements.

Findings

14. In cases like this the division of responsibilities between health and the social services departments requires careful coordination which the AHA have admitted was lacking. I am pleased to see that, as a direct result of this complaint, procedures have been reviewed and that AHA have appointed liaison nurses to remedy organisational deficiencies. I uphold this complaint.

(b) *The complaint about the pick-up stick*

15. The complainant told my officer that the OT had given her husband a pick-up stick prior to his discharge saying that he would find it useful. He had thought it was free and had thanked her but on the day of his discharge he had at the OT's request paid her £3·78 for it. The complainant said that at home he had found the pick-up stick useless.

16. In their report to the Minister the AHA said that the complainant's husband had used a pick-up stick in the hospital and had expressed the wish to use it at home and to pay for it. It was possible for the aid to be obtained free through the SSD but the AHA said that the husband had wanted to take it immediately. The OT confirmed this statement to my officer and said that she therefore had to charge him for it. She said that before he was discharged she had asked him if he had found it useful and if he wanted one to take home. He replied that he would like one although, the OT said, he could have refused it.

Findings

17. The complainant's husband appears to have been surprised that he had to pay for the pick-up stick. Although one could have been supplied free by the SSD he preferred not to wait for it. In the circumstances the OT had no alternative but to charge him. I do not uphold this complaint.

(c) *The complaint about the notification to the FP*

18. In her letter the complainant said that the FP was not informed of her husband's discharge for five days and she told my officer that when he first visited he had said that he had no notes concerning her husband's drugs.

19. The AHA told the Minister that although the discharge letter was not posted until 24 April the FP was notified on the day of discharge. I have seen that there is an entry in the medical notes dated 22 April 'FP informed of patient's discharge'.

20. The FP told my officer that he was informed of the husband's discharge by telephone on 22 April and that all the necessary information, including that concerning drugs, was provided. He said that he had visited him that day and that he had enquired about the drugs, because sometimes a patient would be given last-minute instructions from ward staff just prior to discharge.

Findings

21. I am satisfied that the hospital advised the FP promptly by telephone of the husband's discharge and that the necessary infomation about his drugs was provided. I do not uphold this complaint.

(d) *The complaint about the domiciliary nursing service*

22. In her letter of complaint and in an interview with my officer the complainant said that the district nurse (the DN) who visited her husband could not do his job satisfactorily and that he offered no help or advice. She said that his standard of hygiene was low, that sometimes the sheets he provided were dirty and on several occasions they had had to be returned. His methods of handling her husband were, she said, inadequate and she had found his advice to her on lifting him to be impracticable. She said that despite requests that her husband should be bathed daily the DN was often too busy to do so.

23. The AHA said that experienced district nursing staff visited the complainant's husband twice daily during the first few days and daily thereafter. On the afternoon of the discharge the DN talked to the complainant and her husband for about an hour. As the husband did not wish to go to bed he was helped on to a settee and the DN showed the complainant how to lift him into a wheelchair. The AHA said that all the linen came direct from the linen pool and that on one occasion a small corner of a sheet had accumulated some dust. Although the DN had considered this insignificant it was replaced immediately the complainant commented on it.

24. The DN in a statement to the AHA and in an interview with my officer said that the complainant's husband had been specially referred to him as he had experience of dealing with patients with spinal injuries. He said that he had visited the husband in the hospital on 10 April and that he had later visited the husband's home. On the day of his discharge he had stayed for an hour to assess the situation, to settle in the husband and to try to build up a relationship with him and his wife. He had showed her a different method of transferring her husband from his chair because she would not use the hoist provided. He said that she had wanted a 24-hour domiciliary nursing service and that he had had to explain to her that due to his other commitments he could call only at intervals and could not stay for as long as they would wish. He agreed that they had asked for the husband to be given a daily bath but as on most days he could spend only three-quarters of an hour with him this was not possible, although he *was* given a bed bath each day. Later, he said, a more satisfactory hoist was provided enabling the husband to be immersed in the bath. He confirmed that the complainant had rejected several sheets provided by the hospital laundry, as they had small dust stains but he said that the complainant had never complained to him about his hygiene standards. I have seen the DN's log which states that he and his colleagues paid about 50 visits to the complainant's husband from 21 April to 30 May when the complainant and her husband engaged private nurses.

25. The DN said that he had discussed the case both with the FP, who had seemed satisfied with the efforts he was making, and also with his nursing officer. The latter told my officer that although when he visited them the couple were very critical of the assistance given with particular reference to aids and equipment, they made no complaint about the domiciliary nursing service.

Findings

26. I am satisfied, that bearing in mind his other commitments the DN provided a reasonable service and offered help and advice. His inability to meet all the demands made by the complainant to her dissatisfaction with the domiciliary nursing service. On the evidence I find no justification for this and I do not uphold this complaint.

Conclusion

27. I have upheld the primary complaint, about unsatisfactory liaison between the AHA and the SSD in the *organisation* of domiciliary services in this case but I have not upheld the other specific complaints. I welcome the remedial measures taken by the AHA (paragraphs 13 and 14) and I hope the complainant will gain some satisfaction that as a direct result of her complaint other people will benefit. The AHA have asked me to convey their apologies to the complainant in this report and I gladly do so.

Case No. W398/80–81 – Accident to elderly patient whilst travelling in ambulance

Background and complaint

1. On 16 November 1979 the complainant's mother, aged 73, was taken by ambulance from her home to the treatment clinic (the clinic) for elderly, sick and mentally infirm (ESMI) patients at a hospital (hospital A). During the journey she fell off her seat and broke her left femur, and she was subsequently taken to a different hospital (hospital B) where she died on 27 January 1980.

2. The complainant says that: –

(*a*) the Area Health Authority (the AHA) failed to ensure that the ambulance crew were sufficiently experienced to deal with an ESMI patient like the complainant's mother, or that they had been properly instructed in the action to take in the event of an accident such as hers ; and that

(*b*) the way the AHA dealt with her complaint was unsatisfactory.

Jurisdiction and investigation

3. The complainant's solicitors (the solicitors) who submitted the complaint on her behalf told me that she had decided not to take legal proceedings in respect of her mother's death and therefore I decided to investigate her complaints. During the investigation I obtained the AHA's comments and I examined relevant papers. My officer interviewed the staff concerned and he also met the complainant. I have studied the notes of the inquest into the mother's death and police statements about the accident, and my officer also interviewed a police inspector and a police constable.

(a) *The complaint about the ambulancemen's lack of experience and instruction*

A. The evidence given to the Coroner and his verdict

4. In evidence given at the inquest the ambulance driver (the driver) told the Coroner that he had braked sharply to avoid a collision. He said that he was told by the ambulance attendant (the attendant) that the complainant's mother had slid from her seat on to the floor. The driver said that he parked the ambulance and got into the back where he saw that she had been obviously shaken and that he had made a quick examination of her lower limbs but found nothing amiss. When they arrived at hospital A she had complained of pain and had been unable to stand up. The driver said that he had then called two more experienced ambulancemen and after they had examined her it had been decided to take her to hospital B on a stretcher. The attendant told the Coroner that he had asked the complainant's mother at the beginning of the journey whether she required the use of a seat belt but that she said she did not. He said that as far as he knew there were no standing orders that passengers had to have seat belts whether they liked them or not and he knew of no standing instructions prescribing what to do if a passenger was hurt during a journey. The driver also told the Coroner that he knew of no mandatory instruction regarding seat belts. It was stated at the inquest that the driver was a state enrolled nurse (SEN) and had commenced work in the ambulance service some two months prior to the incident ; and that the attendant, who had less than one month's experience, had attended the basic two weeks' induction course. It was also stated that the complainant's mother was sitting in the ambulance in a single seat which had an arm rest on the right hand side only and was fitted with seat belts. The seat was at the front left hand side of the vehicle just behind the door leading to the driver's cabin. The Coroner said that he would return a verdict of accidental death and that he would give the cause of death as pulmonary embolism from leg-vein thrombosis due to a fracture of the shaft of the left femur sustained when the ambulance 'braked sharply and so precipitated Mrs ———— from her seat'.

B. The evidence given to me

5. The solicitors in their submissions to me and to the AHA said that it was apparent from the attendant's evidence at the inquest that he had had a minimum of experience and that, whilst they appreciated that an attendant had to gain experience at some point, they felt that it was 'impracticable' to start with an ambulance full of ESMI patients who needed considerable care and attention. They also referred to the inexperience of the driver and said that it was apparent from his evidence at the inquest that he was not sufficiently experienced medically to be able to diagnose a serious fracture of the thigh. They said that the complainant's mother and the other patients in the ambulance had insufficient mental capacity to be able to decide for themselves whether to accept the offer of a seat belt. The solicitors said that in their opinion those responsible for induction courses were not discharging their responsibility to make the ambulance crew aware of the 'mental limitations with regard to any sick patient's

judgment'. They said that it appeared that there was no policy about the use of seat belts and that there were no standing orders regarding 'the conduct to patients in accidents'. The solicitors said that, as they had no evidence to the contrary, they accepted that the complainant's mother had been offered a seat belt, but they said that the complainant had been surprised that her mother had refused the offer because her mother had proved 'exceedingly acquiescent to all requests' during the four and a half months that the complainant had nursed her. The complainant confirmed to my officer that she could not imagine her mother refusing to wear a seat belt.

6. After the solicitors had written to me the area chief ambulance officer (the ACAO) sought the advice of a consultant orthopaedic surgeon about whether an ambulanceman fully trained to DHSS standards in ambulance aid and also a qualified SEN of some five years standing could reasonably have been expected to detect the fracture immediately after the accident in the ambulance. The consultant orthopaedic surgeon said that if the amount of deformity of the fracture was the same as that shown on the x-rays at the accident and emergency department he would have expected ambulance staff or SENs to diagnose that the femur had been broken. He thought that there was a possibility however that the femoral fracture could have been very little displaced initially and have only become more obviously displaced during subsequent movement. He said that it might then have been possible to suppose that on a quick 'general' examination of a patient who was a little confused and upset that, at that stage, the deformity might not have been present and therefore the fracture could have been missed.

7. The driver repeated to my officer the account of the incident which he had given to the coroner. He said that he and the attendant had intended asking a doctor to examine the complainant's mother when they reached hospital A. However, on arrival there, the mother complained of pain and was unable to move her left leg. He had known that a more experienced ambulance crew were at the hospital and when he had explained to them what had happened they took control. The driver told my officer that although he could not remember the complainant's mother actually taking her seat in the ambulance when he collected her from her home, he was 'consciously sure' that she had been offered a seat belt. He said that he had not been given any instructions about the use of seat belts on the training courses that he had attended and that, when acting as an attendant, he would put a seat belt on a patient if he thought that the patient would wear it; if not, he would leave it off. He said that he had made out an accident report at the ambulance station because of the injury that the complainant's mother had sustained. I have seen that the driver completed a vehicle accident form which included the information that she had sustained a fractured femur.

8. The attendant told my officer that he had offered the complainant's mother a seat belt but that she had refused to wear it. He said that his usual practice was to offer patients a seat belt and advise them that they would be safer with it on, but that if they refused to wear it he did

not insist. He said that he treated all patients, including ESMI patients, in the same way. He said that at his induction course he had asked about the use of seat belts and he had been told that there was no set rule that patients should be fastened in, but that they should be warned of the risks. The attendant said that the driver had examined the complainant's mother and that she had seemed all right. She had not complained of pain during the remainder of the journey to hospital A.

9. My officer also interviewed the ambulanceman who had examined the complainant's mother on her arrival at hospital A and he said that he had taken her to the clinic on many previous occasions. He recalled one occasion when he had fastened her seat belt and she had made it very clear that she did not want it. When he had called for her on subsequent journeys her husband had sometimes said to him 'Don't fasten her in today'. He also said that she, like many patients, preferred to sit in the same seat on every journey, and that the seat that she had occupied when the accident had occurred was her usual one. Another ambulanceman confirmed to my officer that on other occasions she had refused to wear a seat belt.

10. The AHA's assistant chief ambulance officer (the Asst. CAO) told my officer that the seat that the complainant's mother had occupied had been intended for an attendant and not for patients. He said that these seats had now been fitted with a second arm rest and staff had been told not to let patients sit in them.

11. A senior principal administrative assistant of the ambulance service (the SPAA) told my officer that, at the time of the accident, ambulancemen had been told to advise patients to wear seat belts but that if a patient refused to wear one they were not to use force since that would technically constitute an assault. He also said that notices were displayed in ambulances advising patients to wear seat belts. (My officer saw that there was such a notice in the ambulance that the complainant's mother had travelled in.) The SPAA told my officer that since this accident, and a similar one, advice from Counsel had been obtained, and the instructions to ambulancemen had been made more comprehensive. I have seen that ambulancemen are now advised that if a patient refuses to wear a seat belt they should use their own judgment as to whether to try to persuade them and that if the patient is considered to be mentally incapable of making a decision they should fasten that patient's seat belt compulsorily.

12. The AHA told me that the driver had qualified as an SEN in the Army in 1974. He had been appointed as a trainee ambulanceman in September 1979 when he had attended an induction course as recommended by the National Staff Committee for Ambulance Staff. He had been assessed as having above the average requirements for ambulance work and very good at the practical aspects. He had then attended a residential course in ambulance aid for six weeks during October and November 1979 and had obtained the highest class of overall assessment for theoretical knowledge and practical ability. The AHA said that the attendant had been appointed as a trainee ambulanceman on 29 October 1979 and had attended an induction course early in November. His practical standard had been assessed as good.

13. While I was conducting my investigation the Department of Health and Social Security issued a report by the National Staff Committee for Ambulance Staff entitled 'Care of the sitting case patient' and the report is relevant to this complaint. At the time of his interview with my officer the Asst. CAO said that the AHA had not reviewed the induction training of their ambulancemen in the light of that report but that they would be doing so. However, he said that since the attendant had undergone his induction training the syllabus had been revised and that it included a visit to a geriatric hospital during which ESMI patients were seen.

Findings

14. There is some doubt about whether the information that the AHA say was given to ambulance staff during their induction courses about seat belts was as clearly imparted to the ambulancemen as the AHA believe. I am pleased to say that I have been assured by the AHA that steps have been taken to make sure that there is no such confusion now. I am also pleased to have learnt that seats such as that which the complainant's mother occupied are not now used for patients and have been made safer for staff.

15. The evidence shows that the complainant's mother occupied the seat of her own choice and that she was offered a seat belt which she refused. I am satisfied that the driver as an experienced SEN was competent to decide whether or not a fracture had occured and that it may not necessarily have been easy to detect the fracture in the leg immediately after the fall. But in any case, the driver's actual decision about the extent of the injury was made in the exercise of his professional judgement and on that I may not comment. However, as soon as the driver and the attendant realised that the complainant's mother might have sustained an injury they called for more experienced help. She was taken immediately to hospital A and a report on the accident was made. Nor do I find any fault on the part of the ambulancemen in not insisting on fastening the seat belt when, as I find, she was unwilling for this to be done. Even a mentally infirm person may unfasten a seat belt in transit. I do not therefore find this complaint made out.

(b) The way in which the complaint was dealt with

16. I have seen that on 19 November 1979 the complainant wrote on behalf of her father who she said was extremely distressed, to the ACAO about the injury sustained by her mother. The area administrator (the AA) replied to the complainant on 20 December but the complainant's father telephoned the SPAA disputing some of the statements made in the AA's letter. Following further enquiries a letter was sent by the AA to him on 15 January. (I am sorry to say that he died about 2 months after his wife.)

17. The solicitors wrote to the AHA on 20 June 1980 (see paragraph 5) saying that they had been instructed to take civil proceedings in respect of the fatal accident and they invited the AHA to make an offer to settle out of court. They referred to the inexperience of the ambulance crew and the

capacity of the complainant's mother and the other ESMI patients to decide for themselves whether to accept offers of a seat belt. They asked whether the AHA intended to amend any of their policies in these respects.

18. In his reply of 7 July the AHA's legal adviser (the LA) said that he could not agree that there was any liability attaching to the AHA arising from the death of the complainant's mother. He said that there were no statutory conditions regarding seat belts but that they had been fitted in the ambulance and that she had been invited to use one but had refused. He also disputed that she was incapable of making such a decision.

19. The LA wrote to the solicitors again on 30 July saying that as a result of the unfortunate tragedy, consideration was being given as to whether certain patients should be strapped into their seats with or without their permission and that advice from Counsel was being obtained. The LA also said that the AHA were considering whether all seats in sitting-case ambulances should be fitted with arm rests as an additional precaution. He concluded his letter by expressing sympathy to the complainant.

20. The solicitors replied to the LA on 15 August 1980 saying that the complainant was still not entirely satisfied and they repeated their concern about the inexperience of the driver and the attendant. In his reply of 9 September the LA said that the system for training for ambulance men was sound and that at some time a newly trained man had to be sent out to do the job in order to gain experience. He also felt that the two ambulancemen involved had done everything they could in the circumstances and repeated his regret on behalf of the AHA for the unfortunate consequences.

21. The LA told my officer that his replies to the solicitors had been prepared by the then chief legal executive (the CLE). The CLE told my officer that he based his opinion about the mother's ability to make a decision for herself on the offer of a seat belt from the evidence given at the inquest. He said that other information given in the replies was based on his knowledge of how ambulancemen worked.

Findings

22. The AHA provided reasonable replies first to the complainant, then to her father and, despite the fact that there was the possibility of legal action, finally to the solicitors. They indicated what action they were taking and apologised to her. I do not uphold the complaint that the AHA dealt unsatisfactorily with her complaint.

Conclusion

23. The coroner's verdict was that the accident did contribute to the death. I have given my findings in paragraphs 14, 15, and 22. I hope that the complainant will gain some comfort from the fact that I have been assured that the AHA have reviewed their training programmes for ambulancemen, and the safety of seats in ambulances. The AHA have asked me in this report to extend again their regrets and sympathy to her for the distress this accident caused, and I gladly do so.

Case No. W.399/80-81 – Lack of supervision in adolescent unit

Background and complaint

1. The complainant's daughter (then 13) was admitted to the adolescent unit of a hospital (the unit) on 17 October 1978. He complains through his Member of Parliament (the Member) that:

(*a*) he wanted to remove his daughter from the unit but the registrar threatened at the time of his daughter's admission, and the consultant threatened on two other occasions, that if the complainant did not leave her there voluntarily she would be detained compulsorily ; and that

(*b*) when she was admitted he was told that she would be effectively supervised and kept away from adult patients, but on 20 March 1979 she was allowed to leave the unit alone and had sexual intercourse in another part of the hospital with an adult patient.

Investigation

2. During the investigation I obtained the comments of the Area Health Authority (the AHA) together with copies of the medical and nursing notes and other relevant papers. One of my officers met the complainant and the medical and nursing staff involved. The actions of social workers, who are local authority employees, are not within my jurisdiction but my officer interviewed them. The complainant's account of the events given in paragraphs 3, 4, 5 and 21 below has been compiled from letters to the Member and from his interview with my officer.

(a) *The complaint about the threats of compulsory detention for the complainant's daughter*

3. The complainant said that he had sought medical advice because his daughter had become 'quiet and withdrawn' for a week during each of three consecutive months and as a consequence the consultant had visited her. In the following month the problem recurred, and the consultant suggested to the complainant that he took his daughter to the unit and left her there if he approved of the hospital. The complainant said that with his wife (his daughter's stepmother) he looked round the hospital and the unit. He said that he was reluctant to leave his daughter because the unit was joined to accommodation for adult psychiatric patients, although when the consultant had seen his daughter at home she had said the unit was completely separate. The complainant said that he spoke to a staff nurse (the first SRN) and told her that he had decided to take his daughter home and that as a result of that conversation the first SRN had spoken to the registrar. The complainant said when he started to leave with his daughter he was threatened 'with legal or compulsory commitment of my daughter should I not leave her there voluntarily'. He said that he knew that his daughter needed help and he did not want to get involved in legal complications, so he reluctantly agreed to leave her in the unit for a week or two to see whether she improved. The complainant's wife confirmed her husband's account of the circumstances of their daughter's admission.

4. The complainant said that during a visit to his daughter two or three weeks' later she complained to him that she had been moved into another ward which also accommodated adult psychiatric patients. The complainant said that this had made him very upset and he had tried to take his daughter home. The consultant spoke to him on the telephone and told him that because of a shortage of nurses his daughter had been moved to the adult ward for a few hours. The complainant said that the consultant informed him that she would not allow him to take his daughter home. The consultant had said that she was reluctant to use the law to make him leave his daughter in the unit, but he told my officer that she had said something like 'You give me no choice. I have to get the police in legally. We can keep her here.' The complainant said that he had given in to the threats.

5. I have seen that, as part of the daughter's care, meetings were held by the hospital staff with her mother, her father and stepmother. The complainant said that during one of these meetings the consultant had said that she had come to the conclusion that electro-convulsive therapy (ECT) was necessary. The complainant said that he had been concerned about this proposal as the consultant had earlier told him that she did not like to use ECT treatment. The consultant and the registrar had both tried to explain to him the effect of ECT treatment but when he had asked if it could cause mental damage he had not been satisfied with the reply. The complainant said that he had therefore refused to give permission for his daughter to have ECT and had then asked the consultant if he could take his daughter home for two weeks to see if that would improve her condition. He said that the consultant refused to allow him to do this and they had a discussion about referring her to another consultant for a second opinion. The complainant said that the consultant said that she was prepared to do this but not to allow his daughter to leave the unit and she told him that she would involve the police and the courts if the complainant tried to take his daughter home.

6. The AHA told me that they did not think that they could usefully add anything to their report (the report) which was sent to the Member by the Department of Health and Social Security (DHSS) in August 1979 and which gave their comments, and those of staff concerned, about each of the complainant's specific complaints. The AHA said that it was contrary to normal policy to seek detention orders for adolescents and that as the consultant had been aware of the complainant's anxiety she had arranged for him to make a preliminary visit to the unit before he agreed to his daughter's admission. This indicated therefore that the consultant had not been prepared to admit the daughter without her father's consent. The AHA said that the complainant's daughter had not been moved permanently to another ward but on either 4 or 5 November, a week-end, she had spent four hours in a ward for disturbed adult patients. The reason for this was probably that the rest of the unit had gone on an outing and the complainant's daughter was too ill to go with them. The AHA said that there had been four patients on the adult ward on 4 November and five on 5 November. The AHA said that on that occasion the consultant had pleaded with the complainant not to take his daughter home and had

told him that if he did so he would have to sign a form acknowledging that it was against medical advice. The report made no reference to any discussion about her discharge after ECT had been suggested.

7. The consultant told my officer that prior to the daughter's admission to the unit she had treated her as an out-patient because the parents had refused to have her admitted either to a children's hospital or to the unit. She said that the complainant had telephoned her on 16 or 17 October saying that he could not cope with his daughter and she had suggested that the daughter be admitted to the unit but that it was important for the complainant to visit to ensure that he was satisfied with it. She said that she had not been present when the complainant's daughter was admitted but she might have telephoned the registrar. She had, however, told the nursing staff that the daughter was to be admitted if the complainant and his wife agreed.

8. The registrar told my officer that before the admission the consultant had telephoned him and had said that the complainant's daughter was rather poorly and needed physical as well as emotional care. The consultant had made no mention of compulsory detention. The registrar said that the complainant had been reluctant to leave his daughter and that he had told him that in his clinical opinion the daughter ought to be in hospital. He might have said that he would have to talk to the consultant about keeping her compulsorily. He had meant this as a statement of fact and not as a threat and he still considered that he was right to have said what he did. He had not gone into details of what compulsory detention involved as the complainant had then agreed to his daughter staying in the unit.

9. The consultant told my officer that she had not been aware that the complainant's daughter had been temporarily transferred to an adult ward until she received a telephone call on 5 November from the first SRN saying that the complainant wanted to take his daughter home. The consultant said that she spoke to him by telephone and pleaded with him to let his daughter stay in the unit because she needed nursing care and she assured him that she would enquire about the reason for the daughter's transfer to the adult ward. She had also told the complainant that if he insisted on taking her home he would have to sign a form saying that he did so against medical advice. She said that the complainant had asked her what she would do if he took his daughter home. She said that she would inform his family doctor and possibly the social services who could explore the possibility of his daughter going into care, but she said that this would be a sad outcome and disadvantageous for his daughter. She was emphatic that she neither threatened the complainant nor mentioned the courts or the police to him. She said that after about an hour's telephone conversation he had agreed to leave his daughter in the unit as it was necessary for her health.

10. The consultant told my officer that by 9 November there had been little improvement in the daughter's condition. She had considered the advisability of using ECT and had discussed this with her staff. She had asked

the complainant for permission to give ECT in the future if she thought it was in his daughter's best interest but he became very angry. She made it quite clear that no treatment would be given against his wishes. The complainant left after threatening to take his daughter home at his own risk if, after a further two weeks in the unit, there was no improvement in her condition. He had said that she would then have two weeks at home and if there was still no improvement in her condition he would bring her back to the unit and agree to ECT treatment. At that point she had suggested that a second opinion be obtained. The consultant said that she had not referred to police involvement and that she had not threatened the complainant at all, either on this or the previous occasion (paragraph 9).

11. The registrar could not recollect either of these two incidents although he said that he might have been present. He told my officer that he thought that if the complainant had tried to discharge his daughter the consultant would have considered the advisability of a care order because of her clinical condition.

12. A sister of the unit (the sister) told my officer that she had not been on duty when the complainant's daughter had been admitted but the daughter had been very disturbed at first and had not responded to treatment. She said that the complainant did not appear to understand that his daughter had to settle down and that he seemed to expect an instant cure. The sister said that she recalled that at one meeting with the doctors the complainant had been very difficult. She said that the consultant had explained to him that there was a Mental Health Act and that if in their opinion the complainant's daughter needed to stay in hospital they could easily keep her. This was simply an explanation, not a threat. The sister said that possibly because of his own concern about his daughter the complainant appeared to misinterpret the intention of everything that was explained to him.

13. None of the other nursing staff interviewed by my officer could remember any suggestion of a care order or compulsory detention for the complainant's daughter. However, a student social worker (the student SW) told my officer that she had been present when the consultant had discussed ECT with the complainant. She said that he had been very alarmed and had wanted to withdraw his daughter from the unit. The student SW said that the consultant had been worried about the daughter's lack of response to treatment and had suggested to the complainant that if his daughter was not detained compulsorily she would not get any hospital treatment. The student SW said that there was 'quite a lot of emotional blackmail' although she thought that the consultant was motivated by the hope of getting a rapid response from the daughter. The student SW said that the consultant had made no attempt to reason with the complainant. The student SW said that social services had definitely been mentioned in the conversation and she recalled the consultant saying something like 'we could call the police in to take [the complainant's daughter] into care so I could treat her in hospital'. The student SW told my officer that she had had to explain to the complainant that he had certain rights and that action could not be taken as easily as the consultant had been suggesting ; she had also explained to him what happened when admission was converted from a voluntary to a compulsory one.

14. The consultant told me that it was possible that unintentionally the student SW may have confused two separate discussions. The first was with the complainant, the registrar, the sister and the student SW, when ECT was considered because the complainant's daughter had failed to make any progress. The consultant said that she had not implied any compulsion for the daughter but the complainant then asked the registrar and the student SW whether they would consider ECT if the daughter were their child. The registrar said that although he would not agree at that time he would be guided by the professional under whose care his child was. The student SW said she would not agree.

15. The consultant said that later, when the complainant was *not* present, there was a staff discussion which was of an academic nature. They considered certain hypothetical situations. The consultant said that she pointed out that if its life was in danger a child could be taken on a place of safety order to hospital or children's home. Following that, the child could be taken into care but she emphasised that this did not apply to the complainant's daughter as her life was not in imminent danger. The consultant said that during the course of a long discussion the student SW told her that she did not agree with her point of view. The consultant said that she explained to the student SW that in that eventuality the responsibility would be hers and that a child like this needed not only medical care but nursing care. The consultant said the student SW said that she would consider care proceedings. The consultant confirmed to me that she did not at any time consider converting the admission from a voluntary to a compulsory one.

16. The student SW later confirmed to my officer that separate discussions had taken place as described by the consultant, but she reaffirmed her description (see paragraph 13) of the tone and content of the discussion with the complainant.

17. The clinical notes record that the complainant left his daughter in the unit on 17 October but that on 23 October he told the registrar that he wanted to take her home. An undated case summary refers to the complainant's 'reluctance and apprehension' on his daughter's admission to the unit. The nursing notes for 5 November say 'Parents visited this afternoon and wanted to discharge their daughter. After talking to [the consultant] on the telephone he changed his mind'. On 9 November it is noted that the complainant was 'totally against' ECT, and wanted to take his daughter home for a fortnight to see if she would improve. The family therapy session notes for 9 November also record the complainant's refusal of ECT. On 11 December, a record of a conversation between the complainant and the sister says that 'The [complainant] pointed out that he resented [the consultant] because she always seemed to be too busy and did not let him get a word in'.

Findings

18. It was the registrar's opinion on 17 October that the complainant's daughter needed to be admitted to hospital and, as I am satisfied that he made that decision soley in the exercise of his clinical judgment, I cannot

question it. He has stated that he might have explained to the complainant that he could not allow the daughter to be taken home before he had discussed the possibility of compulsory admission with the consultant, and that he had intended that statement as a purely factual explanation. The complainant had interpreted it as a threat. I accept the registrar's contention and I do not uphold the complaint against him.

19. The complainant and the consultant agree that during their long telephone conversation on 5 November there was a reference to the possibility of a care order being made if the complainant took his daughter home. The consultant says that this was in response to a question from the complainant and that it was not intended as a threat. I am sure that she had the daughter's best interest in mind throughout her conversation with the complainant and that she tried to explain the alternative means of achieving this. I believe that the complainant's deep concern for his daughter led him to misinterpret what was said and he wrongly concluded that he was being threatened. I do not uphold this complaint.

20. The consultant says that when she spoke on 9 November to the complainant about ECT for his daughter she did not make any threat to him. The complainant and the student SW say she did. There is, however, no dispute that the daughter's needs were uppermost in the consultant's mind. I do not find this complaint made out.

(b) *The complaint about supervision and sexual intercourse with an adult patient*

21. The complainant said that the consultant had told him that the unit was completely separate from the main hospital and that he was also told that although the girls went to the canteen they were always supervised. Later he was told that sometimes there was a 'social' when psychiatric patients visited the unit but this was always under supervision. He said that on one occasion a nurse had shown him a letter his daughter was writing to another female patient. This said that one of the male patients wanted to have sexual intercourse with her. He and the nurse had told her not to be silly and that she was too young for sexual intercourse. The complainant said that the nurse had reassured him that the girls were always under supervision and that a nurse went with them to the canteen. However he said that on 20 March his daughter had sexual intercourse with the male patient on two occasions although this was not discovered until 29 March.

22. The AHA made no specific comment in the report about the daughter's general supervision but they said 'sexual intercourse supposedly took place in the toilets off the patients' coffee lounge. We only have the accounts of the complainant's daughter and the male patient (the first male patient) to go on. [The first male patient] has told [the sister] that intercourse was only attempted once . . .'. They also told DHSS that they understood the complainant's concern and said that the unit was not ideally sited and a new site had been found.

23. The consultant told my officer that she had never discussed the daughter's supervision with her father, nor had she discussed whether the daughter would be kept away from the other patients. She said that she could not believe that the complainant had been told that his daughter was *always* supervised because it was impossible to have total supervision, although the girls were escorted whenever they went outside the hospital. She said that the complainant must have known that his daughter met other patients because on one occasion she went to a 'disco' and won a radio as a prize. She said that the girls in the unit had complained about always being kept in the ward and it had been agreed that they could leave the unit in groups for half an hour, provided that they informed the staff first. The consultant said that the complainant's daughter was easily led and had been with a group of other girls on the occasion of the sexual intercourse incident. The consultant said that on 29 March the sister told her that she had heard from the other girls that the complainant's daughter had had sexual intercourse. The consultant said that she had been very concerned and, with the registrar, she had questioned the complainant's daughter, who said that she had had sexual intercourse a couple of weeks previously. The registrar had examined her. The consultant said that prior to this incident she had not known of the daughter's interest in the first male patient and that normally it was the ward sister who talked to the girls about sex and emotional involvement.

24. The registrar told my officer that he had been present when the nursing staff had told the complainant that the unit was completely separate and that the children had no contact with other patients. The nurses had said that there was complete supervision and the children were escorted wherever they were likely to go. He said that in his opinion at the time of her admission the complainant's daughter needed total supervision, but that later it had been felt that because of her emotional and mental development total supervision was inappropriate and that she should be allowed to go with the other children. The registrar said that the girls were allowed to go out on their own and that they were told when they could go and how long they could be away. He further said that he did not know much about the daughter's behaviour before the incident with the first male patient and only afterwards did he learn about the letter she had written (see paragraph 21). He said that he was not surprised that the complainant was upset but that there had been no warning of this particular risk and danger. He did not think that nursing staff could have supervised the daughter for eighteen hours a day with six or eight other girls to look after and in a ward in which the doors were not locked.

25. The sister told my officer that it was unit policy to tell parents at the time of a patient's admission that as a reward for good behaviour the children were allowed out in a unsupervised group between 12.30 and 1 pm when they usually went to the canteen. She said that it had been pointed out to the complainant that his daughter was not escorted everywhere and that she would come in contact with other patients. She said that the unit policy was to make girls responsible for themselves. The sister said that

because the complainant's daughter had become interested in sex, which was normal at her age, everything about sex had been explained to her. She said that the daughter had been in a unit with other adolescents and that it was impossible to stop them talking to the adult male patients, but that there had never been any similar trouble before this incident.

26. The first SRN told my officer that the complainant would have been told when his daughter was admitted that the unit was part of a large psychiatric hospital and there would be some contact with patients from other wards. The first SRN said that the complainant knew that his daughter went to the canteen in a group because on one occasion she had been there when the complainant visited. He also knew she mixed with other patients at 'discos'. She said that on these occasions a nurse would always have accompanied the complainant's daughter although the group of girls would go to the canteen unsupervised. She said that sometimes after school or before supper they were allowed to go in an unsupervised group to the coffee lounge. The first SRN told my officer about an incident on 6 February when the complainant's daughter had been found in the canteen sitting on the lap of another male patient (the second male patient) (see paragraph 31). She also said that she had been on duty all day on 20 March and that she had no suspicion before she went off duty that anything amiss had occurred. She told my officer that the first male patient was an 'inadequate lad – younger than his years' and that he had previously had a friendship with another girl in the unit.

27. Another SRN on the unit (the second SRN) also told my officer that it was their policy to tell all parents when their children were admitted that there were times when they would be unsupervised, for example to go to the canteen or for a walk. The second SRN said that she was the nurse who had counselled the complainant's daughter about the letter (see paragraph 21) and that it was 'quite a nasty letter' to a female patient whom the daughter had met in the canteen. She said it used unpleasant words and talked about the daughter having sexual intercourse, although 'not as plain as that'. The complainant had arrived whilst she had been talking to his daughter. He had read the letter and had 'told off his daughter', saying that she was not to talk to men or boys and that she could not have any boy friends until she was 18. The second SRN said that she had told the complainant that his daughter met men and boys and that he must not tell her not to talk to them as she had come into the hospital not talking at all. My officer told her what the complainant had said about being reassured by her statements about supervision (see paragraph 21) and she denied making those statements because, she said, they were not true. She was on holiday from 19 March and knew nothing of the incident with the first male patient.

28. A student nurse told my officer that she had been on duty in the unit from about Christmas time and that when she started there a nurse accompanied the girls wherever they went, including the canteen. However the girls had said that as a reward for good behaviour they wanted to be given more trust and that the system had therefore been relaxed to the extent that the girls were allowed to go out in a group for ten or fifteen minutes unsuper-

vised. A state enrolled nurse confirmed that this change had taken place. The student nurse said that she did not know if anyone had told the complainant about the relaxation in supervision.

29. The student SW told my officer that the complainant's daughter was quite rebellious. She did not think that the complainant would have been told that his daughter was always supervised as girls did go out of the unit alone. She said that although they were supervised as much as possible some of the girls were in the unit because they were beyond parental control and it was not surprising therefore that there were difficulties in controlling them in the ward.

30. The nursing records show that on several occasions the complainant's daughter had been led into trouble by the other girls, and on one occasion they say that she was frightened of being rejected by the other girls. On other occasions it is recorded that she left the unit without permission. In the unit conversation book there are several references to girls in the unit meeting male patients.

31. Specific incidents concerning the complainant's daughter which are relevant to this complaint are mentioned five times in the records. The first is on 6 February when, as the result of a telephone call from canteen staff, a unit nurse found her sitting on the lap of the second male patient 'kissing him with a cigarette in her hand. Was returned to the ward and given a talking to.' On 9 February the conversation book records ' – she has been writing silly letters about having sex with [the first male patient] (she thinks that's what he wants and she told the girls she's going to let him)'. On 11 February the nursing record says 'Had to be brought back to ward from canteen because she was with [the first male patient]', and again on 11 March 'Report that she has been behaving in a provocative manner towards male patients in coffee lounge. Has been counselled by nursing staff'. A statement made by the sister on 29 March says, in part 'It has been confirmed today by both parties that sexual intercourse has taken place between [the complainant's daughter] 13 years patient in [the unit] and the [first male patient] . . . . The incident occurred on Tuesday, 20 March 1979 between 12.30 pm and 1.00 pm in the toilet area of the patients' coffee lounge. [The registrar] carried out medical examination and felt sexual intercourse had taken place. . . .' The medical notes confirm the registrar's examination of the complainant's daughter and his conclusion. A note of an interview between the sister and the first male patient says, in part 'I pointed out [to the first male patient] that he had been warned on numerous occasions with regard to the girl's ages and the legal implications of committing sexual acts with them, but obviously all this had been to no avail. . . .'

Findings

32. There is both uncertainty in, and a conflict of, evidence from the hospital staff about what the complainant was told about his daughter's supervision but I am satisfied that he believed from what he had been told that she would be effectively supervised. The incidents recorded in paragraph 31 should have forewarned the staff and I consider that they failed in their duty to provide reasonable supervision. I uphold this complaint.

Conclusion

33. I have given my findings in paragraphs 18, 19, 20 and 32. I have been told by the AHA that the unit has been closed and that it will not be re-opened at the hospital. The AHA have asked me in this report to convey their apologies to the Member and to the complainant and I gladly do so.

Case No. W.413/80–81—Events following death in hospital

Background and complaint

1. The complainant's aunt, aged 82, was admitted to the ward of a hospital (the hospital) on 4 February 1980. After an initial improvement, her condition deteriorated and she died there on 18 March. The complainant said that:—

(*a*) although her aunt died at about 11 am when she and a friend were present, she later learnt that the body had still not been removed from the ward when the undertaker visited the hospital at 2.15 pm; and

(*b*) after a social worker (the SW) had requested on 13 March 1980 that her aunt's pension book should be sent to her office at the hospital the complainant became concerned about the security of such documents but was unable to obtain satisfactory explanations and assurances from the Area Health Authority (the AHA).

Investigation and jurisdiction

2. During the investigation I obtained the written comments of the AHA and I examined these and other relevant papers, including the complainant's correspondence with the AHA—some of which took place via a Member of Parliament. One of my officers interviewed the nursing and administrative staff involved and she also met the complainant. Although the actions of social workers (who are employed by local authorities) are outside my jurisdiction, my officer spoke to the SW to obtain background information. The complainant asked that her aunt's friend should not be involved in the investigation unless it was essential. I have respected her wishes and in this report I refer to her aunt's friend as 'Mrs A'.

(a) *The complaint that the body as left on the ward for over three hours*

3. The complainant explained to my officer that she had been informed by Mrs A of her aunt's admission to hospital and together they visited regularly for several weeks. On 17 March 1980 she had received a telephone call from the hospital to say that her aunt's condition was poor and she and Mrs A visited her that evening. On the advice of the staff they returned home for the night. The next morning they visited her again and, at about 11 am, they noticed that she looked very peaceful and they thought she had died. The complainant went and told the ward sister (the first sister). About five minutes later a 'young woman with a stethoscope' came and drew the curtains round the bed, examined her aunt, and then told them she was dead. They left the hospital shortly afterwards having called at the sister's office on the way

out where they were told to collect the death certificate and her aunt's property between 2.00 pm and 2.30 pm the next day.

4. The complainant said that after leaving the hospital she went to make arrangements with a local undertaker who offered to drive her to the registrar's office the next day. On 19 March she collected the certificate of cause of death and, as she was leaving the hospital building, she saw the undertaker talking to a porter. Later, in the car, the undertaker commented that he had been to the hospital at about 2.15 pm the previous day and her aunt's body had still been on the ward, and that the porter had not known there had been a death.

5. The complainant wrote two letters on the 13 April 1980 ; the first was addressed to the ' hospital secretary'. This was about another matter which is not the subject of my enquiries, and it did not say anything about the alleged delay in removing her aunt's body. The second letter, which did refer to this, was addressed to a Member of Parliament.

6. In her letter to the Member the complainant expressed concern that her aunt's body had apparently remained in the ward for over three hours after death; had she known this was likely to happen she would have stayed to ensure that it was treated with respect and dignity. She said she felt that even if such a delay was only occasional it represented a callous lack of consideration. The Member sent the complainant's letter to the area administrator (the AA) on 21 April and he replied on 20 May 1980 saying that it was unusual for a body to remain on the ward for three hours ; he explained that it sometimes took up to twenty minutes to obtain a doctor to certify death and perhaps half an hour for last offices ; and that, at the time, nursing staff were heavily committed to 'lunchtime duties'. He said that these factors might help to explain part but not all of the alleged three-hour delay but he gave an assurance that 'if such a delay did occur, the body . . . was nevertheless treated with due respect and dignity.'

7. The complainant wrote direct to the AA on 9 June 1980 repeating her concern ; she said that she had spent long periods in various hospitals and the rule was always 'to remove the body quickly and quietly . . . within minutes rather than hours . . . I accept no excuse for the treatment of my aunt's body'. The AHA replied in a letter of 11 June saying that they regretted that they could add nothing further and repeated the assurances given to the Member. The complainant remained dissatisfied and wrote to me on 5 January 1981.

8. The first sister, whom the complainant saw on the morning of her aunt's death, told my officer that she could not remember anything about the incident ; it was her usual practice to tell relatives about the arrangements for the collection of the certificate of cause of death and personal property but she could not remember specifically talking to the complainant. She said that the ward was a very busy geriatric ward and that the staff might have to delay attending to a body at certain times of the day. She recalled that lunch was brought to the ward at 11.30-11.45 am and explained that this involved moving patients from the day room ; seating them at tables

in the ward ; and 'toileting' them before and after the meal. She said that although a trained nurse could confirm death a doctor had to come to sign the certificate of cause of death ; the body would have to be straightened and traditionally was left for some time before the last offices were carried out ; a trolley would have to be equipped with the necessities for these and the offices could take at least 30-45 minutes. When the offices had been completed the ward would get in touch with the porter's lodge to arrange removal of the body to the hospital mortuary. The subsequent interval would depend on whether or not a porter was immediately available.

9. My officer also interviewed the present ward sister (the second sister) who said that it would be difficult to remove a body discreetly at lunch time when small tables were placed in the central 'gangway' between the beds. She said that lunchtime was early at 11.30 am and that necessary lunch time duties would not be completed until 12.30 or 1.00 pm. My officer visited the ward and observed that it is circular with the beds, individually screened, placed round the outside wall and round a substantial central pillar.

10. The staff nurse (the SN) who was on duty when the complainant's aunt died, told my officer that she was the 'young woman with a stethoscope' described by the complainant. I have seen that it was she who made the last entry in the nursing record and signed the death notice both of which record the time of 11.10 am. The SN said that, as a state registered nurse she was allowed by the hospital regulations to state that death had taken place, although a doctor had to certify the cause of death. She was sure that the body would not have been left in full view of other patients and that the curtains were drawn around the bed. She said that a body would not be removed during lunchtime because patients would be sitting in the centre of the ward and it would be all too obvious what was happening. The area nursing officer (the ANO) confirmed to my officer the information about the last offices and made the point that the nursing staff themselves did not like a body to remain on a ward any longer than necessary.

11. The sector administrator (the SA) told my officer that he could not either substantiate or disprove that the body had remained on the ward for over three hours although he had spoken to the undertaker who had confirmed that the body had still been in the ward at about 2.15 pm. He explained that the time at which a porter was requested by a ward was not recorded ; a message was left with the porter's lodge. There was no reason why a porter should know about a death if he had not dealt with it himself. He confirmed that lunch was served early and said that it was taken by the porters to the wards on unheated trolleys and the nursing staff could not therefore delay serving meals and had to be ready when they arrived.

12. In his written comments to me the AA said: 'The AHA accepts that in this instance the complainant's aunt's body remained on the ward longer than is normal after death and this was caused not by callousness but by the exigencies of the services on that particular day.'

Findings

13. It is not disputed that the complainant's aunt died at around 11 am and I have no reason to doubt that her body was still in the ward some three hours later. Like the AHA, I have not been able to establish exactly what happened in the interim or the time that the body was removed. But I accept that there was a delay because she died shortly before lunch time when patients from the day room were brought into the ward for their meal. It would clearly have been lacking both in respect to her and in consideration to the other patients had the necessary procedures been started before the inevitable bustle of lunch time was over and the ambulant patients had been returned to the day room. I think it was this that contributed largely to the delay. While I understand the complainant's concern, I do not think that her aunt's body was treated with any disrespect.

(b) *The complaint about the security of patients' pension books*

14. The complainant told my officer that before her aunt died she had only recently moved back into the area and that her aunt had relied on Mrs A for help. She had not known the state of her aunt's finances and whether or not any advice about their management had been given to her on admission; but she knew that Mrs A held money to pay her aunt's rent and to provide other wants whilst she was in hospital, and that before her aunt's admission Mrs A had occasionally collected her aunt's pension when the weather was bad. When it became clear that her aunt was in poor condition, Mrs A had asked her what should be done with the pension book. The complainant knew that Mrs A had spoken to a local office about it but was not sure whether it was that of the Department of Health and Social Security (the Department) or the Social Services Department of the local authority. She said that Mrs A had received a letter from the SW at the hospital asking for the pension book to be sent to her and that she and Mrs A had been surprised that the SW had become involved. The complainant warned Mrs A not to release the pension book and wrote to the local office of the Department. In a letter dated 16 March 1980 which I have seen, the Department said that Mrs A had advised them that she (Mrs A) had possession of the pension book and explained the procedures for acting as an agent.

15. Sadly, the complainant's aunt died shortly afterwards and on 13 April the complainant wrote the two letters I refer to in paragraph 5. In her letter to the Member she expressed concern that elderly or confused patients could be asked to hand over their pension books, which could then be subject to abuse by unauthorised persons. She also said that the instruction given in the pension book—that it should *not* be returned if the pensioner went into hospital—was in conflict with the SW's request.

16. On 20 May 1980 the AA replied to the Member that it was common practice for a hospital to hold pension books either on an agency basis or for safekeeping. He explained that Mrs A had expressed concern about how to deal with the pension and the SW had therefore tried unsuccessfully to telephone Mrs A. As she was going on leave, she had written to her on 13 March 1980. I have seen a copy of this letter which explains that the

SW had tried to get in touch with Mrs A and ends: 'I think, however, that it would be advisable if you could send me Mrs ——'s book and I will then contact the Department of Health and Social Security. I will also have a word with you about the problem when I return from leave'. The AA also explained that the invitation to Mrs A to send the pension book to the SW did not conflict with the advice not to return it to the Department.

17. On 9 June 1980 the complainant wrote two more letters, one to the Member and another to the AA. In his reply of 11 June to the letter received direct from the complainant the AA said that the social worker was a fit and proper person to handle the pension book of hospital patients. In his reply of 20 June to the Member the AA said that the question about social workers would be better answered by the Director of Social Services (the DSS) of the local authority whom he had asked to reply direct. The DSS replied to the Member on 27 June and explained *inter alia* that in the absence of a relative or friend the pension book could be lodged with the hospital administrator or, in exceptional circumstances such as when there was continuing social work (as there was in the case of the complainant's aunt), with the appropriate social worker. He said he understood that it was in fact the practice of the department to forward the pension books of patients in hospital to the hospital's social work department.

18. The SW told my officer that she had been asked by the hospital consultant to make a social enquiry report about the complainant's aunt when she was first admitted to the ward; at that time Mrs A was the only close friend she could trace and it was Mrs A's name that appeared in the admission notes and ward nursing notes. (My officer examined the notes and observed that there was also an undated amendment slip showing the complainant as next of kin.) The SW said that she did not know of the complainant's existence until June when the DSS had made enquiries about the complaint, and that her earlier contact had been solely with Mrs A. She had become involved over the pension book as a result of a telephone call she had received from the housing department of the local authority on 13 March 1980 and had written to Mrs A because she could not get an answer to a telephone call. She had had no reply to her letter. The SW explained that there was a system at the hospital for recording all money, documents and other valuables and that a receipt was given to the person handing them over. A pension book would be given to the hospital cashier's office where its receipt would be witnessed and its custody registered.

19. The SW's contemporaneous notes record that on 13 March she had learned from the housing department that Mrs A had been in touch with them because she held the pension book but was concerned about the aunt's mental capacity.

20. The sector administrator told my officer that the written procedure laid down by the AHA (which I have seen) requires all pension books, other than those held personally by patients who wish to keep them, to be handed in to the administrator to be registered by the cashier's department

who are responsible for their security and for the payment of pensions and allowances where appropriate. These instructions follow the central guidance given to health authorities by the department.

Findings

21. I am in no doubt that Mrs A was concerned about the aunt's pension book and that she expressed her concern to the local authority—who got in touch with the SW concerned. Her actions are not within my jurisdiction but I think it is only fair to say that I consider that her suggestion that the book should be sent to her was obviously intended to be helpful; and I believe that at the time she had no knowledge of the complainant's interest. As to the AHA's response to the complainant's representations, I find them factually correct. However, I think that, when it became obvious in June 1980 that the complainant was still not satisfied, they could with advantage have explained to her how the SW fitted in to the hospital team who were caring for her aunt rather than simply say, as they did, that the SW was a fit and proper person to handle the pension book.

22. Apart from this, I find no fault with the AHA.

Conclusion

23. I have given my findings in paragraphs 13 and 21-22 of this report. The AHA acknowledge that the body remained on the ward for longer than was usual or to be expected, and have asked me to express their regrets to the complainant that this should have been so. But I accept that there was no fault on their part in respect of that unfortunate circumstance.

Case No. W.416/80-81 – Urgent hospital admission overlooked

Background and complaint

1. The complainant's father, aged 77, was referred to hospital (the hospital) by his family practitioner (the FP) on about 26 March 1979. He was seen on 5 April 1979 by a consultant orthopaedic surgeon (the consultant) who decided that he should be admitted urgently to the hospital.

2. The complainant says that:

(*a*) his father's admission was overlooked and that it was not until the FP telephoned the hospital in September 1979 that arrangements were made to admit him ; and that

(*b*) the response to his complaints by the Area Health Authority (the AHA) was unsatisfactory.

Investigation

3. During my investigation I examined the clinical notes and the correspondence relating to the complaint. My officer interviewed the complainant and members of the medical and administrative staff involved.

(a) *The complaint about admission*

4. In his letters and in his interview with my officer the complainant said that on about 26 March 1979 the FP had referred his father to the hospital, where he had seen the consultant on 5 April who had told him that he would have to be admitted to hospital. The complainant said nothing happened until September 1979 when the FP telephoned the hospital and his father was admitted the following week. The complainant said that sometime after his father's admision the FP told him that he had received a letter in April saying that his father would be sent for urgently. The complainant also said that his father was found to have a malignant condition, and that he died in November 1980.

5. The AHA told the complainant that his father was seen as an outpatient on 5 April 1979, when urgent admission was advised but that due to an unfortunate oversight, which was very much regretted, he had not been sent for immediately as had been intended. The AHA also said that had the complainant's father been admitted earlier it was extremely unlikely that the outcome would have been any different. The AHA told me that there had been an unfortunate breakdown in communication, that they accepted the criticism the complainant had made and that they had apologised to him.

6. The consultant told my officer that his then secretary (the secretary) had been on leave when he saw the complainant's father at the outpatient clinic. Normally she was present with him and he explained to her which were the urgent cases and at the same time he could supervise the waiting list. Because of her absence he had written the clinical notes by hand and he had dictated on to tape a letter to the FP saying that the complainant's father would be admitted the next week. The consultant said that his name had been put on the waiting list properly but thereafter he had been overlooked. He added that he would not have told the complainant's father that he would be admitted urgently as he would not have wanted to alarm him. The consultant said he had not known at the time that the secretary had been deciding which patients should be admitted and that his registrar was not supervising the waiting list as he should have done. The consultant agreed that it was his responsibility to supervise his registrar.

7. I have seen that the complainant's father's clinical notes for 5 April 1979 contain an entry which concludes 'TCI [To come in] urgently for excision biopsy', and that the waiting list slip entry read 'exc. [excision] biopsy lump anterior aspect of the upper left thigh'. The consultant's letter to the FP says 'this man has a rather hard lump in the anterior aspect of the upper left thigh which may well be a fibro-sarcoma. I have arranged to have him in urgently for excision/biopsy'.

8. There were two orthopaedic registrars in post during the period March to October 1979. Their periods of employment were consecutive and I was informed that the registrars did not meet. At separate interviews they told my officers that the admission of urgent patients to the hospital was arranged entirely by the consultant and the secretary, and one of them added that when the consultant was on leave he left instructions about the admission

of patients to the secretary. The registrars said that they had duties in a second hospital where non-urgent cases were admitted and although they had responsibilities for admitting patients to that hospital this was under the close guidance of the consultant. My officers pointed out to each of the registrars that the job description for the post they had held included 'To arrange admissions from waiting lists' but both the registrars said that decisions about admissions to the hospital had not in practice formed any part of their duties and neither had they been given any instruction about it nor had they been asked why they had not carried out that duty.

9. The secretary confirmed to my officer that she had been on leave when the complainant's father attended the outpatient clinic on 5 April and that another secretary (the second secretary) had added the father's name to the waiting list and a third secretary had typed the letter to the FP. She explained that if a patient was to be admitted urgently his name and details of his condition were noted on a 'pink slip'. She told my officer that she put patients' names on pink slips if the consultant said they had to come in soon or urgently, or if she thought it was necessary. As many of the consultant's patients had painful, though not necessarily life-threatening conditions, about half his waiting list was on these pink slips. The secretary explained that neither the consultant nor the registrar ever looked at the waiting list and that she had been responsible for calling patients in. She said that she had not liked having that responsibility. She explained that the complainant's father's name was on a 'pink slip', and on the waiting list in the correct way, but that because of lack of information she had not realised how important the admission was and had overlooked it. She said that when the FP telephoned she had explained to the consultant what had happened.

10. The second secretary told my officer that after the outpatient clinic which the complainant's father had attended she had added the appropriate patients to the waiting list. She said that she had put his particulars on a 'pink slip' in the correct manner. She said also that at the time neither the consultant nor the registrar ever looked at the waiting list, and that it had been left to the secretary to call patients for admission.

11. The supervisor of the medical secretaries (the supervisor) told my officer that she had not known that neither the registrar nor the consultant were supervising the waiting list and that the secretary had been selecting patients for admission. She said that the secretary was conscientious, but she lacked the requisite knowledge to make a medical judgment.

12. The sector administrator (the SA) told my officer that he had been informed by the supervisor that there had been no medical supervision of the waiting list and that whilst he had not discussed this with the consultant, he understood that the registrar in post at the time of the SA's interview with my officer had decided to undertake the supervision. The secretary, the second secretary and the supervisor each told my officer that this improvement had been made by the registrar then in post of his own accord.

13. The area general administrator (the AGA) told my officer that it was clear that there was need for clinical involvement in the management of the waiting list and that he had been assured by the administrators at the hospital that the present system made it unlikely that the same mistake would happen again.

14. The FP told my officer that although his records were not now available he was almost certain that the complainant's father had not consulted him during the period from March to September 1979, when the complainant had contacted him. On then checking his records he realised that the father had not been admitted and he immediately contacted the hospital whose responsibility it was to summon the patient. He further said however that an earlier admission would have made no difference to the eventual outcome in this case.

Findings

15. Had the complainant's father himself been aware of the urgency in his case or had he contacted the FP I am sure that this regrettable delay would not have occurred. His admission was certainly overlooked by the hospital and the overriding cause of this was lack of proper management of the consultant's waiting list. This maladministration led to a serious failure in service. I uphold this complaint.

16. At the conclusion of my investigation the AHA told me that they have emphasised to all members of the consultant medical staff that the management of inpatient waiting lists is a medical responsibility which cannot be delegated to a member of the secretarial staff and they have asked them to review their arrangements accordingly. In my view that is not sufficient. Consultants must certainly determine medical priorities for admission but the AHA in turn must routinely monitor the administrative procedures adopted. In this case the AHA did nothing in this respect until the complaint was received some nineteen months after the event. Fortunately they then found that in the meantime a newly appointed registrar of his own initiative had decided to exercise medical supervision of his consultant's list. I am glad to report that the AHA have confirmed that they accept this monitoring role.

(b) *The complaint about the AHA's response*

17. In his letter to me and in his interview with my officer the complainant said that after his father's death he wrote to the hospital. His first letter dated 11 November 1980 was not acknowledged and he said that the explanation he received in reply to his second letter of 14 December (see paragraph 5) was totally inadequate. He also said that although the statement in the letter that 'it is extremely unlikely that the outcome would have been different' might be 'statistically true', it was impossible to predict accurately the course of the disease in an individual case and his father might have lived longer if he had been operated on earlier.

18. I have seen that the AGA's reply to the complainant tendered the AHA's sympathy to him and his family on the death of his father and concluded:

> '. . . due to an unfortunate oversight which is very much regretted he was not sent for immediately as was intended.
> It is perhaps also unfortunate that you or your father did not contact us around that time to enquire as to the position but the consultant advises me that the tumour was already advanced at that time and it is extremely unlikely that the outcome would have been any different.'

The complainant said he took exception to the suggestion that he or his father should have contacted the hospital. He had been living abroad and did not know there was anything wrong and his father had been given no indication that he should be admitted urgently to the hospital.

19. The SA told my officer that he should have acknowledged the first letter of complaint, but had omitted to do so, although he had initiated the necessary enquiries. I have seen that on 5 December the SA notified the AGA of the complaint and sent him the draft of a reply part of which he said had been dictated by the consultant and which read '. . . When he was seen here urgent admission was advised and, owing to an oversight, [the complainant's father] was not sent for immediately as intended. It is such a pity that you or your Father did not contact us around that time but as the tumour was already well advanced it is unlikely that the outcome would have been any different.' In a covering letter to the AGA the SA said 'It is regrettable that there was a delay between April and September 1979 during which time the patient could have been admitted.'

20. The consultant told my officer that it had been very frustrating to receive the complaint after the death of the patient as there was nothing anyone could do about it. He said he had not known the complainant had been abroad and knew nothing of his father's illness, but he had dictated part of the SA's draft reply and although the SA had said it was 'a bit strong' he stood by it. He said he felt the AHA's reply was adequate and full of apologies, and that he had done his best in the circumstances. He felt that the delay in admission was an unfortunate oversight and that a personal apology by him was unnecessary.

21. The AGA told my officer that it was the AHA's policy to acknowledge letters of complaint and he did not know why the complainant's original letter had not been acknowledged. He said that when the SA had sent him the draft reply he had been unhappy about part of it and had spoken to the consultant about it. He said that in deference to the consultant's very strong view he had agreed to include a reference to the family's involvement but he had modified it. He said that he had felt when drafting the reply that the most important thing was to admit the mistake. He saw no merit in giving any more details. He said the letter contained the AHA's apology and he had hoped the complainant would find the general context of the letter acceptable.

Findings

22. I uphold the complaint about the way the AHA responded. The reply sent to the complainant was insensitive.

Conclusion

23. I have given my findings in paragraphs 15, 16 and 22. The complainant's father was not given the efficient service to which he was entitled and the answer his son received to his justified complaint was unsatisfactory. The AHA have asked me in this report to repeat their apologies to the complainant which I gladly do and they have given me their assurance that steps have been taken to improve the management of the consultant's waiting list.

Case No. W. 430/80-81 – The admission of an elderly woman to hospital

Background and complaint

1. In April 1980 the complainant's mother, aged 72, was admitted to hospital (hospital A) where it was diagnosed that she was suffering from Crohn's Disease. After she was discharged from hospital her family practitioner (the FP) continued to treat her but during a stay with another son her condition deteriorated. She returned home and when the complainant was unable to get in touch with the FP on 16 July he called an ambulance. She was taken to a second hospital (hospital B). She was discharged a few hours later but re-admitted under the care of a consultant physician (the physician) during the same night after referral by a partner of the FP (the FP's partner). She was transferred to the geriatrician's care on 17 July and died the following day.

2. The complainant said that:

(*a*) when his mother was discharged on 16 July the hospital staff knew that there was no one at home and that he had disposed of her bed;

(*b*) a nurse told his neighbour they could not find a hospital bed for the complainant's mother but he later learned from another patient that there were several empty beds;

(*c*) the nursing staff did not check with his mother after giving her a tablet and as a result she appeared to be frothing at the mouth; and

(*d*) his letter to the hospital administrator (the administrator) was not answered for five months and the reply suggested that the complainant should not have called the ambulance for his mother.

Investigation

3. During the investigation I obtained the written comments of the Area Health Authority (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 hospital medical, nursing and administrative staff and with the FP and his partner. She also met the complainant and his neighbour.

(a) *The discharge to the empty house*

4. In his letter to the administrator and in discussion with my officer the complainant gave the following account of events. He said that when, in April 1980, his mother had been admitted to hospital A the consultant surgeon (the surgeon) diagnosed Crohn's Disease. She returned home and received treatment from her FP. Subsequently she stayed with another son some distance away but when she returned home on 12 July she was not well and had lost even more weight. On 14 July the FP visited her at home and returned the following day to take a blood sample. He told her that she might have to go into hospital that day or the next.

5. On the morning of 16 July she seemed worse and was unable to eat. The complainant learned from the FP's receptionist that the results of the blood test had not been received. He telephoned again later in the day and the receptionist told him the results of the test had arrived but that the FP was out. She told the complainant that the FP would call on his mother later. However, because he thought his mother was so unwell, he decided not to wait and he called an ambulance to take her to hospital. He did not accompany his mother because he knew she would have to spend some time in the accident centre before being admitted to a ward. He and a family friend, who was a nurse and who stayed the night of 15/16 July with the complainant's mother, stripped her and found that the mattress was soaked with a brown fluid which had a highly offensive smell. The friend thought the condition might be infectious and they therefore decided to burn the mattress and the bed. The complainant then took the friend home.

6. The complainant did not have a telephone and he arranged that his neighbour would take any message from the hospital. He said that his neighbour telephoned the hospital during the afternoon and was told that the complainant's mother did not need medical treatment; she just needed nursing. The neighbour was also told that the staff were having great difficulty in finding a bed for the complainant's mother and she was asked to telephone again later.

7. In discussion with my officer, the neighbour said she was told by a nurse that unless a bed could be found the complainant's mother would have to be sent home. She told the nurse that she thought the complainant's mother was not well enough to come home and that in any case her bed had been destroyed. The neighbour telephoned the hospital again later and said she spoke to the same nurse. The nurse told her that the staff had not been able to find a bed in hospital and that an ambulance was bringing the complainant's mother home. The neighbour explained that there was no one at home and repeated that the bed had been destroyed. The nurse said she would try to stop the ambulance but thought it had already left. The complainant's mother arrived home at about 8.30 pm and the ambulance crew found nobody at home. They got in touch with another of the complainant's brothers and he let his mother into her home.

8. The FP told my officer that following the mother's visit to one of her sons, he was called to see her on 14 July because the complainant thought her condition had deteriorated. The FP arranged to call back the next day to

take blood for some tests. When he did so on 15 July he told her and her son that, depending on the results of the tests, she might have to be admitted to hospital. He explained to my officer that he would have expected the results of the tests to be available at about lunchtime on 16 July and that he would then have decided whether to send her to hospital. The FP said that twice during the morning of 16 July the complainant telephoned to say that he was very concerned about his mother and each time the FP told him that once he had the results of the tests he would see what could be done. However, before he had such an opportunity, the complainant telephoned for an ambulance and his mother was taken to hospital B.

9. The FP said that it was normal practice at hospital B for the doctor on duty in the accident centre to telephone the family practitioners for information when one of their patients was admitted as an emergency. As far as he could recall he had received such an enquiry about the complainant's mother. The FP's partner told my officer that at about 7 pm on 16 July he received a telephone call from the registrar who had examined the complainant's mother in the accident centre (the registrar). The registrar had said that he could not find a bed for her and she was therefore being sent home. The two doctors agreed that it would be necessary for a community nurse to call and the FP's partner made the necessary arrangements.

10. The registrar told my officer that when he examined the complainant's mother he found that she was not acutely ill although she had a long term medical problem. He therefore approached the senior house officer to the consultant geriatrician (the first SHO) to see whether a geriatric bed was available but was told that there was not one. He then telephoned senior members of the nursing staff at other hospitals (the peripheral hospitals) to see whether they could take her but he was told that there were no beds. Although he did not think she needed an acute medical bed the registrar also asked the physician's senior house officer (the second SHO) whether he was willing to admit her. He was not and the registrar therefore decided to send her home. He added that, contrary to his expectation, she said she wanted to go home.

11. The registrar said he notified the FP's partner that the complainant's mother was going home and that she would need community nursing and home help. Although the registrar knew from the message from the complainant's neighbour that the mother's bed had been destroyed he thought he had no choice but to send her home because he was unable to find a suitable hospital bed for her. The registrar told my officer that as far as he could remember he also knew when he discharged her that there was no one at home but he understood that either her son was at the neighbour's house or the neighbour had a key. He said he would not discharge a patient home if no one had been notified but in this case the FP's partner had been informed and was aware of the situation. He had no recollection of speaking to the neighbour.

12. The sister in the accident centre (the accident centre sister) told my officer that she was on duty from 12.30 until 8.30 pm on 16 July. She

remembered the complainant's mother as an emaciated old lady who did not want to be in hospital. When the complainant's mother arrived it was necessary for the nursing staff to bath her before a doctor examined her. She recalled speaking to the neighbour on the telephone on one occasion when she was asked whether the complainant's mother was being admitted. She told the neighbour that they were having some difficulty finding a bed for her and that she might have to go home. The accident centre sister denied saying that the complainant's mother just needed nursing since that was not her view. The accident centre sister said she did not speak to the neighbour again on the telephone. She said that it was most unusual for a patient to arrive in such a neglected condition as did the complainant's mother and the absence of any direct enquiry from a relative had made communication difficult.

13. The senior nursing officer (the SNO) told my officer that she expected the nursing staff on duty in the accident centre to ensure that when a patient was discharged there was access to her home and someone was expecting her. She said that it seemed that in this case there had been a breakdown in communication between the registrar and the nurses. She said that she had concluded soon after the complaint was first made and during her discussion with the nursing staff who could remember the complainant's mother, that the registrar had been in touch with the neighbour and knew about the home circumstances. She further concluded that the nursing staff were not aware of them. In evidence to my officer none of the nurses except the accident centre sister could remember speaking to the neighbour but one nurse thought the registrar had spoken to the neighbour himself.

Findings

14. There were no beds (apart from orthopaedic and accident beds) within the control of any of the medical staff of the accident centre to which patients could be admitted and in these circumstances, difficult decisions have to be made there when no other 'firm' is prepared to take in a patient. The registrar has said that he concluded that the complainant's mother was not acutely ill and although he made a number of enquiries in the hope of finding a bed for her, he was unsuccessful. He then decided that there was no alternative but to send her home into the care of her FP. In my view, faced with this dilemma, he should have approached the consultant responsible for the running of the centre, the consultant orthopaedic surgeon. The latter told my officer that he would not have expected to be approached in such circumstances and I am therefore pleased to record that a consultant with particular responsibility for the centre was appointed while my investigation of this complaint was in progress.

15. When the registrar discharged the complainant's mother he was aware that her bed had been destroyed and has said he thought that he knew no one was at home. I do not consider that his telephone conversation with the FP's partner was sufficient to entitle the hospital staff to think that the complainant's mother could be sent home by ambulance without further communication. The accident centre sister has admitted that the condition in

which the complainant's mother arrived at the hospital and the absence of any communication from any relative was an unusual feature and I think this should have served to underline the necessity for further enquiry. I uphold this complaint.

(b) *The empty hospital beds*

16. In his letter to me and in discussion with my officer the complainant said that during the night of 16/17 July the FP's partner referred the complainant's mother to hospital B ; the complainant accompanied her to the hospital and saw her admitted to the ward. He went home and when he visited his mother the following day he found that a lady who lived nearby was occupying a bed in the same ward. She told him that there had been empty beds on the ward for some days.

17. The FP's partner said that after the complainant's mother had returned home on the night of 16 July he received a call from the complainant to say that he could not cope with his mother at home. The FP's partner telephoned the geriatricians but was told that there were no beds available ; he asked the physicians but they said the complainant's mother was not really a medical problem. The FP's partner then visited her at her home and concluded that she required in-patient care. He telephoned the surgical team but they would not take her. He was however able to persuade the medical team to take her in. The physician told my officer that this accorded with his practice of admitting patients with social problems and sorting out the difficulties later. In the event, because the family had had reason to complain about the treatment by the physician of another member of the family, the complainant's mother was transferred on 17 July to the care of the geriatrician.

18. The first SHO (who was a member of the geriatrician's 'firm') told my officer that he was only responsible for geriatric beds at hospital B and because there were no empty beds on his ward on 16 July he would not have gone to see the complainant's mother in the Accident Centre. The registrar said that he approached the nursing staff at the peripheral hospitals (paragraph 10) because he needed a bed for the patient and thought that if he could locate one he would then try to persuade a doctor to admit her. The SNO said that the nursing staff would not have told the registrar even if there were empty beds in the peripheral hospitals because at two of them the patients remained in the care of family practitioners who might not be prepared to accept a patient from another part of the district. As for the third peripheral hospital, admissions were under the control of the geriatrician and were not normally made without a domiciliary visit by him. The registrar told me that at the time he was not aware of that procedure.

19. I have examined the bed occupancy figures for 16 July. These show that although all geriatric beds at hospital B were occupied there were four female medical beds available there. There were also empty beds at the peripheral hospitals.

Findings

20. On 17 July the complainant's mother was in a medical ward where there certainly were empty beds on the previous day as the complainant claimed. Although, in the registrar's clinical judgment the mother had not required an acute medical bed, he had asked the second SHO whether he was willing to admit her. However, bearing in mind that the mother had travelled in an ambulance unaccompanied and no relative had been in touch with the hospital that afternoon, I think it is unlikely that the difficulties the complainant faced when his mother's condition deteriorated on the morning of 16 July would have been given much emphasis in the conversation between the registrar and the second SHO. In those circumstances it is not surprising that the second SHO was not willing to admit the mother. I am satisfied that before she was admitted a few hours later, the FP's partner had been able to judge for himself her condition and her home environment and to give the physician's staff a better picture of the situation. Her admission then was in line with the physician's normal practice (paragraph 17).

(c) *The tablet*

21. In his letter to the administrator the complainant said that when he visited his mother on the afternoon of 17 July she appeared to be frothing at the mouth. He mentioned this to a doctor on the ward (the house officer) who spoke to a nurse and told the complainant that it was a tablet which had been placed on her tongue and was dissolving. The complainant thought someone should have checked that his mother, who had difficulty in swallowing, had taken the tablet.

22. The house officer told my officer that he was unable to remember the incident. The staff nurse on the ward recorded in the nursing notes on 17 July that the complainant's mother had difficulty in swallowing whole tablets but when my officer met her she was unable to remember the incident described by the complainant or why she had recorded that comment in the notes. Both she and the ward sister told my officer that the nurses who give drugs stay with patients until they have taken their tablets. The only explanation the ward sister could give was that the drug might have been given with milk and the mother regurgitated it.

Findings

23. I have no doubt that the incident happened much as the complainant described it; however I do not think his mother suffered any hardship as a result of it and therefore I do not uphold this complaint.

(d) *The handling of the complaint*

24. The complainant wrote to the administrator on 4 August 1980 describing the events of 16/17 July and asking for an investigation. He also asked why his mother's death certificate gave the cause of death as chronic ulcerative colitis when she had been treated for Crohn's Disease. The

administrator sent a substantive reply on 15 January 1981. The complainant thought it had taken the administrator a long time to reply; he said he had tried to telephone the administrator several times but was always told that he was at a meeting and that the reason for the delay was that the doctor was on holiday. The complainant also objected to the contents of the administrator's reply. He thought it implied that he was responsible for much of the distress caused to his mother because he had called an ambulance on 16 July. Moreover the reply did not answer his question about the cause of death.

25. My officer discussed with the administrator the sequence of events when handling the complaint and his account is confirmed by copies of internal correspondence which I have examined. He said it took longer than he would have liked for the substantive reply to be sent to the complainant and gave the following explanation. The complainant's letter was received and acknowledged on 6 August; on the same day the administrator wrote to the four consultants who at some time were involved in the case and to the SNO. On 11 August the consultant orthopaedic surgeon who was responsible for the accident centre (the orthopaedic surgeon) sent the administrator his comments and on 18 August the geriatrician replied briefly about his involvement in the patient's care. The complainant wrote again to the administrator on 18 September and an acknowledgment was sent. The consultant physician gave his comments on 2 October and the SNO replied a few days later. The administrator drafted a reply to the complainant on 11 November and sent it to the consultants for comment. He told my officer that there had been some delay in drafting the reply partly because he was waiting to see whether the fourth consultant, the surgeon, would comment and partly because he was busy himself at that time.

26. On 12 November the complainant wrote once more to the administrator pointing out that he had been waiting three months for a reply and a week later the administrator said that he hoped to be able to reply within the next few days. He had not at that time received the comments of the consultants on his draft but he told my officer that it was very unusual for the consultants to disagree with what he drafted. In the event however, while the geriatrician and orthopaedic surgeon had no comment to offer on it, the physician and surgeon notified him on 26 November and 8 December respectively that they would like some alterations made to the proposed reply. The administrator revised his reply to take account of the comments he had received. Because the surgeon was by then on holiday he submitted it to the physician and the district administrator for comment. Further amendments were suggested and the surgeon who had by then returned from an extended holiday abroad agreed the reply and it was finally sent on 15 January. The administrator admitted to my officer that some of the delay in replying to the complainant could have been avoided but that it was mainly due to the difficulty in drafting a reply which was acceptable to all those concerned with the patient's care.

27. There was no reference in the administrator's reply to sending the complainant's mother home knowing that no one was there to let her in.

The accident centre sister told my officer that it was usual for the accident centre to telephone a patient's home before the patient returned to ensure that the ambulance crew would be able to obtain access. I have also noted that the SNO concluded after she had made her initial enquiries that the accident centre nursing staff had not made suitable enquiries to ensure that there was adequate home care and had suggested that they should apologise for any distress which was caused by the 'management' of the patient. The administrator however explained to my officer that he had omitted any reference to this point because he had concluded that the home situation was known and had been considered. Consequently no apology had been included in the reply.

28. The administrator added that he had remarked that distress might have been avoided if admission had been arranged by the FP instead of using the emergency ambulance service, because one of the consultants had made a comment to this effect.

29. In the administrator's reply he made the point that in April 1980 the consultant found that the complainant's mother had colitis which the pathologist at that time said showed features of Crohn's Disease. I have seen from the correspondence that one consultant told the administrator that Crohn's Disease was a variation of ulcerative colitis while another said it was not the same but a similar condition. In discussion with my officer these consultants explained that the conditions are very similar and symptoms, management and treatment are also very similar particularly in the short term. They also explained that Dorbanex (to which the complainant referred when my officer met him) would not normally be given to treat either condition and would have been prescribed to treat particular symptoms.

Findings

30. Much of the delay in replying to the complainant's letter was caused by the consultants' comments about the descriptions of Crohn's Disease and ulcerative colitis. But the administrator has admitted that some of the delay was avoidable. I accept that it is possible that the return journey to the mother's home on 16 July might not have occurred had she first been referred to the hospital by her FP or his partner, but I am satisfied that the complainant thought that he was acting in his mother's best interests in calling in the ambulance when he did. Therefore I think it would have been better had the administrator's reply included an apology for the distress caused when the mother was sent home at 8.30 pm by ambulance without ensuring that there was someone at her home to let her in, rather than to relate the distress to her son's action. I find that there were shortcomings in the handling of this complaint.

Conclusion

31. The FP had seen the complainant's mother on 15 July and had concluded then that her condition did not require emergency admission. The following day her son thought her condition did so. There were empty

beds in the medical ward on that afternoon but without the knowledge that the complainant felt that he was no longer able to help his mother, the second SHO decided, in the exercise of his clinical judgment, that the mother's condition did not then warrant admission to such a bed. Later that night the FP's partner saw the complainant's mother and concluded that she needed to be admitted due to her condition and because the complainant could no longer help his mother. In the knowledge of these medico/social circumstances the physician's 'firm' then agreed to accept her.

32. The complainant was justified in bringing to my notice the way his complaints were handled. But more importantly, I believe it was an error of judgment to have sent his mother home before establishing that she could be received there. The complaint underlines the importance of ensuring that elderly patients are not discharged to an empty house and the need for special care when there has been no direct communication with a relative of the patient whose discharge is contemplated. The AHA have asked me to convey to the complainant their apologies for the shortcomings revealed by my investigation. This I gladly do.

Case Nos. W. 48/81-82 and W. 298/81-82 – Delay in providing transport between two hospitals and lack of personal privacy

Background and complaint

1. The complainant's mother, aged 66, was injured in a road traffic accident on 27 September 1980. She was taken to hospital (the first hospital) and she was discharged on 5 October. Her family practitioner saw her on 9 October and arranged for her to attend the hospital next day. She was taken there by ambulance on a stretcher and arrived about noon when she was transferred to a trolley in the fracture clinic.

2. The complainant told me that she would not be taking legal action in respect of the matters about which she was complaining, and I agreed to investigate her complaints that:

(*a*) insufficient efforts were made to ensure personal privacy for her mother in the plaster room ; and that

(*b*) her mother was put on a very hard, uncomfortable and unsafe trolley from noon onwards. From 2.40 pm until 6.15 pm she was left on the trolley first in the fracture clinic and then in the accident and emergency department (the A & E department) awaiting an ambulance to take her to another hospital (the second hospital), and during this time she suffered pain and great discomfort.

3. I also agreed to investigate the complaint that the Area Health Authority (the AHA) had failed to give the complainant a substantive reply to her complaints and those made on her behalf by the Community Health Council (the CHC). When I informed the AHA of my investigation they told me that the complaint had not been dealt with in accordance with their complaints procedure. The district administrator (the DA) carried out a re-investigation at the same time that I was conducting my inquiry and sent the complainant a report (the report) about her complaints.

Investigation

4. During my investigation I obtained the comments of the AHA in respect of all the complaints and those of the Regional Health Authority (the RHA), which is responsible for providing ambulance services, in respect of complaint 2(*b*). I examined relevant documents and my officers interviewed the medical, nursing, ambulance and administrative staff involved. One of them also met the complainant. Her evidence in paragraphs 5, 12, 13 and 28 is summarised from her letters and from her interview with my officer.

(*a*) *The complaint about personal privacy*

5. The complainant said that after her mother arrived at the first hospital she had a radiological examination and that plaster of paris had been applied to her ankle. Soon afterwards she had needed to use a bed pan, but as she was confined to a trolley it had been difficult for the nursing staff to find a suitable place, and the only solution had been to take her into the plaster room. The complainant said that as she and a nurse (the first SEN) had been assisting her mother a woman and two children entered the room. She said that her mother, who was fully exposed, had been very concerned. The complainant said that while she did not blame the staff she felt that the facilities available in the fracture clinic had not been designed for people as immobile as her mother.

6. In the report the DA told the complainant that when her mother had been taken into the plaster room the trolley had been positioned with its back (which had been raised) facing the door, and that her mother had been further shielded from view by having a blanket placed over her. He said that while her mother had been using the bed pan another patient and a nurse (the second SEN) had inadvertantly entered the room, but that his enquiry had found nothing to suggest that the complainant's mother had been fully exposed. The DA apologised to the complainant and her mother for the distress that they had been caused.

7. The first SEN in a statement to the AHA and in her interview with my officer said that when the second SEN and her patient entered the plaster room she explained what was happening and the second SEN and her patient left immediately. The first SEN said that neither the complainant nor her mother had seemed disturbed or distressed by the interruption. She also told my officer that because the clinic had finished she thought that the plaster room would provide sufficient privacy for the complainant's mother.

8. The second SEN in a statement to the AHA and in her interview with my officer said that she could not recall an incident involving two children, but that she remembered taking a woman into the plaster room to apply a plaster. The complainant's mother had been in there on a trolley; she had been completely covered with a blanket and it had been impossible to tell that she was using a bed pan. The second SEN said that after she had realised what was happening she had ushered her patient back towards the door but, before they had gone out, the complainant's mother had been taken off the bed pan, and therefore she had brought her patient back.

9. My officer visited the fracture clinic and the nursing officer (the first NO) responsible for it and the A & E department told him that the two tables in the plaster room, around which curtains could be drawn, were fixed to the floor, and that it would have been impractical, in her view, to have used the curtains to provide more privacy for the complainant's mother.

10. The DA told the complainant in the report that they were aware of the unsuitability of the temporary accommodation that was currently being used as a fracture clinic. He said that the purpose built fracture clinic was destroyed by fire in 1978 and since then the service had been provided from a disused ward. He said that the district management team were pressing the AHA and the RHA for funds to construct a new clinic and that as a consequence of her complaint they would be pursuing the matter again. The area administrator (the AA) told me that he would wish to qualify what the DA had said to the complainant about the fracture clinic and said that the one that had been destroyed had been an old, single storey building. He said that the fracture clinic was now housed in very much better accommodation and that the delay in replacing it with a permanent building arose because the RHA intended to provide a large new accident hospital there.

Findings

11. Bearing in mind the limitations of the accommodation available and the complainant's mother's immobility I do not criticise the staff for the way they looked after her. It was unfortunate that her privacy should have been interrupted. The DA and the AA differ over the quality of the accommodation that is currently provided compared with that which was there previously, but they have both told me that the question of more suitable accommodation is currently under discussion. I do not uphold this complaint.

(*b*) *The complaint about the trolley and the time that the complainant's mother had to spend on it*

12. The complainant said that the trolley on which her mother was put when they arrived at the fracture clinic was very hard and uncomfortable, and was a type which, in her experience, was normally used only to transfer patients from one place to another. Her mother had been unable to lie flat and the only way to raise the head of the trolley had been to use a chair. The complainant said that she had never known the head of a trolley to be propped up in this way, and that she had to make frequent observations to ensure that the chair did not become dislodged.

13. The complainant said that it had been decided to admit her mother to hospital and at 2.40 pm they were asked to wait in the fracture clinic for an ambulance to take them to the second hospital. The complainant said that between 2.40 pm and 3.50 pm she asked a clerk and an enrolled nurse how long they would have to wait for the ambulance, but that neither knew. Because the fracture clinic was about to close, at 3.50 pm the complainant and her mother were taken to the A & E department to await the ambulance. The complainant said that she complained to a receptionist there on at least three occasions between 3.50 pm and 6.15 pm. The receptionist had contacted

ambulance control but she had been unable to give her any idea of how long they would have to wait. The complainant said that by 6.15 pm her mother was very distressed with pain and they had received no assurance that an ambulance would be provided. She said that the A & E sister (the sister) was sympathetic but was unable to obtain any further information from ambulance control. The complainant therefore spoke to a more senior member of the nursing staff (the second NO) who, she said, had been 'appalled', and immediately made arrangements for the complainant's mother to be admitted to the first hospital and for an ambulance to take her to the second hospital the following morning. The complainant said that at 7.10 pm her mother was taken to a ward for the night.

14. In his report the DA said that when the complainant's mother arrived at the fracture clinic she was transferred to one of the two trolleys that were available there. He said that it was the usual practice for patients who arrived in the fracture clinic on a stretcher to be transferred to a chair. He said that the complainant had been asked twice whether she would like her mother to sit in a chair but that, on each occasion, she had said she preferred her to remain on the trolley. The DA said that the back-rest on the trolley would tilt to only 45° and, because the complainant had wished her mother to sit more upright, the back-rest had been supported by a chair which was the only means available, and the DA understood that the complainant had accepted its use. After the plaster of paris had been applied, the nursing staff had again offered to move her mother from the trolley to a wheelchair so that she would be in greater comfort, but the complainant had again declined the offer.

15. The DA said that the only in-patient orthopaedic bed available had been at the second hospital. The complainant's mother had been given tea and sandwiches while they were waiting and she had appeared to the nursing staff to be reasonably comfortable. He said that nursing staff made a number of telephone calls to the ambulance service out-patient control centre (out-patient control) which, my officer was told, is away from the first hospital. At about 4 pm, as the fracture clinic was about to close, the complainant's mother was transferred to the A & E department. The DA said that when the second NO had been informed that an ambulance would not be available, she had offered to order a taxi to take the mother to the second hospital, but that the complainant had thought that a taxi would be unsuitable because of the pain that her mother was experiencing. The second NO had therefore decided to arrange overnight admission for the complainant's mother.

16. I have seen that the DA referred the complaint about the waiting time for an ambulance to the regional ambulance officer (the RAO). In his reply the RAO said that the out-patient control staff could not remember the case. His examination of the records had shown however that the request for transport had been received at 2.35 pm and that there had been 'an initial reluctance' to accept the case because of an arrangement with the first hospital that patients should be transferred to the second hospital on Mondays, Wednesday and Fridays, and that these journeys had to be booked before

noon the previous day. He said that only in exceptional circumstances would journeys to the second hospital be accepted at short notice and that when they were, the ambulance service was unable to guarantee the time when the journey would be made, or even if it would be undertaken that day. The RAO said that it had proved impossible to provide a suitable ambulance for the complainant's mother without causing delay and distress to other patients. The RAO said that at 6.24 pm the controller at out-patient control had asked the ambulance central emergency control if an emergency vehicle was available but none was. At 6.40 the controller told the first hospital that the complainant's mother could not be taken that day. The RAO said that there was no record at out-patient control of any telephone calls from the hospital between 2.35 pm and 6.40 pm but that such calls would not necessarily have been recorded.

17. The RHA told me that a decision should have been made before out-patient control staff referred the request to central emergency control at 6.24 pm and that either further attempts should have been made to arrange transport or the first hospital should have been told earlier that an ambulance was unavailable. The RHA said that this incident was extremely unusual and that there had been an obvious failure in the established procedure.

18. One of the nurses (the third SEN) told my officer that when the complainant had asked if it was possible to 'sit her mother up a bit', she had suggested wedging a chair between the head and the base of the trolley, and she remembered the complainant saying 'What a good idea'. A senior enrolled nurse in the fracture clinic (the SSEN) told my officer that he had worked there for fifteen years, and that he had used a chair for this purpose many times and had never known one to collapse. The second NO also told my officer that this was a common practice and in her opinion perfectly safe. The first NO told my officer that she regarded the practice as potentially unsafe and that, following this complaint, she had told nurses not to do it. She said that subsequently she had obtained a new type of trolley and that its head could be raised to an almost vertical position.

19. The ambulance liaison officer who is stationed at the first hospital (the ALO) told my officer that until 5 pm all requests for ambulances should be made to her office at the hospital and not to out-patient control. She said that she did not keep permanent records so that she could not check whether or not she had received any messages about the complainant's mother, but she had no recollection of one. The ALO said that if, when she received a request she found that out-patient control and the neighbouring ambulance service were unable to help, she telephoned central emergency control. She said that another option open to her was to use the second hospital's own ambulance. She also said that she would give warning of the likely delay. She said that she had received a copy of the complaint, as she did about any which involved the ambulance service, but that she had not taken any action on it since the delay was not unusual.

20. The receptionist in the fracture clinic who was away on the day in question told my officer that it was her practice to request transport through

the ALO's office. The relief receptionist told my officer that she usually worked in the A & E department. It was her practice there to telephone the ALO's office only if a patient required transport to go home, and she did the same thing when she was working in the fracture clinic.

21. Both the second SEN and the third SEN told my officer that they had telephoned the ALO's office a number of times between 2.30 pm and 3.30 pm to enquire about the transport. The third SEN said that she had been told that transport would be provided but that it would be a little while before it arrived. The second SEN said that she had been told, before 3 pm, that transport would be provided but that it would not arrive until about 8 pm, and that she had told the complainant's mother so. The first SEN told my officer that she received a telephone call from the ALO's office at about 3.30 pm to the effect that the mother would be taken to the second hospital that day. The ALO told my officer that neither she nor her assistant had any recollection of receiving or making these telephone calls.

22. The first SEN said that at about 4.30 pm she took the complainant's mother to the A & E department and left her notes with the receptionist. When she returned to the fracture clinic she had telephoned the sister to tell her that the ambulance service had agreed to take the complainant's mother to the second hospital and that she would require a meal if she had a long wait. The sister told my officer that she was certain she did not receive the telephone call which she would have remembered because it would have been so unusual. The first SEN said that she then telephoned the SSEN at home to tell him what had happened. The SSEN confirmed to my officer that he received this telephone call.

23. The sister said that between 6 and 6.15 pm the A & E receptionist told her about the complainant's mother. She had enquired whether an orthopaedic bed was available in the first hospital but none was and, therefore, she telephoned the ambulance service—probably central emergency control. She said that she had told them that transport was required urgently and that she had been given the impression that transport would be provided, but that it could be as late as midnight. After speaking to the complainant the sister said that she had called the second NO.

24. The A & E receptionist told my officer that she could not remember making any telephone calls specifically about the complainant's mother, but she said that her practice was to telephone the ALO's office at thirty-minute intervals and ask about all the patients who were awaiting transport. She said that when the ALO's office was closed she telephoned out-patient control.

25. The station officer who had been on duty at the out-patient control told my officer that he could not recall the case. He said that it appeared from their records that the first hospital had said that the complainant's mother had to be taken and that he had told the first hospital that he would try to provide a vehicle. He thought that he would have allocated a vehicle, but that something had probably gone wrong and eventually he had con-

tacted central emergency control. He said that the records also showed that he had contacted the neighbouring ambulance service but that they could not help.

Findings

26. In my judgment each part of this complaint is justified. The complainant's mother had to wait an unconscionable time for an ambulance, on a trolley that was unsuitable. She was not given any firm indication about when she would be taken to the second hospital, and it is apparent that one reason for this was the uncertainty that she would be taken at all that day. I think that the nurses did what they could but they could not get any information themselves. I uphold this complaint.

27. But the matter cannot stop there. The wait would have been bad enough if it had been an isolated occurrence but clearly it was not and therefore it did not cause the concern it should have done to many of the staff involved either at the time or when the complaint was made. My investigation has shown that organisation of the ambulance service was deficient and that the first hospital's system for summoning ambulances was confused. The RHA have told me that improvements will be made in the liaison between the staff of the first hospital and the ambulance service. The AHA have told me that steps have been taken to improve the operation of the ambulance service as far as the health district is concerned and that staff will be properly instructed in the procedure for ordering ambulances. They have also assured me that they will keep the length of time that patients have to wait for ambulances under closer surveillance.

(*c*) *The complaint that the complainant's mother did not receive a substantive reply to her complaints.*

28. When she wrote to me on 27 April 1981 the complainant said that she had written to the sector administrator (the SA) on 24 October 1980 setting out her mother's experiences at the hospital but that, apart from an acknowledgment dated 28 October, she had not received a reply to her letter. She said that the CHC had also written to the SA on her behalf, but they had not received any response either.

29. I have seen from the SA's files that on 28 October 1980 he acknowledged the complainant's letter of 24 October, and sent copies to the appropriate senior nursing officer (the SNO), the general surgeon and the orthopaedic surgeon for their comments. The orthopaedic surgeon replied to him on 3 November and the general surgeon on 7 November. The SNO had difficulty in obtaining information from her subordinates but she replied to the SA on 13 and 14 November and forwarded additional statements from nursing staff on 8 December. The CHC had written to the SA on 14 November and 30 January 1981. The SA told my officer that he had replied to the complainant on 6 March 1981, and there is a copy of a reply on his file, but the complainant told me that she did not receive it.

30. The SA told my officer that the responsibility for the delay in sending a reply to the complainant had been his, and that the delay had been due

to pressure of work. He said that he was 'snowed under' with complaints and a high proportion were about the A & E department, the fracture clinic and about one other department. He said that his failure to reply to two letters from the CHC had been due to an oversight.

31. I have seen that when, because of my investigation, the DA became aware of this complaint he wrote to the complainant, and to the CHC, saying that he would be carrying out an immediate and thorough re-investigation. When that was completed, the DA wrote to the complainant enclosing the report and his replies on specific matters have been included as appropriate in this report. He told her that he fully accepted that the reply which had been sent to her on 6 March was totally unsatisfactory. He also offered to meet the complainant if she would find it helpful. He apologised on behalf of the AHA and the RHA. The DA also wrote to the CHC. He replied to the points that they had raised and he apologised for the fact that their letters to the SA had gone unanswered.

32. The DA told my officer that he was not satisfied with the approach to complaints at the first hospital and that since this complaint, a study day had been held for administrators and senior nursing officers to try to improve the approach and attitude to complaints.

Findings

33. This complaint was very serious. Whatever other pressures of work the SA should have prepared a reply with a high degree of priority, not only because of its intrinsic importance but also because it should have caused him to be concerned about the standard of service available to other patients. I uphold this complaint. I have been assured by the AHA that their complaints procedure has been thoroughly reviewed and improved.

Conclusion

34. The complainant's mother had considerable cause for dissatisfaction with the service she received at the hospital. The complainant had equal cause for dissatisfaction in the way that her complaint was handled initially. I hope that they will both gain some satisfaction from the improvements that have been and are being made as a consequence of their complaints (see paragraphs 27 and 33). The AHA and the RHA have asked me in this report to convey their deep regret to the complainant and her mother for the distress they have been caused and I am very glad to do so.

Case No. W.219/81–82 – Accommodation and facilities provided for a private patient.

Background and complaint

1. The complainant was admitted as a private patient to the ophthalmic ward (the ward) of a hospital (the hospital) on 21-24 April and 10-12 June 1981 for the extraction of two cataracts. He contended that he was grossly

overcharged for the accommodation and food he was offered and complained that:–

(*a*) his accommodation comprising a cubicle was poorly decorated and sparsely furnished, the washing and lavatory facilities were inadequate, and the cubicle was attached to the section of the ward occupied by female patients ;

(*b*) the accommodation for private patients elsewhere in the hospital was of a higher standard and the other cubicle in the ward similar to his own was occupied, free of charge, by a National Health Service (NHS) patient ;

(*c*) the standard of food was 'terrible' ; and

(*d*) he was required to pay in advance for his first stay ; he paid retrospectively for the second but this account was presented in an objectionable manner.

Investigation

2. In the course of the investigation I obtained the written comments of the Area Health Authority (the AHA) and examined the relevant administrative and financial records. One of my officers met and discussed the complaints with members of the medical, nursing and administrative staff involved and with the complainant. My officer visited the ward and the private wing of the hospital.

(a) *Accommodation*

3. In discussion with my officer and in correspondence, the complainant said that on the two occasions he was admitted to the hospital he was accommodated in a cubicle which was 'tatty', to say the least, and which could have done with a coat of paint. The cubicle was small, measuring approximately 10 feet by 8 feet and contained only a bed, a locker, a hard stool under the bed, an angle lamp and a folding shelf. There was nowhere to hang his jacket and trousers and he had to ask a nurse for a coathanger on which to hang his clothes from a picture rail. He also had to ask for a chair when his wife and friends came to visit him. There was no washbasin and the bathroom and lavatory were some 30 yards away which necessitated making a journey which, after an eye operation, took some time. The complainant said that the cubicle was attached to that part of the ward occupied by female patients and he found it extremely embarrassing to sit in the ladies' part of the ward where there were armchairs and tables especially when one of them screamed out 'there is a man in here'.

4. The ward to which the complainant was admitted is the only eye ward in the hospital. It is situated on the first floor and close to the eye theatre. It comprises two sections, one containing five beds and occupied by male patients when the complainant underwent his two operations in April and June 1981 and the other (to which two cubicles are attached) which was occupied at the relevant times by female patients. My officer found that the size of the cubicle was broadly as described by the complainant and that it contained the furniture the complainant described.

When the AHA gave their initial comments to me they acknowledged that the standard of decoration was not ideal but reasonable and my officer found this to be so.

5. The consultant ophthalmologist who treated the complainant (the consultant) told my officer that the unit was established after his patients had experienced difficulties when they had been nursed in non-specialist eye wards. Eyes were particularly delicate after an operation and there had been two or three cases of a graft being destroyed. The consultant explained that the unit was staffed by nurses trained in ophthalmic care and that the cubicle was sparsely furnished because it was all too easy for visually handicapped patients to trip, stumble or fall and ruin an operation. He thought it was his duty and that of the hospital to eliminate potential danger and the absence of furniture was for the benefit of the patient. He said that even if the accommodation had been larger he would still have insisted on it being sparsely furnished. The consultant explained that wash-basins were not necessary since experience had shown that patients had ruined operations by washing themselves carelessly – even splashing water might infect an eye. Nurses therefore bathed the patients. He said that he always explained to patients the nature of the cubicles and the medical reasons for their austerity. He said that he was certain that he had explained the reasons to the complainant before his first admission. I have seen the letter the consultant's secretary sent to the complainant on 16 March giving details of the arrangements for the first operation and provisional arrangements for the second. The letter explained that private patients for eye surgery were taken into the general eye ward as the special nursing care required for eye surgery was not available on the private floor; the letter added that the consultant had asked for the complainant to be accommodated in a cubicle which should afford him some privacy.

6. My officer spoke to three senior nurses having responsibility for the war – a senior nursing officer (the SNO), a nursing officer (the NO) and the ward sister. It was generally acknowledged that the accommodation was no more than adequate but all three thought that it was more important that those nursing patients who had had eye operations should have had special training. The ward sister remembered that when the complainant arrived at the hospital for his first operation he did not like the cubicle and said that it was inadequate. However, after she had explained that the nurses on the ward were trained in ophthalmic nursing care and after he had seen the consultant, he agreed to stay. The three members of the nursing staff all confirmed that the consultant desired as little 'clutter' as possible in the cubicle. It was pointed out that although there was no wardrobe, there were clothes cupboards outside the cubicle but the ward sister agreed that there had been other complaints about the cubicle accommodation. The senior nursing staff were sure that a chair would have been provided when it was requested. As regards the wash-basin, it was explained that the nurses bathed the patients in order to avoid infection to an eye on which an operation had been performed and to ensure that grafts were not disturbed. They acknowledged that it was unfortunate that the area to which the cubicles were attached was, at the time of the complainant's admissions, for female

patients and that the lavatory for male patients was a short walk away. But the nursing staff made the point that eye patients were always escorted there and everywhere. The consultant said that generally patients who had undergone eye operations were required to remain quiet and to make as little movement as possible.

Findings

7. In the light of previous experience an ophthalmic unit was established in the hospital and the consultant decided in the exercise of his clinical judgment that private patients needing ophthalmic treatment should be accommodated in it. I think it right that private patients should have the benefit of the specialist nursing training that is available to NHS patients there since the cost of the nursing care forms part of the substantial daily charge private patients are asked to pay. In the course of the investigation it was suggested that the specialist medical and nursing care received by the complainant in the eye ward had to be weighed against the accommodation but I do not accept that since the nursing care is also enjoyed by the NHS patients and the consultant's fees were paid for separately. The consultant also decided in the exercise of his clinical judgment that only essential furniture should be permitted in the cubicle and I do not question that. The decorative state of the cubicle was found to be acceptable even if not ideal and I make no criticism in that respect. But I do think that the complainant was justified in his criticism of the size of the cubicle and its location. Its size prevented him sitting out in an armchair in it and he was obliged to sit with female patients in the open area. I have no doubt that one of them expressed surprise, if not concern, that he should be sitting in an area normally occupied by women and that he was embarrassed. Furthermore I do not think it unreasonable for a patient to expect his clothes to be kept in the accommodation he is occupying, when he has agreed to pay in excess of £100 per day for that accommodation and service.

8. The complainant was certainly notified that a cubicle had been requested for him and the consultant is sure that he explained, before his admission, the medical reasons for its austerity. But I have no doubt that the patient still thought that he was going to get rather more than he did for his money. Department of Health and Social Security Memorandum HC(80)5 which, among other things, gives advice to health authorities on the collection of charges made to private patients, recommends that patients should be fully informed before they sign or give an undertaking to pay the appropriate charges, of the nature of the facilities being made available. It is emphasised to the health authorities that these explanations should always be given and that it is not sufficient to rely on the patient reading the form of undertaking to pay the charges or to assume that information has been given to him at an earlier stage. I have found no evidence that the hospital gave the complainant this information.

(b) *Comparison with other private patients' accommodation in the hospital*

9. The complainant recalled that during his second stay at the hospital he met a NHS patient occupying a cubicle similar to his own who said that

she was paying nothing for that accommodation. He wondered how a NHS patient could be given the same accommodation free of charge while he was paying £101.60p per day. And, by chance, he also saw the private patient wing and believed it to be more comfortable, better decorated and the rooms better furnished. By comparison, he thought the cubicle accommodation left much to be desired and he found it difficult to accept that so small a difference between charges as £10 per day could be justified by so great a difference in accommodation.

10. Under Section 65 of the National Health Service Act 1977 the Secretary of State for Social Services may authorise the extent to which accommodation and services at a hospital may be made available to resident patients who give an undertaking to pay such charges as he determines. Since 1968, authorisations have been in terms of the number of hospital beds that can be used by private patients and not in terms of particular beds set aside for the sole use of private patients. This allows both flexibility in enabling private patients to be accommodated in that part of the hospital most suited to their medical needs and also secures more effective use of all beds.

11. The AHA do not deny that NHS patients on the ward are accommodated in the cubicles if they are not occupied by private patients, or that the private patients' wing also accommodates NHS patients. They explained that the use of the cubicles and private wing by NHS patients depends upon the number of private patients admitted to the hospital at any time and pointed out that the hospital's resources have to be fully utilised. The cubicles in the ophthalmic ward were not reserved exclusively for private patients although they tried to place private patients in them whenever possible.

12. As for the variation in standard of accommodation between that offered to the complainant and that offered in the private wing of the hospital, my officer found when he visited the private patients' wing that patients were accommodated in their own rooms (not cubicles) which were larger, carpeted and included a bed, wardrobe, chest of drawers, bedside table, over-bed table, television and telephone. Washing facilities were available in each room. The AHA acknowledged that the standard in the private wing was higher than that in the ophthalmic ward but they told me that this was reflected in the respective charges of £101.60p and £111.70p per day for 'other accommodation' and single rooms. As I have said the complainant did not think that the difference of some £10 adequately reflected the difference in standards at the hospital and both the consultant and the ward sister agreed with him. Nevertheless, these charges were determined nationally by the Secretary of State as provided by the National Health Service Act 1977 and I know that the classification of a cubicle as 'other accommodation' is in accordance with the DHSS Memorandum to which I have already referred.

Findings

13. The relevant legislation provides no basis for the widely-held belief that a higher standard of accommodation should be provided for private

patients than for NHS patients. A private patient may choose the consultant in whose care he wishes to be and is entitled to greater privacy than a NHS patient. But a private patient in a NHS hospital does not necessarily enjoy better accommodation. Neither does the practice of allowing NHS patients to use the same accommodation as private patients, which the complainant found difficult to understand, run counter to any advice given by the Department of Health and Social Security. The AHA charged the complainant at the appropriate rate determined by the Secretary of State for 'other accommodation'. The complainant did not think the differential was sufficient and said that the charges he had to pay were in excess of those for a de-luxe five star hotel. It seems to me that this argument ignores the fact that when a patient chooses to be admitted to hospital as a private patient all the services he receives have to be paid for including the nursing care. I do not uphold this complaint.

(c) *Food*

14. The complainant said that the food served during his two stays at the hospital was 'terrible'. He said that he limited himself to brown bread and butter and tea for breakfast and that the lunch and supper were uneatable. He recalled greasy chops, an 'indescribable' pancake and haddock and he said that he gained the impression that there was a shortage of food in the hospital. His wife brought in food when she visited him. He said that he fully appreciated that food in the hospital was cooked in bulk but he felt that a better effort could have been made.

15. The SNO and NO said that the catering officer at the hospital dealt with complaints about food quickly and in person and that had the complaint been made at the time he would have visited the complainant to see what was wrong. The ward sister did not recall receiving any complaint about the food from the complainant while he was on the ward. And when the initial investigation of this aspect of the complaint was undertaken by the hospital, I have seen that the assistant catering manager recorded in an internal memorandum that no notification of a complaint was received by his department from the complainant at the time.

16. I took evidence from the catering officer in May 1981 in the course of the investigation of a similar complaint. He explained to my officer then that since 1979 he has provided for all patients a choice of five main dishes at lunchtime and four at supper and two additional choices and a cooked breakfast for private patients: patients ordered their meals a day in advance. He said that the catering service received far more compliments than complaints and he doubted if more than two or three written complaints were received in a year. From his diary he noted that he dealt with no more than four minor grumbles in a period of five months in 1981. A survey undertaken in 1981 showed a high level of satisfaction with the standard of food at the hospital and the ward sister confirmed that she had not heard of any general complaints about the food on the ward.

Findings

17. The provision of food in a large hospital is a difficult task and may well disappoint those patients who expect as high a standard as they receive at home. I know from another investigation I have carried out that the catering manager at the hospital follows up complaints immediately they are made to him and this is clearly the best way to deal with a complaint about a particular meal. However I have seen no evidence that the complainant expressed his dissatisfaction with the catering during his stays at the hospital. Had he done so, I am satisfied that the catering officer would have seen him and attempted to resolve his difficulties. Although the complainant did not give the hospital details of what particularly displeased him the hospital expressed their regret in their response to his complaints that he did not like the food provided. In these circumstances I do not think they could have done more.

(d) *Payment of the charges*

18. The complainant said that for his first stay he was required to pay £300 in advance of a final bill for £304·80p. He was told that the reason for this was that the hospital was trying to prevent bad debts. Had he not paid in advance he said it had been made quite clear to him that he would not have been admitted to the hospital. He was not required to pay in advance for his second stay but before his discharge he was presented with his account for £203·20p on a 'scruffy piece of paper'. He added that a few days after his second discharge he received a further bill for £5·98p relating to a telephone charge. He said that he could not have made a telephone call as the cubicle had no telephone. He felt that after an expensive stay at the hospital with poor accommodation it was a very poor 'joke'. When he telephoned the hospital and complained about the bill, he was informed that he had been charged in error and that the mistake had arisen because there was another person with the same surname in the private patients' wing. But he said that he never received a letter of apology for the mistake.

19. The chief accountant at the hospital (the CA) told my officer that in order to reduce the number of bad debts a system of deposits had been introduced. I know from other cases I have received that 'deposits' are required by many hospitals and that they are no more than payments in advance. The practice has the support of the Department of Health and Social Security. The consultant's letter of 16 March (paragraph 5) addressed to the complainant warned him of the possibility of a request for a deposit on admission. As regards the complainant's second stay, the CA confirmed that as the finance department had received assurance from the consultant about the patient's responsible attitude they were confident that he would meet his debt. The CA added that the complainant had anyway given a written undertaking to pay. It is hospital policy to notify a patient as quickly as possible of any debt and that accords with good administrative practice. Moreover I have noted that the undertaking to pay the appropriate charges which the complainant signed at the beginning of his second stay indicates

that accounts should be settled weekly or on discharge. I have seen the bill he was presented with and the receipts he was given and I do not find them 'scruffy'.

20. As for the telephone bill the CA explained that charges ancillary to a main account were sometimes difficult to identify before the main account was given to the patient. The telephone bill had been a supplementary charge prepared by the finance department after the daily list of telephone calls made by patients had been received. The CA confirmed what the complainant was told, namely that at the time of his second stay at the hospital there was by chance a patient in the private wing with the same surname to whom the account should have been sent. At that time the list of telephone calls did not include the patient's sex or initials. It was not disputed that the complainant had been incorrectly charged but the CA said that the procedure had now been altered in that the telephone list gave details of the initials and sex of the patient against whom a supplementary charge was to be made. However, later in the investigation I discovered that the patient for whom the complainant had been mistaken did not have the same surname. I have seen a copy of a letter dated 3 July from the district treasurer saying that the invoice for the telephone calls had been cancelled and apologising for the 'embarrassment' caused. Unfortunately the complainant has no recollection of seeing this letter.

Findings

21. I make no criticism of the hospital for requesting a payment in advance before the complainant was admitted on 21 April nor for giving him the account for accommodation and services for his second stay when he was discharged on 12 June. I do not consider he was justified in describing the accounts or the receipts as 'scruffy'. The presentation of the telephone bill was a mistake. He was not given an accurate explanation of it but I am satisfied the district treasurer apologised. It is unfortunate that the letter in which the apology was included was apparently not received by the complainant but I have seen that it was correctly addressed.

Conclusions

22. I have no doubt that the complainant was dissatisfied with the food he was given while in hospital but his proper course was to have asked at the time for his complaints to be brought to the notice of the catering manager. He did not do so and since I have not found evidence of general dissatisfaction with the standard of catering, I have not taken this complaint further. The AHA's apologies for their mistake in sending the complainant the telephone bill did not reach him and they have asked me to convey these to him now in my report. This I gladly do. I have not upheld any other aspects of the complaints set out in paragraph 1(b) and (d).

23. As I have already indicated I have investigated other complaints from private patients using the facilities of National Health Service hospitals and I have consistently taken the view that even though particular beds do not have to be designated for the use of private patients, a patient may properly

expect that the standard of accommodation and service maintained by the hospital will match more or less the payment demanded for it. The complainant had nothing but the highest praise for the service of the nursing staff but I have concluded that the accommodation did not come up to the standard he was entitled to expect. In their reply to the complaints the hospital expressed their regret that the complainant was not satisfied with it but I do not think that is enough. First, in order to prevent a repetition of this type of complainant from private patients using the ophthalmic ward, I believe that the hospital should ensure that private patients are informed in writing of the special accommodation arrangements and what they comprise. I therefore invited the AHA to introduce this procedure and I am pleased to report that they have agreed to do so. Second, in my judgment, the complainant is entitled to be repaid an element of what he paid to the hospital in respect of his first stay. As regards his second stay, since he knew what accommodation to expect and, before he was re-admitted, he had adequate opportunity to ask the consultant whether he had access to private beds elsewhere, I do not consider any repayment is appropriate. Accordingly, I also invited the AHA, in view of the shortcomings in the accommodation I have mentioned in paragraph 7 and their failure to inform the complainant of the accommodation that had been arranged for him, to consider making a repayment to him within the limits I have recommended. However the AHA could not agree to making any payment to him. They told me that they are not empowered to make a repayment of private patient charges although they acknowledged that an *ex-gratia* payment could be made if the circumstances justified it. In my judgment the circumstances do justify it.

24. Despite being informed of that judgment, the AHA have continued to argue, among other things, that private patient charges 'reflect simply the benefit of access to hospital facilities' rather than being related to any specified standard of accommodation or service. In my judgment that argument is manifestly fallacious if only because charges are made on a daily rate basis, so that a patient who stays six days in hospital pays twice as much for access to services as one who stays only three. But the fundamental point is much simpler and it is this. The initiative for seeking the Secretary of State's approval for the authorisation of private accommodation rests with the AHA. If that authorisation is approved the AHA are obliged to offer accommodation at the rates fixed by the Secretary of State. If therefore they have no accommodation which can justify those charges they should acknowledge this by upgrading the accommodation or taking steps to have the authorisation rescinded. A patient minded to be a private patient would then be faced with either going elsewhere or accepting to be a National Health Service patient. I see nothing wrong in that. But purporting to offer accommodation for private patients which is in fact seriously below the standard which could reasonably be expected having regard to the charges and then insisting on payment for it, seems to me unconscionable. It might be an alternative, if it is practicable, to require that private patients inspect the accommodation offered before agreeing to pay for it. I have already found that in respect of the complainant's *second* stay in hospital, that is what in effect happened. The patient may then be deemed to have consented to pay for accommodation which he has seen and

inspected beforehand, in which case he cannot complain of its inadequacy. It follows that I must report with regret that I have found in this case an injustice which has not been remedied.

Case No. W.220/81–82 – Arrangements for hospital discharge.

Complaint and background

1. The complainant's grandmother ('the patient'), aged 83, fell at home during the night of 30/31 December 1980. The following morning she was taken to the accident and emergency department (the A and E department) of a hospital (the hospital) but was discharged home later that day. She became ill during the night and was admitted to the hospital on 1 January where she died that day. The complainant said that:–

(*a*) the arrangements made by the hospital for the patient's discharge on 31 December were unco-ordinated and unsatisfactory; and that

(*b*) the Area Health Authority (the AHA) failed to deal with her complaint satisfactorily.

Investigation and jurisdiction

2. During the investigation I obtained the comments of the AHA and I have examined the medical and nursing records and other relevant documents. One of my officers interviewed the nursing and administrative staff concerned. He also met the complainant and her mother, who had accompanied the patient to the hospital on 31 December. The summary of events in paragraphs 3 and 4 is based on that interview and on the complainant's letter of complaint. It was explained to the complainant that I cannot investigate actions taken in the care or treatment of a patient if in my opinion they arose solely in the exercise of clinical judgment, and that I could not therefore question the doctor's decision not to admit the patient on 31 December if he had also taken into account her home circumstances.

(a) *The complaint about the discharge arrangements*

3. The complainant and her mother said that the patient had had a series of falls during the weeks prior to 30 December and when that night she fell again she had also suffered breathing difficulties. The complainant's mother, who was with the patient, had been unable to put her to bed and she sat with her until 7.45 am on 31 December when the home help (who came daily) called and ordered an ambulance. The patient was examined by a doctor (the A and E doctor) in the A and E department, given oxygen, and underwent a number of tests. The complainant's mother said that at one stage the A and E doctor thought that the patient should be admitted but that the decision would be made after the medical senior house officer (the SHO) had seen her. The SHO examined her and said that he could find nothing organically wrong and told the complainant's mother that she would be discharged home. The complainant's mother said that she questioned this decision in view of the patient's condition and told the SHO that there was no

one at home to look after her. The SHO answered that the patient was a social problem and that the hospital would get in touch with the social services department (the SSD). Soon after this a staff nurse told the complainant's mother that they had arranged for a 'welfare officer' to be at home when they arrived there.

4. The complainant's mother said that on their return home she contacted the SSD but they said that they did not know anything about the patient's discharge. She also telephoned the family doctor (the FP) because the hospital had given her a letter addressed to him. The FP asked her to take that letter to his surgery, but the complainant's mother told my officer that she could not leave the patient who spent the night wrapped up in front of the fire. She said that at 7.45 next morning a district nurse (the DN) called and said that in view of the patient's condition she could not accept responsibility for her continued welfare at home. The DN called an ambulance and the patient was admitted to the hospital immediately and died there later that day.

5. In his reply of 3 April 1981 to the complaint the acting district administrator (the ADA) said that after her arrival at the hospital at 8.59 am the patient was seen first by the A and E doctor and later by the SHO. The SHO had taken her medical history, made a full examination, assessed the results of tests, and concluded that there was no medical condition requiring her immediate admission. He had also taken a social history which had indicated that she had a home help, was visited twice-weekly by a district nurse and was seen regularly by neighbours and by her daughter. The SHO had felt that the patient needed more support at home and therefore the community nursing service (the CNS) had been telephoned and in turn they agreed to alert the district nursing department. The ADA explained that he could not obtain the SHO's comments as he had by then left the hospital but he said that the consultant physician (the physician) had formed the opinion from the medical notes that the patient's condition had worsened after her discharge on 31 December, as on her admission she had congestive heart failure for which immediate treatment was begun.

6. My officer was unable to interview the SHO because he had died in a road accident in February 1981 but I have seen that his entries in the medical records for 31 December conclude as follows:–

> 'I can find no medical condition requiring stat admission. Recommend [increased] social services.
> —S. services to be informed
> —letter to [FP].'

I have also seen a copy of the letter which the SHO sent to the FP. It provides details of his findings based on the hospital tests and his examination of the patient but no mention is made of the SSD. The letter also said that the SHO understood that the patient had a home help, that the district nurse attended twice a week and that she had visits from a neighbour. He concluded that since she had seen the geriatrician in the past, if her condition deteriorated then they might wish to admit her for rehabilitation.

7. The A and E consultant (the surgeon) told the AHA that it had been the opinion of the A and E doctor that the patient required admission to a medical ward but he pointed out that the decision about admission under the care of that speciality was the responsibility of the SHO.

8. The staff nurse who, according to the hospital's records had been primarily concerned with the patient in the A and E department and who had contacted the CNS told my officer that she could not remember her or the events complained of. However she said that she would have contacted the CNS on the instructions of the SHO and that she would have tried to keep relatives informed of the arrangements which were being made. She doubted if she would have given the impression that a social worker could be available immediately at a patient's home as she knew this to be impracticable. I have seen that the staff nurse noted in the records that at 14.50 CNS had been contacted regarding the SHO's instruction and that the DN would be contacted by CNS.

9. The CNS nursing officer (the NO) told my officer that the message from the staff nurse about the patient had been recorded by a clerk and I have seen that the entry includes the following note: 'Being dis. pm 31.12.80. [SHO] writing to [FP] to ask for increased Social Services', and it is further noted that the message had been passed to the DN. The NO said that the entry showed that no degree of urgency had been indicated when the message was given. She said that the DN was contacted after she had completed her afternoon rounds at 5 pm and had confirmed that she would visit the patient the following morning. The NO said that had a visit during the evening of 31 December been requested, this would have been arranged.

10. I have seen that in his report to the AHA about the complaint the physician, after describing the events of 31 December and 1 January, said 'It is most unfortunate that the patient died after admission to hospital. It is difficult to answer the question as to whether she was wrongly discharged the day before because I did not see her. The physician wrote a further report after he had seen the complainant and her mother on 27 May. He said that their main criticism had been that the urgency of the matter should have been stressed to the district nursing and social services. The physician said that, in retrospect, it would clearly have prevented much anxiety and distress had the patient been admitted on her first attendance but that there had been no clear medical reasons for her admission. He had pointed out that although district nursing, social services and the FP had been notified perhaps they had not been told with sufficient urgency that they should visit the patient promptly.

11. The assistant divisional director of the SSD told my officer that they had no record of any message from the hospital asking for extra help for the patient, neither was there any record of the social workers at the hospital being asked. He said that SSD had been approached by the complainant's mother and as a consequence of that call they had arranged extra help.

Findings

12. The SHO decided in the exercise of his clinical judgment and after taking into account the need for domiciliary support services, that there was no reason for the patient's immediate admission. I cannot therefore question that decision. However, whether or not that decision was dependant upon the provision of those services that day, will never be known in view of the SHO's death. But it is clear that in arranging for such support (a) no urgency was conveyed to CNS, (b) the letter to the FP was not delivered to him until the following morning and (c) no contact was made by the hospital with the SSD. In all the circumstances I consider that the discharge arrangements were less than satisfactory and I uphold this complaint.

(b) *The complaint about the AHA's handling of the complaint*

13. On 14 January 1981 the secretary of the Community Health Council (the secretary) wrote on the complainant's behalf to the ADA. He acknowledged the complaint and sought the comments of the surgeon who had replied to the ADA on 23 January, explaining what the A and E doctor had done but pointing out that it was the SHO who took the decision not to admit the patient. The ADA therefore wrote to the physician who replied on 17 March. The ADA's reply to the complainant of 3 April, part of which is summarised in paragraph 5 above, also included an apology for the delay, extended sympathy to the complainant and offered her a meeting with the physician. In her complaint to me she described the letter as vague and somewhat tardy.

14. The ADA's letter contained considerable medical detail which had been provided by the physician. The secretary wrote on 1 May to accept on behalf of the complainant the offer of a meeting and he set out the points which were still causing the family concern. These were:—

'(i) Is an explanation in layman's terms possible, since the family have had some difficulty in understanding some of the points made in your letter.

(ii) No mention is made of whether the community nursing services or social services were contacted following the patient's discharge.

(iii) The family would like to know why the doctor who made the decision to discharge is no longer in the employment of the health authority and why no reference is made to the other two doctors involved in the case and the two ambulancemen who were also involved.

(iv) The family would like to know why the patient was not admitted to a hospital bed by the casualty officer, whose opinion it was that she should be admitted.

(v) The family believe that the patient should have been kept in overnight for observation and refused to accept that the hospital did not have a place available.'

On 27 May the physician met the complainant, her mother and the secretary and the complainant told me that he showed great understanding and compassion but he had not reassured them.

15. The ADA told my officer that his reply had been 'quite technical' because the complaint had been about the medical care given and clinical decision made. He had paraphrased the physician's comments but it could have been both dangerous and misleading for him to try to place his own interpretation on those comments. He knew that the secretary was helping the complainant and as he had suggested a meeting he felt that the medical terms could be explained by the physician himself. The ADA said that the delay in replying to the complainant had been due to the physician being on leave, who had had to obtain information from the records having not seen the patient himself.

Findings

16. There was some unavoidable delay in replying to the complainant but I do not criticise the way the AHA investigated the complaint or their response to it. They arranged a meeting, with the consultant present, at which they tried to explain the points of doubt which still worried the complainant. That this did not succeed is I am sure due to the complainant's unshakable belief that the patient was wrongly refused admission on 31 December. I think that the AHA did their best and I do not uphold the complaint regarding its handling.

Conclusion

17. I have given my findings in paragraphs 12 and 16. I sympathise with the complainant and her family in the death of their relation. The AHA have asked me to convey on their behalf in this report their regret for any distress suffered by the family and this I gladly do.

Case No. W.376/81–82 – Damage to patient's teeth while undergoing operation

Background and complaint

1. The complainant was admitted to hospital (the hospital) on 8 September 1981 for a gynaecological operation. She states to me that on admission she told the hospital staff that she had one capped tooth and a second one bridged and that a note to this effect had been made in her case notes. The teeth were broken while she was under anaesthetic. The Area Health Authority (the AHA), in reply to her representations, expressed their regret that the damage had occurred but told her that they could not accept responsibility for it.

2. The complainant wrote to me in November 1981 and complained about the way the AHA had dealt with her representations to them.

Investigation

3. During my investigation I obtained written comments from the AHA and examined these and other relevant papers. My officer interviewed the staff involved and he also met the complainant.

4. The complainant wrote to the administrator at the hospital on 16 September 1981 explaining that her teeth had been broken while she was under anaesthetic. She said that the teeth had cost her £96 in the previous July and she asked who would compensate her for their replacement and what procedure she should follow. The assistant area administrator (the AAA) told her in a letter dated 1 October that while she was recovering from the anaesthetic she had bitten hard on an airway that had been placed in her mouth. A member of the nursing staff had heard the teeth break and had quickly removed the broken pieces in order to prevent her swallowing them. He expressed regret that the damage had occurred, but said that the AHA were 'unable to accept any responsibility in the matter'. The complainant was dissatisfied with the reply and wrote to the AAA saying that she could not accept the explanation and suggesting that the anaesthetist should have taken some precaution to prevent the incident. On 23 October the AAA replied that there was nothing he could add to his earlier letter and that the AHA could not accept any responsibility.

5. The complainant told my officer that on the day of the operation, immediately before receiving pre-operative medication, she was asked by a member of the ward staff whether she wore dentures. She replied that she had *three* capped teeth and she saw the nurse write down this information. (I have seen the 'pre-operative list' on which is recorded '3 upper front crowned teeth'.) She said that on waking up in the recovery room of the operating theatre she vaguely recalled being told by a nurse that her teeth had been broken ; and she also remembered being told so later on, when she had returned to the ward, by a man she thought to be the anaesthetist. She told my officer that the teeth concerned had been supplied in July 1981 at a cost of £96 and she showed him a bill for the subsequent repair work in the sum of £90. This was hand-written on A5 writing paper bearing the name and address of the dental practice; and it was not clear whether it was for National Health Service or private work.

6. I have seen the AHA's accident and action reports which record the nature and cause of the accident and the extent of the injuries as: '2 broken capped front upper molars ' and ' no negligence—patient bit hard on airway whilst in spasm during recovery from anaesthesia. If no airway had been in place she would have had difficulty in breathing. . . . On hearing the cracking sound [the nurse] removed the crowns as patient was in danger of inhaling same as she was still unconscious.'

7. The nurse referred to in the accident and action reports told my officer that the breakage had occurred about two and a half minutes after the complainant had come into the recovery area. She thought it was because the complainant experienced a spasm during her recovery. She said she had reported the incident to the nurse in charge of the theatre and to the nursing officer. She showed my officer an airway similar to that used for the complainant; it was mainly of soft plastic but had a hard plastic mouthpiece.

8. The anaesthetist told my officer that before starting the complainant's anaesthesia he had been told by the nursing staff that some of her teeth were capped and had seen the record in her notes. He said it had become

necessary during the operation to insert an airway so as to maintain the free flow of gases to the patient's respiratory system. After she had been transferred to the recovery area he had been told by nursing staff that she had bitten on the airway and the capped teeth had been broken. He had gone to see her immediately to check her continued safe recovery. I have seen the 'operation sheet' on which is recorded '3 upper front capped teeth' and 'Recovery: while airway still in patient bit on it and broke 2 front capped teeth.'

9. The AAA told my officer that he had not treated the case as a complaint but as a 'small claim' which, under the normal procedure, fell to be dealt with by himself and the area treasurer. He had received a report of the incident from the nursing officer and, in the light of this, he and the area treasurer had decided that, although it was an unfortunate case, there was no evidence of negligence by the hospital staff; that the authority could not be held liable; and that therefore compensation for the cost of repair should not be offered to the complainant.

10. In a further conversation with one of my officers the AAA said that there was another case in which the AHA *were* considering the possibility of repairing a patient's teeth under the hospital dental service. This case, he said, was different from that of the complainant in that the accident had occurred in a different hospital, at which a consultant oral surgeon was based, and his team had been called in shortly after the mishap. He said he thought that, in the complainant's case, it would have been appropriate for the consultant to have got in touch with his dental colleague with a view to providing repair under the hospital dental service. But, by the time he (the AAA) had learned of the complaint, the complainant had already had the repair carried out.

Findings and conclusion

11. The decision of the anaesthetist to insert the airway was clearly taken in the best interest of the patient and was in any event a matter resting solely on his clinical judgment, which is not for me to question.

12. The AAA and the area treasurer decided that, because in their view there was no negligence on the part of the hospital staff which contributed to the complainant biting on the airway and breaking her teeth, they would not offer her any compensation for the cost of repair. However, the accident was certainly in no way the responsibility of the complainant who suffered it while she was unconscious and wholly under hospital care. In my opinion this is a case in which the AHA should have arranged for the repair to be carried out by the hospital dental service. As they did not do this, I consider that they should have offered her an *ex gratia* payment of the NHS charge payable by the patient for the repair necessitated by the accident. I am glad to be able to report that the AHA have accepted this view and that they will shortly be getting in touch with her with a view to arranging a payment to her. I regard this as a satisfactory outcome of my enquiries.

Case No. SW. 17/80-81 – nursing care and treatment following road accident

Background and complaint

1. Mr A, a 27 year old Canadian lawyer studying at a Scottish university, was admitted to an infirmary (the infirmary) on 22 July 1979 having been injured in a road traffic accident. He died there on 28 July.

2. His friend (Mr B), acting on behalf of the family made representations and submitted a detailed report (the report) of their complaints to the health board (the board). However having received no substantive reply after six months he complained to me of maladministration by the board. I agreed to investigate this and the following further complaints, namely that:

(*a*) the procedure at the Infirmary for identifying accident victims was either inadequate or failed in this instance as some thirty hours elapsed before Mr A's family were notified of his admission although he was carrying sufficient means of identification for his family in Canada to have been informed almost immediately ;

(*b*) on three occasions inaccurate, misleading and conflicting information was given to Mr A's family and friends about the nature and extent of his injuries and prognosis ;

(*c*) on a number of occasions the insensitive attitude of and comments by some members of the medical and nursing staff caused Mr A's family and friends unnecessary distress ;

(*d*) a doctor failed to telephone the family in Canada as had been arranged ; and that

(*e*) no one other than next-of-kin was permitted to visit Mr A.

Investigation

3. During the investigation I obtained the Board's comments and examined relevant documents from the board's files including the clinical and nursing notes. My officer discussed the complaint with members of the board's administrative staff, medical and nursing staff of the Infirmary, and an officer of the ambulance service. She also met Mr B and his wife and Mr C, Mr A's flatmate.

Jurisdiction

4. The actions of police officers are outside my jurisdiction but my officer met a police constable (the PC) who attended the scene of the accident in which Mr A was injured and a police Inspector (the Inspector) to obtain background information.

(*a*) *The complaint about the procedure for identifying accident victims*

5. In the report Mr C said that late on 22 July a policeman visited him telling him of the accident some hours earlier and that the motorcyclist, believed to be Mr A was critically ill in the Infirmary. The policeman said that before contacting Mr A's family in Canada it would be necessary for his identity to be confirmed and Mr C agreed to do this.

6. At about 11 pm Mr C telephoned the ward (the first ward) and offered to go there at once, but he was told that Mr A would be in the operating theatre until about 2 am and it was agreed that he should telephone again at 8 am. He did so and was told that as the first ward was 'rather busy' it would be more convenient if he would come between 10 and 11 am. Mr C arrived at 10 am and the senior house officer (the SHO) told him that Mr A had been transferred to another hospital (the hospital) for a special x-ray (the scan). Mr C offered to go there but the SHO suggested that he should come back to the Infirmary at 1 pm as Mr A would certainly be there then. Mr C returned at 1 pm and was told, by another doctor, that Mr A was either just about to leave the hospital or was already on his way back and he was asked to wait. At 2 pm he made further enquiries of this doctor who checked and apologised saying that there had been a misunderstanding and that Mr A was still at the hospital. Mr C left after agreeing to telephone the first ward at 4 pm.

7. At 3.45 pm and at 4.30 pm Mr C telephoned the first ward but was told on each occasion that Mr A had still not returned. At 4.45 pm he telephoned again and spoke to the ward sister (the sister) who he said was 'curt': he told my officer that he was annoyed, very worried and frustrated at this time that such a relatively simple procedure was proving to be so difficult. He said he had tried to explain to the sister that the Police needed his confirmation of Mr A's identity before they would contact his family in Canada, but she persistently interrupted his explanations saying that medical matters were their primary concern. He said that he had not disputed that but he had pointed out that he had been prepared to go anywhere since 11 pm on the previous night to identfy Mr A. It was eventually agreed that he should visit the first ward at 6 pm when he did identify Mr A, and he telephoned the Police. At 2.30 am (BST) on 24 July Mr A's family in Canada were informed of the accident. Mr C said that there seemed to be a lack of urgency on the part of the staff of the first ward in helping him and no co-ordinated communication.

8. The report pointed out that on 27 July the family were given many documents found on Mr A in the Infirmary and from these his identity could have been conclusively established within an hour of the accident and his family could have been informed at least 24 hours' earlier. The family wondered what had happened to these documents between 22 and 27 July as the envelope containing them was dated 27 July.

9. The divisional nursing officer (the Div NO) in her investigation of the complaint for the board stated that 'where at all possible the Police prefer a physical identification of the patient despite the availability of documents' and it was the need for this which held up notification of the accident to Mr A's family. In their reply to me the board said that the difficulties over identification related to 'Police as opposed to hospital procedure'.

10. The PC and the Inspector told my officer that it is a police responsibility to establish the identity of accident victims. In this case his flatmate was nearby and was willing to make the identification and this was considered

to be the safest course before contacting the family in Canada. They also said that it is the responsibility of the hospital concerned to notify relatives of a patient's condition but that they frequently act on behalf of hospitals and ask relatives to contact the hospital for more detailed information. The PC said that as their main concern was the critical condition of the injured motorcyclist no search for identity documents was made before he was taken by ambulance to the Infirmary. His identity was then unknown but later they learned of Mr C's address and it was recorded that this had been 'obtained from documents in his [Mr A's] possession'. The PC surmised that this information had come from the Infirmary. I have seen a police standing order that 'the responsibility for notifying relatives of casualties taken to hospital for treatment rests with the institution concerned'.

11. The sister in charge of the Infirmary's Accident and Emergency Department (A & E) on the evening of 22 July was unable to remember Mr A. However both she and the A & E night sister said that if a document such as a driving licence or credit card was found on an unconscious patient they would assume the patient was the person named thereon and this information would be given to the Police who would try to contact relatives. I have seen that Mr A's name, address and date of birth were entered on the A & E records and an extract from the A & E 'Patients Clothing' book records among additional items '1 credit card + cards'. Both A & E sisters commented to my officer that in view of the documentary evidence it seemed that the patient's identity was known during the short time he spent in A & E. I have also seen that his possessions were transferred with him when he went to the first ward and later to another ward (the second ward). The Div NO explained that the envelope containing his valuables had required replacement when the contents were rechecked on transfer. Hence it bore the later date.

12. The night sister on duty on the first ward when Mr A was admitted from A & E told my officer that she was unable to recall any telephone calls from Mr C but that she thought it reasonable that he was advised to attend in the morning to identify Mr A. The sister told my officer that when she came on duty in the morning she learned that Mr A had still to be formally identified, but she was unaware that Mr C had been given a time to do so. If his call had come through to the sisters' room at 8 am either she or the night sister would have taken it but she had no recollection of it. There was a second telephone on the ward and if the call had been taken by a nurse she should have been told. I have been unable to identify any nurse who can remember taking such a call. The sister said that while it was undoubtedly true that they were 'rather busy' at that time it was a simple procedure to identify a patient and would have caused no disruption to the ward routine.

13. The SHO told my officer that when he arranged Mr A's transfer to the hospital for the scan he did not know that Mr C had been told to attend the Infirmary to identify him. He said that the scan procedure was not usually a long one and so he had suggested to Mr C that rather than travel to the hospital he should return to the Infirmary after a few hours. The SHO did not know why Mr A's return was delayed. The case notes suggest that

because of his condition he was kept at the hospital for observation. In a written statement to the board the sister said that when she spoke to Mr C in the afternoon she found him rude and unwilling to accept reasonably what she was telling him. However she later acknowledged to my officer that she had not appreciated the delays he had experienced and in the light of these she accepted that his frustration was justified.

14. I have seen that the Scottish Home and Health Department have stated (1978 (GEN)15, Appendix paragraph 5) that identification of a 'casualty' was a police responsibility and that they would inform the next of kin. The district medical officer (the DMO) told my officer that the circumstances of this complaint had been raised informally at meetings of the district management team who had considered whether any steps could be taken to ensure that such a situation could not happen again. But after considering all the circumstances they had concluded that while the events of this case were highly regrettable it was altogether an exceptional one where nothing could be done to anticipate and thereby prevent a recurrence. I have been told that the Infirmary now has its own scanning equipment.

Findings

15. The written instructions of the police (see paragraph 10) and the guidance to health authorities (see paragraph 14) are conflicting and should be reconciled. However in practice there does not usually seem to be any difficulty and in this case the police were fully prepared to inform Mr A's family once they had been satisfied as to his identity. It is not for me to comment on their procedure. Some delay at the Infirmary before Mr C could see Mr A was unavoidable but equally there is no doubt that subsequent delays could have been avoided and are to be regretted. I uphold the complaint that the Infirmary's action did cause unnecessary delay in the notification of Mr A's accident to his relatives in Canada.

(b) *The complaint about inaccurate, misleading and conflicting information :*

(1) *Siting of limb fractures and the advice about whether Mr A's mother should travel to see her son*

16. The report said that when Mr A's family were told of his accident his brother (Mr D) telephoned the SHO who informed him that the patient had sustained 'damage to the head and arm'. Mr D asked if his mother should travel immediately to see her son but he said that the SHO suggested it might not be necessary for her to do so immediately and perhaps she could wait a day or so. Mr D then contacted another brother (Mr E) who immediately telephoned the SHO who told him that the patient had a ' broken elbow and wrist on the right side ' and had also sustained a critical head injury. When he enquired about the extent of the head injury and asked for a more complete diagnosis he was told that his brother was 'seriously ill'. Again he requested more details and was told 'As I've said before your brother is seriously ill'. Mr E asked the SHO if he thought his brother would die but he repeated that he was 'seriously ill' and then hung up.

17. The SHO told my officer that he could remember speaking to Mr E but he had no recollection of speaking to another brother. He said that he explained the patient's injuries, stressing the seriousness of the head injury and he accepted that he may have inadvertently given wrong information about the siting of the limb fractures. He was asked if the patient would live or die and when he replied that there was a 'possibility' that he might die he received the retort 'That is not what I asked you—is he going to die.' The SHO told my officer that there is always that possibility in such cases but that it is impossible to be definite and his reluctance to do so seemed to irritate Mr E greatly. The SHO said that he was asked if Mr A's mother should travel to see her son, but because of the distance involved he found this question difficult to answer and he replied to the effect that 'If my brother was in such a serious condition I think my parents would travel to be with him', but he thought that this indefinite answer displeased Mr E as much as his previous one. He had no recollection of saying that Mr A's mother should wait a day or so before deciding to travel and he denied hanging up on Mr E. My officer spoke to the former registrar (the registrar) who said that when he met the patient's mother and Mr E on their arrival at the Infirmary (paragraph 19) he learned that they had been given incorrect information about the positions of the limb fractures. He said that Mr E was most concerned that this should have happened and he kept harping back to it, wanting the details of these fractures explained. The registrar said that he had great difficulty in focusing attention away from the limb injuries which were, he said, 'insignificant' in comparison with the major head injury that had been sustained.

(2) *Siting of skull fractures and extent of brain damage*

18. The report said that on 24 July the SHO informed Mr B's wife that Mr A had sustained a fracture of the skull which had affected the right frontal part of the head and the posterior area of the skull and that this had resulted in damage to the back of the brain. He told her it was difficult to assess the extent and effect of the brain damage but that the brain stem had been badly damaged and that if Mr A did regain consciousness there would definitely be 'a deficite'. When Mr A's mother and Mr E arrived at the Infirmary on 25 July the registrar explained to them that Mr A had injuries and brain damage to the front of head and he indicated the place of fracture by pointing to his forehead; and he went on to explain that only medication could be given to relieve the pressure caused by the brain swelling. In the evening Mr A's mother and Mr E visited the Infirmary again when the sister informed them that the patient's skull fracture was not an eggshell fracture but was a hairline crack running the length of the forehead. In the light of the information they had been given the relatives felt there were grounds for guarded optimism and later that evening Mr E, in the presence of Mr B and his wife, explained to his mother that as the main injuries were to the front of the head and as the back of the head was not damaged, then as the swelling at the front of the head subsided the functions controlled by the back of the brain would presumably recover as pressure there was relieved. Mr B's wife told my officer that she realised upon hearing this that the information Mr A's mother and Mr E were

given about the position of fractures and areas of brain damage bore no relation to what the SHO had told her earlier. This alarmed her but she decided to say nothing about it. However at 3 am on 26 July Mr. A's mother was informed that her son had suffered a cardiac arrest and together with Mr E and Mr B and his wife she went to the infirmary where the registrar explained that because of the cardiac arrest it could be inferred that Mr A had also suffered damage to the back of the brain. They were also told that this damage was not and could not have been known prior to the cardiac arrest.

19. The SHO confirmed to my officer that he told Mr B's wife that Mr. A had skull fractures at the back of the head and that it seemed probable that there was brain damage there and at the front. He said that she seemed to appreciate the severity of the situation. The registrar explained to my officer that he was off duty when Mr A was admitted and did not resume work until 25 July when he familiarised himself with the case history and treatment. A little later he was informed of the arrival from Canada of the relatives and was asked to speak to them. He said it had been his understanding from the initial study of the x-rays that the skull fractures were to the front; that the frontal lobes of the brain and the brain stem had been damaged and that the investigations indicated that it was unlikely that surgery could be employed to reduce the brain swelling present. He said he told them this; that the injuries were very serious; and that whilst Mr A's condition had been stable since admission this could not be taken to be an improvement.

20. The registrar was still on duty when Mr A suffered the cardiac arrest and he spoke to his relatives and friends when they arrived at the Infirmary. He said he explained to them that the cardiac arrest had been caused by pressure on the brain stem caused by bruising from the injury to the back of the head and that this indicated the extent of the brain damage which had been sustained and that the patient's condition was now particularly serious. The registrar said Mr E immediately and rightly drew his attention to the fact that he had earlier told them the injury was to the front of the head. He therefore went to the doctors' room where he re-studied the x-rays which confirmed the fractures were at the back of the skull and he confirmed this with the SHO. He returned and apologised to the relatives for misinforming them. He told my officer that he was very sorry that he had made a mistake but he stressed that this had not affected Mr A's medical management. He said that he told the consultant neurosurgeon (the consultant) of his error the following day and that when he met the relatives on a later occasion he again apologised for the 'mix-up'.

21. The sister told my officer that she was not confused about the position of Mr A's skull fracture and what she had been doing was to describe its nature and not its position. She said it is possible that in doing so she drew an imaginary line and she accepted that if she had done this across her forehead this could have inadvertently misled the relatives.

22. The consultant in a written statement to the Board and in his interview with my officer said he deeply regretted that because he was operating

at the hospital he was unable to meet Mr A's relatives when they arrived at the Infirmary as was his usual practice. He felt that had he been able to do so the opportunity for incorrect information being given would not have arisen and the doubt about the reliability of information given subsequently would have been avoided. The registrar had informed him that he had misinformed the relatives and the consultant said that on the first occasion he met the relatives and friends he apologised for this and explained that it had not affected Mr A's treatment.

23. My officer discussed the complaint with the professor of the Department of Surgical Neurology at the university (the professor) who was called in by the consultant (see paragraph 26). The professor explained that the assessment of head injuries is unpredictable and that this presents doctors with a dilemma because they do not wish to be either too optimistic or too pessimistic. He stressed that Mr A's prognosis had never been good but the days following the accident, when his condition remained stable, seemed to indicate that there was an increase in his chances. The professor explained that the cause of Mr A's cardiac arrest indicated that he had suffered extensive brain stem damage.

(3) *The significance of the thumb movement*

24. The report said that following his cardiac arrest Mr A was transferred to the second ward for intensive care. Tests carried out there on 26 July showed no sign of brain activity and on 27 July Mr A's mother and Mr E accompanied by Mr B's wife went to the Infirmary expecting to have to give consent to the withdrawal of all artificial means of life support. Mr E explained to the consultant that before making such a grave decision he had to reassure himself that the information he had been given was correct and he therefore wanted to see the x-rays and reports concerning his brother. The consultant told him he had no legal right to that information but he left saying he would consult with a colleague. Whilst they were waiting the consultant went into the ward and when he came out he said 'There's been a marginal change' (in Mr A) and when questioned by Mr A's mother stated that this was 'for the good'. However he warned them not to raise their hopes too high and left without further explanation. Mr B said this incident only added to the family's distress and confusion.

25. The report went on to say that the consultant returned and showed them the skull x-rays but that Mr E had also wanted to see the limb x-rays. The senior registrar in anaesthetics (the senior registrar) who had been present obtained them and during his explanation of them asked if they had 'heard the good news' and told them that on the previous night he had seen Mr A move his thumb. They said that the senior registrar surmised that this must have been what the consultant meant by 'good news', but he explained that the movement could have been caused by a spinal reflex. Mr B said that the consultant should have informed the relatives of this qualification and thus prevented them from having false hopes.

26. The consultant told my officer that before meeting the family he saw Mr A and was told of the thumb movement which had been monitored

throughout the night. He said he had concluded that it was a reflex action and it had not been his intention to tell the relatives about it. However he was 'pressurised into a comment that there had been a marginal change' the nature of which he said he explained to them telling them that this was not of particular significance and that it was a fairly common phenomennon. He was certain he would not have told them that this was a 'change for the good' as this was not how he viewed the event. The consultant said that he had been ' very irritated' and 'driven to distraction' by Mr E's attitude which he described as 'rude and downright aggressive', demanding to know the minutest details about Mr A's condition, and he decided because of this to ask for the professor's assistance. He also stated that it was quite correct that the relatives had no legal right to see the x-rays but he added that it was often his practice to show them as a matter of course.

27. The senior registrar said he remembered discussing the thumb movement with the family. He said it was Mr E who raised this subject because of something the consultant had said. He confirmed that the thumb movement was being regarded as a reflex action only and not a sign that the patient was responding and he said that he would not therefore have told them that this was 'good news'.

28. The professor told my officer that when the consultant discussed the case with him he told him of the problems he was experiencing in communicating with the relatives. He agreed to see them to explain matters after he had reviewed the case. He said he learned of the thumb movement from the consultant at this time and he had agreed that this was merely a spinal reflex movement. He said he understood that the consultant had informed the relatives of this and he doubted that he would have told them that this indicated a change for the better as he had recognised it for what it was. However, because the relatives had been told of the movement and because of the doubts they had about information previously given he suggested to them that the decision to terminate life support should be reviewed 24 hours later.

Findings

29. I uphold this complaint. Information given by staff was not always completely correct and misunderstanding resulted. But as soon as staff became aware of this, apologies were readily given. However all the evidence I have obtained convinces me that Mr A's care was in no way adversely affected by these failures in communication.

(c) *The complaints about staff attitudes and comments*

(1) *The incident concerning the letter*

30. The report said that when Mr. B's wife visited Mr. A on 24 July she took with her a letter addresed to his family offering them hospitality when they arrived from Canada. She asked the sister if she would keep it for them as that seemed the only sure way of contacting them as soon as possible after their arrival. However the sister said that she could not accept it. Mr. B's wife said that she stressed the letter's importance and the sister told her that

if the letter was accepted it might be mislaid and it would be difficult to ensure that the relatives got it. Mr. B's wife suggested that the letter be placed in the 'Kardex' and she told my officer that at this the sister 'snapped' it from her hand and walked away. The letter was not handed over to the relatives at their first visit to the Infirmary but was at a subsequent visit. Mr. B's wife described the sister as unhelpful, off-hand and rude.

31. In her statement to the board the sister said she felt that the letter was 'being made more of an issue than it warrants' and she told my officer she had no recollection of Mr B's wife explaining its contents. She said that there was no appropriate place on the ward to keep it but that had she known what it contained she would have readily accepted it and would also have offered to contact Mr B's wife by telephone once the relatives arrived at the Infirmary. The sister said that she had not meant to appear unhelpful or rude but she felt that Mr B's wife had been officious and demanding.

(2) *The remark about nationality*

32. The report said that following Mr A's transfer to the second ward in the early hours of 26 July his relatives and friends went there to see him. His mother and Mr B and his wife were waiting in the annex to the ward when they heard the night sister (the second night sister) say in a loud voice 'All these Americans are the same anyway'. Mr B commented that this was 'callous, unconstructive and at a minimum indicated that the (second night sister) was unaware of the nationality of her patient'. Mr B's wife told my officer that she was 'outraged' but her husband restrained her from remonstrating with the second night sister telling her that it was neither the time nor place to do so.

33. In a written statement to the board the second night sister denied all knowledge of any such remark and she added to my officer that she was not in the habit of making comments about the nationality of patients. The night duty nursing officer (the night NO) told my officer of her surprise at hearing of this allegation and said that it would have been 'totally out of character'. My officer spoke to three of the four other nurses on duty on the second ward that night who could be traced but none knew anything about the matter and two of them expressed surprise that such a remark had been attributed to the second night sister.

(3) *The remark about the 'dressings'*

34. The report said that on 27 July, when Mr A's mother and Mr E were waiting for the consultant to show them the x-rays (paragraph 24) two men came out of the second ward one saying 'We'll have to change the dressings as there may be some visitors from Canada'. This gave Mr E the impression that dressings were being changed for appearance rather than for medical reasons and he ascertained that his brother was the only Canadian patient on the ward.

35. My officer was advised that the two men referred to would probably have been orthopaedic doctors. She discussed the allegations with the then orthopaedic registrar who vaguely remembered Mr A but could not recall making any such 'insignificant remark'. He confirmed that dressings are changed for medical reasons but said it could be very upsetting for visitors to see a patient with bloodstained or badly soiled dressings and this would be avoided where possible.

(4) *The remark about cultural differences*

36. The report also said that in the course of a discussion on the evening of 26 July about the information given to the family about Mr A's condition, the consultant told Mr E that he was familiar with Canadian and American practice. He said that there were certain cultural differences between them and the English and that here the policy was to introduce relatives to the information gradually 'in order to protect the English'. Mr B questioned whether such cultural differences existed.

37. The consultant in his statement and to my officer said that from his own experiences in Canada and the United States of America he had formed his opinion that such cultural differences did exist. However he felt his comment '. . . in order to protect the English' had been misunderstood. He had said this to try to help relatives understand the junior staff's attitude and had wanted to imply that the British lay knowledge of anatomy and physiology was not equivalent to that of the American or Canadian public and therefore detailed discussion of areas of the brain involved was not useful knowledge to them. He added that he had explained in depth the extent of the injuries and the effects of them on the brain and the poor prognosis. However in retrospect he felt that the relatives and, in particular, Mr E never fully appreciated the severity of the head injury despite the explanations he and others gave.

(5) *The attitude of the consultant in asking the relatives if they wanted 'a lecture'*

38. The report said that when the consultant returned with the x-rays (paragraph 25) he ran quickly through an explanation of them; was quite abrupt; and concluded by saying 'Now, would you like a lecture'. Mr B commented that for the consultant to have adopted this attitude seemed unkind, unnecessary and showed a lack of understanding.

39. The consultant said that at the time he was being considerably antagonised by the attitude of Mr E (paragraph 26). He did not remember making the alleged comment but thought that he may have said something like it.

Findings

40. With the exception of the complaint about the sister's reluctance to handle Mr B's wife's letter – which I regarded as ill advised and wrong – I find the remaining complaints about staff attitudes and comments to be

trivial. What is alleged to have been said quite possibly was said. But any such remarks were certainly misconstrued by the complainers whose own attitudes were excessively critical. I do not find the staff culpable.

(d) *The complaint about the failure to telephone*

41. The report said that following the telephone call referred to in paragraph 16 Mr E again telephoned the first ward in the early hours of 24 July and asked that the Infirmary staff keep the family informed. The person to whom he spoke explained that it was difficult to make long distance telephone calls through the Infirmary's system but agreed to telephone at 8 am and 2 pm (BST). He did telephone at 9 am but the second call was never received.

42. The SHO confirmed to my officer that he had spoken to Mr E on the second occasion he telephoned the first ward on 24 July. He described him as being quite aggressive and he said he 'demanded' that the SHO undertake to telephone at 8 am to inform him of his brother's condition. The SHO said that although this was a very unusual request as relatives usually took it upon themselves to telephone for progress reports he agreed to do so 'to placate him' and he made the call. The SHO told my officer that he was unaware until he read the complaint that he had then agreed to make a further telephone call. He added that if he had made the promise he was sorry that he had not telephoned.

43. There is a manuscript entry in the nursing notes which gives the relatives' telephone number in Canada and written underneath is '8.30 am' and '2 pm' and the former has been scored through suggesting that the scheduled call at that time had been made.

Findings

44. I cannot establish whether a second telephone call to Canada was promised as alleged. However the SHO went out of his way to be helpful and the relatives themselves could easily have telephoned the Infirmary. I dismiss this complaint.

(e) *The complaint about visiting*

45. The report said that when Mr B's wife met the SHO on 24 July (paragraph 18) he told her that as a personal friend of Mr A it would be in order and helpful for her to visit him. However after she had been at his bedside for a short time she was asked by the sister to leave. She asked when she could visit again but the sister said this would not be possible as only next-of-kin would be allowed. Mr B's wife stressed that the next-of-kin had not arrived in the country and as she was a good friend of Mr A she felt that her visits would be in accordance with their wishes. However the sister repeated that only next-of-kin could visit.

46. The sister said in her statement and to my officer that Mr B's wife was unwilling to leave Mr A's bedside to allow routine nursing treatment to be

carried out and that she had to insist that she leave. She explained to my officer that there had been trouble previously with journalists and other people coming into the ward and making enquiries about the condition of accident victims. They were now always careful to identify visitors and their relationship to patients before giving any information or permission to visit. When Mr B's wife asked when she could visit again the sister tried to establish her relationship to Mr A but she found her answers 'cagey and evasive'. The sister also explained that she had the ultimate discretion on allowing visitors but that where friends of a patient were concerned it was her normal practice to tell them that before allowing them to visit she would have to confirm that the relatives had no objection. However she said that she had no recollection of saying that to Mr. B's wife. She still believed that her action was quite correct.

47. A nursing officer (the first NO) confirmed to my officer that the staff of the first ward, which deals with major accident cases, were instructed to establish the identity of all visitors. She said that incidents similar to those described by the sister had occurred and she explained that in cases of even slight doubt the relatives were consulted. The first NO said that in this case however she would have expected the sister to have used her discretion and allowed Mr B's wife to visit until the relatives arrived from Canada. The SHO commented to my officer that as he had given Mr B's wife permission to visit Mr A he would have expected the sister to consult with him before refusing her future visits.

48. Mr B also said that, when he accompanied Mr A's mother to the second ward on 26 July he was told by a nurse (or a sister) that he could not go in with her as only next-of-kin were allowed. He said he asked to see the nursing officer who said that she would have to take up the matter with the doctors in charge. Mr B said it became unnecessary to pursue this further as Mr A's mother seemed content to visit alone.

49. I have been unable to identify the nurse whom Mr B approached and neither the nursing officer identified by Mr B nor another nursing officer (the second NO) had any recollection of speaking to Mr B on the occasion he mentioned.

50. The night NO however told my officer that she remembered meeting the relatives and friends at the second ward in the early hours of the same morning. She said that she had arrived to find Mr. E engaged in a heated discussion with the second night sister about her refusal to allow Mr B's wife in to visit Mr A. She explained that there was a strict rule on the second ward that only two visitors were allowed to each patient because of the risks of cross-infection. However the visitors were insisting that Mr. A's mother, Mr E and Mr B's wife should be allowed at the bedside. The night NO said the second night sister was in a very difficult situation as she was attempting to stabilise Mr A's condition on the life support machine following his cardiac arrest and at the same time she was having to deal with distraught and difficult visitors who were disrupting the work of a vital unit. The night NO said that in an effort to ease the tension a little she suggested

that Mr. B's wife should sit with Mr. A's mother (who was already at her son's bedside) while she took Mr. E and Mr. B to her office to help them make some telephone calls and offer them coffee. The second night sister confirmed that Mr A's visitors had insisted that Mr B's wife should accompany his mother and Mr E to Mr A's bedside but she had told them quite firmly that it was not possible because of the cramped conditions in the unit and the risk of cross-infection. Apart from Mr A's mother who was 'completely numb and was at her son's bedside they refused to accept her explanations because they said Mr B's wife was an ex nurse and could therefore be of assistance. The night NO arrived at about this time and the second night sister corroborated the night NO's account of the action she had then taken. The second NO also told my officer that normally only next-of-kin are allowed to visit on the second ward and a doctor's permission would be sought before anyone else would be allowed to visit.

Findings

51. In regard to the complaints about visiting I find that

(*a*) the refusal of the sister (paragraph 46) to allow Mr B's wife to visit Mr A again on the first ward was a misuse of her discretion, bearing in mind his serious condition and the absence of his family who had not by then arrived from Canada. Furthermore, the SHO has told me that he had already given permission for her to visit. I uphold this complaint;

(*b*) I have not been able to find any member of the staff who can recall the incident described by Mr B (paragraph 48) but as he says that Mr A's mother was content to visit alone I agree with him that this need not be pursued. However my investigation has shown that there was unpleasantness when Mr A was visited on the second ward (paragraph 50). I find that Mr A's visitors, apart from his mother, were quite unreasonable in their demands that all of them should be allowed at the bedside at the same time. The staff reacted perfectly properly in the interest of the patient.

The complaint about the Board's handling

52. Mr B wrote to the board's secretary on 21 January 1980 enclosing the report. In his covering letter he stated that it was being forwarded so that an adequate and full response could be given to reassure the family that everything had been thoroughly looked into and to settle any lingering doubts which might remain; to ensure that the high standards for which the Infirmary had such an enviable reputation were re-established; and to ensure that such events would not be permitted to happen again. He stated that he had been authorised to act by the family's Canadian legal representative (the legal representative) and he offered to make himself available for discussion should this be necessary. This letter was acknowledged on 28 January by the board's chief administrative medical officer (the CAMO), in his then capacity as community medicine specialist who said that the matters raised were being looked into and he would write once his enquiries were complete.

53. On 2 April the CAMO wrote to Mr B to say he had 'very full reports' but that he had been advised by the Scottish Health Service Central Legal Office (the Legal Office) to obtain a proper mandate regarding the provision of the report requested by Mr B. Mr B passed this request to the legal representative who wrote to the CAMO on 16 April to confirm that he represented the family and estate of the deceased and that, upon the family's instruction, he was providing him with a mandate to deliver all reports on the matter to Mr B. The legal representative copied this letter to Mr B who on 23 April also sent a copy of it to the CAMO. On 10 June Mr B wrote to the CAMO, by recorded delivery, saying that he had received no acknowledgement or other communication from him in response to his letter of 23 April and he enclosed another copy of the mandate. On 24 June he wrote to the CAMO, again by recorded delivery, pointing out that he had still not received an acknowledgement to his letter and he told him that unless he received a satisfactory reply within seven days he would refer the matter to me.

54. On 25 June the CAMO replied to Mr B apologising for the lack of acknowledgement of his letters and saying that he had been hoping 'each day to be able to summarise the various reports . . . to provide you with a comprehensive reply'. He explained that he intended dealing with this himself as he had dealt with the case prior to taking up his present appointment, but that he was extremely busy and had not had the opportunity to do so. He said that he had to be away from the office for a few days but hoped on his return to be able to provide him with the necessary reply. On 10 July the CAMO wrote to Mr B saying that on further consideration it seemed to him that it would be simpler to communicate at a meeting the various points arising from the reports he had and he suggested that Mr B should ring his secretary to arrange a mutually convenient time. Mr B received this letter on 14 July and the same day he wrote to me stating that, mindful of the previous correspondence, he found this latest response from the CAMO 'so inadequate that I no longer feel that I can remain confident that any remedial steps which may appear to be necessary will in fact be taken'. Mr B told my officer that he considered the offer of a meeting at this late stage to be 'inappropriate'.

55. I have seen from the Board's files that on 28 January 1980 the CAMO asked the DMO to investigate the matters raised and let him have a full report. In turn the consultant was asked to report on the aspects of it concerning members of the medical staff and the Div NO to investigate the nursing aspects. On 24 March the consultant replied by submitting a four page report in which he dealt in detail with the history of Mr A's condition and treatment; his various contacts with the relatives and his expression of regret that he was unable to meet them upon their arrival at the Infirmary; an explanation of how the registrar came to make the mistake about the siting of the skull fractures; and a description of the meeting between the relatives and the Professor at which he had been present. Meanwhile the Div NO had obtained statements from the sister, the second night sister and the night NO about their involvement with the relatives in the incidents complained of and she sent these under cover of a letter in which she explained the visiting policy on the first ward; the

procedure employed for identifying accident victims; and an account of what had happened to the patient's personal effects. The CAMO told my officer that with the information contained in these replies he could have replied fully and to Mr B's satisfaction but the Legal Office had suggested that an authorisation be obtained from the family. In their comments the Board suggested to me that there was a 'considerable lapse of time' in obtaining this assurance. However the CAMO said that in retrospect this wording was misleading and he explained that after the arrival of the mandate the delay arose because he was just unable to find the time necessary to devote to preparing a reply to Mr B and he had been reluctant to delegate the task of doing so. When he eventually came to deal with the complaint he realised for the first time that Mr B lived locally and not in Canada as he had believed until then, and so he made what he considered to be the 'perfectly reasonable suggestion' to meet with him to discuss the complaint.

Findings

56. The investigation of the complaint submitted by Mr B was carried out expeditiously and it was reasonably thorough. However the results of it were not and still have not been made known to Mr B by the board because the CAMO has not found time to prepare a reply. I find his attitude quite indefensible and I uphold this complaint of maladministration which must have reflected adversely and so unfairly on the reputation of the Infirmary.

Conclusions

57. Mr A's death was tragic and untimely and I sympathise with his family and friends. I have given my findings in paragraphs 15, 29, 40, 44, 51 and 56. The board have asked me to convey to the complainers their apologies for the shortcomings which I have identified, and I am happy to do so.

Case No. WW.33/80–81 – Care and Treament given to patient following stroke

Background and complaint

1. The complainant's father, aged 53, was admitted to hospital ("the hospital") on 17 April 1980 following a stroke. He died there early the following morning.

2. The complainant made representations to the Health Authority (the Authority) who set up a members' committee (the committee) to investigate her complaints. She was not satisfied with their report and complained to me that:—

(*a*) although she and her sister were told shortly after their arrival at the hospital that her father would be given a lumbar puncture as soon as possible, the registrar did not carry it out until some eight hours later and they were not kept informed of the reasons for the delay;

(*b*) her father was not given any emergency treatment and did not receive the intensive nursing care his condition required;

(*c*) nursing staff failed to observe the registrar's instructions to take half-hourly temperature readings ;

(*d*) two sets of the suction equipment which was needed to clear her father's throat proved not to be in working order ;

(*e*) shortly before her father died a nurse abruptly told her mother that there was no hope of his survival ;

(*f*) she and her mother had not previously been told that her father's condition might prove fatal ; and

(*g*) she is not satisfied with the handling of her complaints by the committee.

Investigation

3. During the investigation I obtained the written comments of the Authority and I saw these and copies of other relevant papers including the medical records. One of my officers interviewed the medical, nursing and administrative staff concerned and members of the committee. He also met the complainant, her mother, one of her sisters and her aunt.

4. The National Health Service Act 1977 prevents me from investigating actions which, in my opinion, arise solely in consequence of the exercise of a doctor's clinical judgment. In this report references to the medical background are included only in order to explain the circumstances which gave rise to the complaint.

5. The complainant's evidence is summarised in the opening paragraph of each section of my report and is taken from her letters to the Authority and to me and her interview with my officer.

(a) *The complaint about the lumbar puncture*

6. The complainant said that she and her sister had accompanied their father to the hospital. The nurse (the staff nurse) who admitted their father, at approximately 10.30 am, told them that he would be given tests and a lumbar puncture. And the doctor, who was a house officer (the HO), who examined her father shortly after his admission told the complainant that the medical registrar (the registrar) would carry out a lumbar puncture as soon as possible. The complainant said that, after making several enquiries during both morning and afternoon, she and her sister were eventually told that the doctor concerned was very busy in a clinic but that he would come as soon as possible. At about 5.00 pm she and her sister left the hospital and went to see their family doctor to tell him of their concern at the delay in performing the lumbar puncture. The complainant said that he shared their concern and advised them to get in touch with him again if the lumbar puncture had still not been carried out when they returned to the hospital. At about 6.30 pm the complainant's mother and her aunt had gone to the

hospital; she had joined them there at about 8.00 pm and by then the lumbar puncture had been carried out. The complainant said she believed at the time that the lumbar puncture would relieve the pressure on her father's brain. Although she later accepted that it was a diagnostic procedure rather than a form of treatment, she still considers that, as the treatment depended on the diagnosis, the delay in carrying out the test on her father delayed his treatment. Moreover, they were not kept informed about the reasons for the delay. They had 'just sat and waited for eight long hours'.

7. In an interview with my officer the staff nurse who admitted the complainant's father said that she had told the complainant's sister that a lumbar puncture would probably be carried out. She had also explained what was involved and would have stressed that it was an investigation. She did not remember the complainant or her sister asking for information during the afternoon. In a separate interview with my officer the sister who was on duty from 12.45 to 9.15 pm that day (the sister) also said that she could not remember receiving any request for information. But a state enrolled nurse (the day SEN) told my officer that the complainant and her sister had stayed with their father for most of the afternoon and had kept calling the nurses all the time to ask when the doctor was coming and when the lumbar puncture would be carried out. The day SEN said that she might well have told them that the doctor would come as soon as he could.

8. The HO told my officer that she could not remember whether she had mentioned to the complainant and her sister the possibility of a lumbar puncture. If she had said anything on the subject it would have been that it was a test which would be carried out within the next few hours. She said that she had been present when it was performed but she could not remember the time and could not recall the relatives asking for information or reassurance during the day.

9. In his written comments to me, and in an interview with my officer, the registrar said that he had decided to carry out a lumbar puncture when he had first seen the complainant's father at about 4.00 pm. He had spoken to the relatives at about 5.00 pm and had performed the lumbar puncture by 6.00 pm. He said that the purpose of the lumbar puncture was to determine whether the bleeding was on the surface of the brain or deep inside. In this case it had proved to be the latter, a condition which cannot be corrected by surgery. He said that the usual practice was to wait for some twenty four hours to see whether the patient's condition stabilised sufficiently for surgical assessment and to survive the thirty mile journey to the neurological unit where the operation would take place. The timing of the lumbar puncture during that twenty four hour period was not crucial.

10. The Authority confirmed this in the reply they sent to the complainant after they had received the committee's report. They also said that the lapse of time between the decision to carry out the lumbar puncture, and its performance, had made absolutely no difference to the outcome.

Findings

11. It is not disputed that the lumbar puncture was not performed until some seven or eight hours after the complainant's father was admitted to hospital. The registrar, whose decision it was to carry this out, has said that its timing during the first twenty four hours was not critical. That is a matter of clinical judgment on which I cannot comment. But I do not doubt that the complainant and her sister were told at an early stage of the possibility that a lumbar puncture would be carried out and it is clear that they were, very understandably, anxious about the delay. I do not believe that they were adequately informed either about the nature of the procedure or the delay. To that extent I uphold the complaint.

(b) *The complaint about the lack of emergency treatment and intensive care*

12. The complainant said she was convinced that her father had been neglected at the hospital. She thought he should have been admitted to the intensive care unit (the ITU) when it was discovered that he had a brain haemorrhage as, in her view, he needed the constant attention of a nurse. She was particularly unhappy about the lack of nursing care during the night of 17-18 April and alleged that the night staff would only visit her father when called. Although two of the nurses (the night SEN and the pupil nurse) responded quickly when called, the nurse in charge of the ward (the senior SEN) 'just didn't seem to care'. The complainant also said that, when her father indicated that he wanted to pass urine, the nurse to whom her aunt reported this replied: 'he's incontinent – tell him to do it in the bed and we will change him afterwards'. And that, she said, was what happened.

(i) *The lack of emergency treatment*

13. In his written comments to me and in discussion with my officer the registrar said that on admission no treatment would have been helpful; he needed supportive measures and these were carried out by the nursing staff in accordance with his instructions. The HO told my officer that the complainant's father was a typical 'stroke' patient and that there is not much that can be done for such patients, apart from keeping them comfortable. The consultant physician (the consultant) into whose care the complainant's father was admitted did not see him, but he confirmed that there is no emergency or, indeed, any other specific medical treatment available for the sort of stroke he had suffered. The proper treatment would be conservative, consisting of turning him and monitoring his blood pressure and pulse frequently and keeping his airways clear.

14. The day nursing officer (the day NO) told my officer that patients who had suffered a stroke were not normally nursed in the ITU because there was nothing that could be done for them there that could not be done on the ward. He added that relatives often found this hard to accept.

(ii) *The unsatisfactory night nursing care*

15. The senior SEN told my officer that the nursing staff had treated the patient's pressure areas every two hours and she said that she thought they

had done everything they could for him. She recalled that, during the latter part of the night, the relatives had become rather demanding, had called the nurses back as soon as they had finished attending to him, and had asked for a nurse to stay with him. In separate interviews with my officer the night SEN and the pupil nurse confirmed that, in addition to carrying out regular observations, they had treated his pressure areas and turned him a few times. A nursing auxiliary (the NA) told my officer that she remembered helping the nurses to turn the complainant's father once or twice during the night. The senior nurse on duty in the hospital that night (the acting NO) told my officer that she remembered seeing the complainant's father on three occasions between 10.00 pm on 17 April and 5.30 am on 18 April.

16. An entry in the nursing notes reads: 'pressure areas treated, half-hourly obs. continued throughout night'. Entries in the temperature, pulse, respiration and blood pressure chart (the TPR and BP chart) show that blood pressure and pulse were taken at half-hourly intervals from 7.00 pm until 9.00 pm, at hourly intervals until 3.00 am and then at half-hourly intervals until 4.30 am with a pulse reading at 5.00 am.

(iii) *The remark about the incontinence*

17. My officer interviewed the complainant's aunt about this. She told him that when the father indicated that he wanted to pass urine she had told the sister who said 'don't worry, he's incontinent'. The aunt said that the sister had not made the remark in the terms attributed to her by the complainant. The aunt said that she had returned to the ward but, as she had not wished to tell the father that he was incontinent, had said: 'the nurses are busy . . . they will just have to change the bed afterwards'. The father passed urine almost immediately and she had called the nurses who changed him straight away.

18. When my officer interviewed the sister she could not remember speaking to the complainant's aunt (who was an acquaintance of hers), but she said that she would not have suggested that the complainant's father should urinate in the bed. Apart from anything else, it would have involved extra work for the nursing staff in changing the bed-clothes. None of the other nursing staff whom my officer interviewed could recall the incident. The senior nursing officer (the SNO) said that not only would such an attitude have caused more work for the nurses—it would have 'shown an unbelievable lack of regard for the patient's dignity'.

Findings

19. The complainant was understandably anxious that everything possible should be done for her father. But on the evidence, the constant attention of a nurse was not considered necessary. This is a matter of clinical judgment on which it is not for me to comment. But the TPR and BP chart and the fluid balance chart, whose validity I have no reason to question, do not bear out the complainant's allegation that her father was

visited only twice during the night by the nursing staff. I therefore dismiss it. As to the incontinence incident, I have no doubt that there are occasions when nurses are too busy to attend to patients immediately when needed. But I find it very hard to believe that any nurse would, deliberately, not only ignore a plea for help, but would encourage a patient to urinate in his bed, thereby causing the nursing staff considerable work. I think there must have been a misunderstanding about this and I do not find the complaint made out.

(c) *The complaint that the nurses failed to take half-hourly temperature readings*

20. The complainant said that after the registrar had carried out the lumbar puncture he wrote an instruction that half-hourly temperature readings should be taken. At 3.00 am she noticed that her father's temperature was rising ; she called a nurse and pointed out that, despite the doctor's instruction, her father's temperature had not been taken. The nurse had then taken the temperature charts away. She said that when the registrar had come to see her father at about 5.30 am he had been surprised to find that the charts were missing. She thought it odd that, as she understood it, the committee were presented with a full record of temperatures.

21. The TPR and BP chart records temperature readings at 4.30 and 5.00 am but it does not record any instructions by the doctor as to the frequency with which observations should be made. In an interview with my officer the registrar said that he could not recall his exact instructions; nor could he remember having expressed surprise to find the charts missing, as the complainant had claimed.

22. The day SEN told my officer that the registrar's instructions had been for half-hourly blood pressure and pulse readings. Temperature readings, although not asked for, would nonetheless have been taken every four hours, but half-hourly if any routine reading was found to be high. She thought that it was she who had made out the night TPR and BP chart and that the first few entries on the chart were hers. She normally entered the doctor's instructions at the top of the chart but on this occasion she must have forgotten to do so.

23. The night SEN said that she had understood that the father's temperature was to be recorded only if it was seen to be going up. She agreed that the entries in the chart from 10.00 pm onwards were hers. Although she thought she had entered the *times* in advance as a reminder, she was sure that the *readings* had been made at the correct times—not later, as the complainant had suggested. During the night the chart was removed from the foot of the bed to the duty room where charts were often kept at night. This practice was confirmed by the Senior SEN, who also told my officer that she did not recall removing the chart as the complainant had alleged.

24. When interviewed by my officer the SNO said that she considered TPR and BP charts should normally be kept at the foot of the bed. But she

acknowledged that they were often taken to the duty room in the latter part of the night so that the nurses could refer to them when writing up the nursing notes at the end of the shift.

25. The consultant told my officer that frequent monitoring of temperature was not as important as that of blood pressure and pulse since these tended to change suddenly, giving prompt warning that something was wrong. Temperature on the other hand tended to rise gradually. The SNO and the acting NO made similar comments to my officer.

26. The medical adviser to the committee confirmed to my officer that the TPR and BP chart in his possession was a copy of the one presented to the committee.

Findings

27. The registrar cannot remember what instructions he gave about the recording of temperature. Although the opinions of the nursing staff are divided on the subject, it seems that regular temperature readings were not requested. This was a matter for the registrar to decide in his clinical judgment. I do not therefore uphold the complaint. However, I am concerned that instructions to nursing staff about the monitoring of a patient's condition should be recorded. The fact that this was not done in this case may have been due simply to human error. But I consider that the Authority should take steps to remind their staff of the importance of such records – both for their own protection and for the reassurance of patients or relatives who are anxious lest the medical instructions have not been followed.

(d) *The complaint about the suction equipment*

28. The complainant said that in the early hours of 18 April her father started to deteriorate rapidly and she and her mother thought he was going to choke. She fetched a nurse, who came immediately; but the equipment which the nurse tried to use to clear her father's throat did not work. The nurse ran to the next ward to fetch other equipment. But she saw the nurse testing this equipment which also did not work. She was asked to leave the ward at this point because, she believed, the nurses did not want her to see the difficulty they were having.

29. When interviewed by my officer the night SEN told him that she and the pupil nurse had attended to the father when the complainant told them he was choking. She went to use the fixed apparatus (with which she was familiar from her experience in the operating theatre) but found that a tube which ran from the apparatus to the patient was missing. There was no sign on the equipment to indicate this. Rather than search for a tube she decided that it would be quicker to send the pupil nurse to fetch the portable apparatus from the next ward. Having satisfied herself that that equipment was working, she asked the complainant to leave the room as she appeared to be getting very distressed.

30. The senior SEN and the pupil nurse confirmed this and the senior SEN went on to say that the fixed apparatus, which was brand new, was in place at the time but not all of the tubing had been attached. She thought that if it had been, the equipment would have worked. The acting NO and the sister told my officer that all nurses are trained in the use of such equipment, but the pupil nurse said that it was completely new to her and that she had received no instruction in its use.

31. The SNO told my officer that the tube which runs from the fixed equipment to the patient is a sterile item and is kept in the treatment room which is only a short distance from the side ward. When the side ward is occupied a tube, still in its sterile packet, is normally placed on the equipment in readiness for use. The day NO told my officer that, when he returned from leave on 19 April, he learned that the nurses had experienced difficulty in operating the suction equipment. He had therefore checked all the suction equipment on the ward and had found that it was in working order. But he did not check the availability of the sterile tubing.

32. The Authority told the complainant that on 17 and 18 April 1980 the fixed suction equipment was in the process of being installed but that installation had not been completed. They said that the nursing staff had attempted to use this equipment as they were unaware that it was not fully operational ; but when they realised this they had immediately brought portable apparatus which proved to be in working order. In response to my enquiries they said that the fixed suction equipment was ordered on 18 February 1980, but they were unable to say when it had been installed.

Finding

33. I uphold the complaint that the *fixed* suction equipment could not be used, not because it was not in working order, but because the sterile tubing needed to connect the patient to the apparatus was not there and could not be found immediately. I do not uphold the complaint that the *portable* suction equipment was not in working order, but I accept that there was a delay, however short, caused by the fact that the nurses could not find the necessary connection to the fixed apparatus. This seems to me deplorable and I consider the Authority should take immediate steps to ensure that the sterile tubing is immediately available when needed and that all the staff concerned know exactly where it is and how to operate the equipment.

(e) *The complaint that a nurse spoke abruptly to her mother*

34. The complainant said that she had left the ward at about 5.30 am to telephone her husband. When she returned to the ward she found her mother in a terrible state. She said that, during her absence, her father's breathing had again become difficult and her mother had left the ward to seek help. The nurse to whom her mother had spoken said – 'there is no hope for your husband ; your daughter knows this' – and had promptly walked away.

35. In an interview with my officer the senior SEN denied speaking abruptly to the complainant's mother and telling her that there was 'no hope' for her husband. She said that 'no hope' was not an expression she used, but she might have told her that her daughter already knew about the prognosis. She said she had comforted her when she became distressed at the news that her husband was close to death.

36. The pupil nurse told my officer that she thought that the senior SEN had spoken abruptly to the complainant's mother. She could not remember the exact words used, but she thought they were similar to those the complainant had alleged. She thought that the senior SEN was behaving out of character by speaking in this way and that she might have been under strain because the ward had been very busy that night and they were short-staffed.

37. The acting NO told my officer that she had not witnessed the exchange between the senior SEN and the complainant's mother but she said that, although the senior SEN had an abrupt way of speaking, she could not believe that she would have used the expression the complainant had attributed to her. Her experience of the senior SEN was that she was always very kind and patient. The acting NO went on to say that it was regrettable that, as a result of staffing problems on the ward on the night in question, inexperienced nurses had to deal with grief-stricken relatives. State-enrolled nurses were not usually expected to have to cope with such situations. The SNO said that the nurses were under some strain as a result of the cardiac arrest and subsequent death of a patient in an adjoining ward that night. It had been a particularly difficult experience for them.

38. The Authority told the complainant that, although the nurse concerned had denied speaking sharply to her mother, another member of the nursing staff felt that her colleague might have been a little abrupt. They went on to say that the ward had been short-staffed that night; that there were two other seriously ill patients on the ward; and that the nurses had also had to attend to a patient in an adjoining ward who had suffered a cardiac arrest. They agreed that in this difficult situation, and possibly in an attempt to combat the mother's apparent hysteria, voices might have been raised.

Finding

39. Although I have been unable to establish precisely what was said to the complainant's mother, I think it probable that the senior SEN spoke to her abruptly, albeit at a time which was a difficult one for all concerned. I do not believe that any brusqueness was intentional.

(f) *The complaint that they were not told that the father's condition might prove fatal*

40. The complainant said that when her father was first admitted to hospital she was not unduly worried. She knew that he had had a stroke, but she did not think it was a serious one as he was conscious and talking

intelligently. She had not therefore taken the HO's statement (that the next twenty four hours would be critical) to mean that her father might die. She had first suspected this at about 5.30 am on 18 April when the registrar told her that her father's condition had deteriorated.

41. When interviewed by my officer the HO confirmed that when she had first examined the father she had told the complainant and her sister that the next twenty four hours would be critical. She also thought that the complainant had asked whether her father was going to die, and that she had replied that, although it was difficult to say, it was possible. The HO went on to say that it was her practice not to be unduly pessimistic when explaining a patient's prognosis to relatives. However, at about 5.30 am on 18 April she had told the complainant's mother that her husband was seriously ill and that she did not think he would recover.

42. The registrar told my officer that he remembered speaking to the relatives at about 5.00 pm on 17 April. He had told them that the complainant's father was critically ill and that the next twenty four hours would be crucial; he said he would not have told them that the father might 'die' as this was not a word he used. But he thought the relatives had fully understood the import of what he had told them. Shortly before 6.00 am he visited the father and found him deeply unconscious (and an entry in the clinical notes confirms this). He had then told the complainant that her father's condition had deteriorated. The staff nurse said that she remembered telling the complainant and her sister, when their father was admitted, that the next twenty four to forty eight hours would be critical, but she, too, said that she would not have used the words 'die' or 'death'.

43. The complainant's aunt told my officer that she had been present when the registrar had spoken to the mother about her husband's condition - sometime between 7.30 and 8.00 pm, she thought. Her impression from what she had overheard of the conversation was that the doctor was not holding out much hope for the father's survival, though he had not actually said that he was likely to die. She realised that the complainant's mother did not agree with her account, but she considered that the mother's condition at the time was such that she could not take in what she was told.

Findings

44. I am very conscious of the difficult task that hospital staff have to carry out when informing relatives of the likely prognosis of the patient. They have to make a finely balanced judgment between being too optimistic and so raising hopes that may be dashed and on the other hand being too pessimistic and thus causing unnecessary alarm. I see no evidence here that the staff got the balance wrong. The relatives were told at the outset that the next twenty four hours would be crucial, and I think this clearly meant that the outcome was in great doubt. I do not uphold the complaint.

(g) *The complaint about the committee*

45. In her letter of complaint to me the complainant said that she thought the Authority had not carried out a fair and thorough investigation. She told my officer that their answers merely brushed aside her complaints in an attempt to cover up the inadequacies in the care her father received. She thought that the committee had been too ready to take the side of the nursing staff.

46. The Authority told the complainant that the committee's terms of reference had been to investigate the alleged delay and unsatisfactory treatment received by her father and the alleged failure of two sets of emergency equipment. They said that the committee had met on four occasions during the period 30 May to 7 October 1980 and had interviewed the complainant, her mother and nine members of the Authority's staff. The committee's report had been accepted by the Authority at their meeting on 21 November 1980.

47. The committee was chaired initially by a member (the first chairman) whose appointment to the Authority lapsed before their investigation was complete. His place was subsequently taken by another member of the Authority (the second chairman).

48. In an interview with my officer the first chairman said he was content that the committee had received adequate notice of the investigation and had been able to prepare fully for it. They had had sufficient time to interview everyone and he thought the investigation had been fair. However, they had, in fact, only interviewed the night staff. He thought, in retrospect, that they should perhaps have interviewed the day staff too, but it had seemed at the time that the emphasis of the complaint was against the night staff. He denied that they had been too ready to side with the nurses as the complainant had suggested. He did not recall her mentioning the incontinence incident to the committee.

49. The second chairman, who was interviewed by my officer on two separate occasions, also denied that the complaints had been brushed aside. On the contrary, she said, the committee had had long arguments about them and she was sure that they had not sided with the nurses. However, she told my officer that she felt, in retrospect, that she did not have the complete picture because of the absence of verbatim minutes of the earlier meetings in which she had taken no part. She accepted that, so far as complaint (a) was concerned, the committee's report did not explain the reason for the delay in performing the lumbar puncture, nor offer any response to the complainant's criticism that she and her sister were not informed of the reasons for the delay. When first interviewed the second chairman said that this was because the committee had failed to reach a unanimous decision and the report had therefore been confined to those points on which agreement had been reached. She went on to say that, since she had not been present at the earlier meetings of the committee, she felt that she had no alternative but to accept the views of the other two members, and this was why she had not recorded her reservations. But at the second interview, she told my officer that the reason

for not including reference to the lumbar puncture was that the decision about it was a clinical one. The second chairman said that the committee had not met to discuss the report drafted by the assistant area general administrator (the AAGA). Had they done so she felt that its general tone might have been different. In her first interview with my officer she said that she had asked the AAGA to redraft the report but that he had said that there should be no further delay in replying to the complainant. The report had therefore been 'rushed'. However, in the second interview with my officer she said that, although she had expressed her reservations about the report to the AAGA, she had not asked him to redraft it. The second chairman added that she did not remember the complainant mentioning the incontinence incident to the committee and she also said that, in her view, the day staff should have been interviewed.

50. In separate interviews with my officer the two other members of the committee said that, as far as they were aware, all the decisions of the committee on the complaints put to them by the complainant had been unanimous.

51. In discussion with my officer the AAGA said that he had provided the secretarial support for the committee. For the first few meetings a typist had assisted in taking the minutes but she had been unable to keep up. The AAGA admitted that the minutes were not all they might be. He told my officer that he had drafted both the report which the committee put to the Authority and the Authority's reply to the complainant. He went on to say that the committee had made a determined effort to get at the truth and that the Authority strongly disapproved of 'white-wash'. The AAGA could not explain why the Authority's reply to the complainant made no attempt to account for not keeping her informed about the delay in carrying out the lumbar puncture. The omission had not been deliberate. As to the incontinence incident, he recalled that the complainant had told the committee about it, but as a result of the failure to keep adequate minutes the point had not been recorded and he had forgotten about it by the time he came to draft the report. When asked why the report and the Authority's letter to the complainant stated that temperature readings had been recorded hourly, whereas according to the TPR and BP chart they had not, the AAGA said that the chart was all dots and lines to him and that he had simply repeated what the medical and nursing advisers had told him. He did not recall any request from the second chairman for the report to be redrafted.

Findings

52. I do not think that the committee were biased in favour of the nursing staff, or that they deliberately brushed aside the complaints. Such evidence as I have obtained, although some of it is conflicting, leads me to believe that their investigation was reasonably thorough so far as the night staff were concerned, though I criticise their failure to interview the day staff. My investigation has been hampered by the absence of either a transcript or full minutes of the committee's meetings and the AAGA has accepted that the records were unsatisfactory and that the reply which the Authority eventually

sent to the complainant also contained some inaccuracies and omissions (which are mentioned elsewhere in my report).

53. I consider that the fault here lies not so much in the investigation itself but in the abrupt change of chairman during the committee's proceedings, the inadequate record-keeping of those proceedings, and the failure to consider the draft report in committee. These factors in my view contributed to the inaccuracies and omissions in the reply sent to the complainant and I am not surprised that she was not satisfied with it. I uphold this complaint.

Conclusion

54. I have set out my findings in paragraphs 11, 19, 27, 33, 39, 44 and 52-53. The Authority have asked me to convey to the complainant their apologies for the shortcomings I have found and this I gladly do. They have also assured me that they accept the recommendations I have made in paragraphs 27 and 33.

Case No. WW.40/80–81 – Emergency hospital admission arrangements

Background and complaint

1. The complainant's wife was taken ill during the early hours of 9 October 1980. She was taken by ambulance to hospital (the hospital) and later transferred to another hospital where she died on 15 October.

2. The complainant says that:—

(*a*) although their family doctor (the FP) had made prior arrangements for the wife to be admitted direct to a ward (the ward) at the hospital, she was kept waiting for some twenty-five minutes in a lift before a nurse came to escort her to the ward ; and

(*b*) he is not satisfied with the handling of his representations to the Health Authority (the Authority).

Investigation

3. During the investigation I obtained the written comments of the Authority and I saw these, the relevant correspondence and the medical records. One of my officers interviewed the staff involved in the complaint and another met the complainant.

4. Because I found that there was a conflict between the complainant's evidence of the timetable of events and that of the Authority I have dealt with this in the first part of my report so as to be able to put the evidence of the hospital staff in context.

(a) *The delay in the lift*

5. The complainant said that his wife was taken ill during the early hours of 9 October 1980. At about 3.40 am he telephoned the FP who arrived about five minutes later. After examining the complainant's wife he telephoned the hospital and arranged for her to be admitted direct to the ward and for the

ambulance to take her to the hospital. He also gave the complainant a letter addressed to the house office (the HO) on duty there. The complainant said that the ambulance left the house between 4.05 and 4.10 am and arrived at the hospital at about 4.20 am. Two porters were waiting in readiness and they took the complainant's wife on a stretcher straight to the lift where they were joined by the nurse on duty (the SEN) in the accident department. When one of the porters went to close the lift doors the SEN said that she herself could not leave the accident department and they would have to wait in the lift until a nurse escort arrived to take them to the ward. The complainant said that after waiting for about ten minutes he went and asked the SEN whether anyone was coming to attend to his wife. The SEN had then made a telephone call but he did not know to whom she had spoken. He returned to the lift and after a further ten minutes or so the HO arrived and asked him for the letter the FP had given him. The HO took the letter and went away leaving them in the lift. He made no attempt to escort them to the ward nor did he offer any explanation for not doing so.

6. The complainant said that he had been told that an escort was necessary in case the lift broke down, but he could not understand why the HO could not have escorted them to the ward. A further ten minutes or so passed before a nurse (the staff nurse) came to escort them to the ward. The complainant said that he paid particular attention to the time they eventually arrived there and it was between 4.40 and 4.45 am. Although his wife was being admitted as an emergency they had been waiting in the lift for between twenty and twenty-five minutes.

7. I have seen copies of the timed records of the ambulance service comprising those of the two ambulancemen concerned and of the ambulance control officer (the ACO) on duty. They record the following sequence of events:—

4.10 am	FP's call received by ACO.
4.11 am	ACO's call received at ambulance station.
4.13 am	Ambulance leaves station.
4.18 am	Ambulance arrives at complainant's house.
4.27 am	ACO telephones hospital to arrange for porters to be waiting.
4.40 am	Ambulance arrives at hospital.
4.43 am	Ambulanceman telephones ACO to advise of delay.
5.00 am	Ambulance leaves hospital.

8. The ambulancemen told my officer that after they had arrived at the hospital they had gone to wash the suction equipment which they had used on the complainant's wife in the ambulance. Some five minutes later they were surprised to see that the complainant and his wife, the two porters and the SEN were still waiting in the lift. One of them had telephoned the ACO to say that they were delayed at the hospital; and they then waited until the staff nurse arrived and took the wife to the ward. The ambulancemen estimated that ten or eleven minutes had elapsed between the time of their

arrival at the hospital and the departure of the lift, and a further ten minutes before the ambulance stretcher was returned to them from the ward ; and they confirmed that they had left the hospital at 5.00 am.

9. In her written comments to the Authority when they were themselves investigating the complaint, the SEN said that after ambulance control had telephoned her at about 4.25 am to ask for porters to be standing by to take an unconscious patient to the ward, she telephoned the night sister (the sister) to ask for a nurse escort. When the ambulance arrived she accompanied the complainant and his wife and the porters into the lift and she explained to the complainant that she was waiting for a nurse to escort his wife to the ward. She noticed that the clock opposite the lift showed the time as a little after 4.40 am. After a few minutes he commented about the length of time his wife was being kept waiting after having been rushed to hospital. The SEN said that she then telephoned the sister and told her that the complainant was complaining about being kept waiting. The sister said she would send an escort and when the SEN returned to the lift the HO had arrived and was reading the letter from the FP. The HO said that she had sent for him but when she told him that she wanted a nurse to escort the wife to the ward the HO said that he would do it. The SEN left the lift to ask the sister whether the HO could escort the complainant's wife to the ward. (She told my officer that she had pointed out to the sister that, as the HO was new to the hospital, he might not know the emergency procedure if something happened in the corridor.) The sister said that she would send a nurse to escort them to the ward and, when the SEN returned to the lift and advised HO of this, he left. The SEN went on to say that at about 4.50 a.m. the staff nurse arrived and escorted the wife to the ward.

10. The sister, in her written comments to the Authority, said that she had agreed to arrange a nurse escort for the complainant's wife and had immediately telephoned the ward to do that. A man had answered the telephone but, although he had not identified himself, she had assumed that as there was only one male nurse on duty that night it was the male nurse on duty in the ward to whom she was speaking. She had asked him to go to the accident department to escort an unconscious patient to the ward and had the response 'Who me?'. She had replied: 'Yes. She will be your patient'.

11. About five minutes later the SEN had telephoned again to say that the complainant was complaining about the delay and that the HO had arrived in the accident department. The sister said that she would send someone ; and she immediately rang the ward again. The male nurse answered her call and she told him to go to escort the complainant's wife. He told her that he was the only nurse on the ward and she asked why he had not told her that before. She told him that she would send somebody else. She then telephoned the staff nurse on another ward and asked her to escort the wife to the ward.

12. The sister went on to say that when, at about 6.00 am, she discussed the delay with the SEN she learnt that it was the HO to whom she had spoken

when she first telephoned the ward. She said that at about 6.30 am she had gone to the ward to explain the misunderstanding to the complainant and to apologise to him but he had already left the hospital.

13. The HO told my officer that, while he was awaiting the wife's arrival he had answered the telephone in the ward office. A voice, which he recognised as that of the night casualty sister, abruptly told him to go to the accident department immediately. He said he felt that he and the sister were possibly talking at cross purposes but he thought there must be an emergency and had gone immediately to the accident department to see what was happening. When he arrived there two or three minutes later he found the complainant and his wife, the SEN and the porters waiting in the lift. He said that the SEN had realised there had been a mistake and that she was expecting a nurse. She had then telephoned the sister again. He had not offered to escort the wife to the ward. He had waited in the lift for a short while and had then returned to the ward to await the complainant's wife who arrived about ten minutes later. He added that while the delay had obviously been distressing to the complainant it had not affected his wife's prognosis.

14. The male nurse on the ward told my officer that when the sister asked him to go to casualty he had told her that he was on his own on the ward. The sister then asked him why he had not gone to the accident department when she first asked him and he had replied that she had not spoken to him earlier.

Findings

15. I do not accept that the complainant's wife was kept waiting for twenty to twenty-five minutes, as the complainant claims. According to the contemporaneous ambulance records, whose accuracy I have no reason to doubt, the ambulance arrived at the hospital at 4.40 am and left at 5.00 am. During this time the complainant's wife had to be taken from the ambulance to the lift and from the lift to the ward. And the stretcher had to be returned from the ward to the ambulancemen. Although I have been unable to establish the exact length of the delay in the lift I do not think it can have been for much more than ten minutes. Bu I think it entirely understandable that, at such an anxious time, it must have seemed much longer to the complainant. Nevertheless I uphold his complaint. There was a delay which should clearly not have occurred.

(b) *The Authority's handling of the complaint*

16. The complainant told my officer that he was totally dissatisfied with the explanation the acting district administrator (the ADA) had given him for the delay in admitting his wife. He said that he could not accept, as he had been told, that the sister had mistaken the HO for a male nurse and he considered that the reply he had been given amounted to a complete whitewash. He said that shortly after receiving the ADA's letter he had met him to discuss the complaint but the ADA had added nothing to what he had said in his letter and, as far as remedial measures were concerned, had merely told him that the staff had been instructed to make sure that the same thing

did not happen again. The complainant said he considered that the Authority should have interviewed all the staff involved at a formal inquiry at which he could have been present, given evidence, and possibly asked questions. He complained that no apology for, or explanation of, the delay in the lift had been offered at the time it happened. If one had been forthcoming he would probably have been satisfied and let the matter rest. He felt that the apology contained in the ADA's reply was not a sufficient response to so serious a complaint. He said that his wife, or any other patient in similar circumstances, could have died as a result of the 'misunderstanding'.

17. I have seen that in his letter of reply to the complaint the ADA explained that the delay in the lift had resulted from a misunderstanding between the night sister and the HO. He said that as soon as the complainant and his wife arrived at the hospital the sister had telephoned the ward and had spoken to someone whom she had assumed to be a male nurse (the male nurse) ; she had told him to go to the accident department to escort a patient to the ward and that this had been necessary because the SEN was the only nurse on duty in the accident department and she was unable to leave her post. The ADA went on to say that the person to whom the sister had spoken was in fact the HO. After answering the call from the sister he had gone to casualty, entered the lift and read the letter from the FP. When the HO arrived in casualty the SEN, realising that there had been a mistake, telephoned the sister again and explained the position. Shortly afterwards the staff nurse arrived and escorted the complainant and his wife to the ward. The ADA added that there was a difference of opinion as to whether the delay in the lift had been for as long as twenty minutes but he saw little purpose in arguing the point. He accepted that a delay had occurred and that the complainant must have found it distressing. And he offered his apologies.

18. When interviewed by my officer the ADA said that he had initiated an investigation as soon as he had learned of the complaint and statements had been obtained from all the staff involved. He said he did not feel that the complaint warranted a formal inquiry as the facts were clear-cut and there was no dispute that there had been a delay. He said that he was sorry if the complainant had formed the impression that he had not taken his complaint seriously. He assured my officer that he had and he thought he had convened this to the complainant both in his letter and at their meeting on 10 December. The ADA told my officer that, as the Authority accepted that there had been a delay in the lift, it seemed inappropriate to argue about the length of the delay. In his reply he had therefore made no reference to the times shown in the ambulance records, but had confined his comments to explaining and apologising for the unfortunate misunderstanding. As to the measures which, at their meeting on 10 December, he had told the complainant would be taken to prevent a recurrence, he said that these had been left to the acting district nursing officer (the ADNO).

19. When my officer asked the ADNO what measures he had taken to prevent a recurrence of the incident he said that he had discussed it with his senior nursing officer (the SNO). They had agreed that the delay had been

caused by the failure of the sister and the HO to identify themselves during their telephone conversation. The ADNO had asked the SNO to advise all sisters of the need, when giving instructions by telephone, to identify themselves and the person to whom they were speaking. And he added that the SNO had also told the night sisters that, when there is only one nurse on duty in the accident department, they should relieve the nurse so that she can act as escort. He said that these instructions had been given orally to the SNO and the night sisters but they would be put in writing. The ADA later wrote to me to say that this had been done on 30 October 1981 and that, on the same date, he had written to the sector administrators to underline the importance of *all* staff establishing the identity of the person to whom they were talking on the telephone so as to avoid ambiguity or misunderstanding.

Findings

20. I do no uphold this complaint. The ADA carried out a thorough investigation during the course of which he obtained the written comments (which I have seen) of the principal staff involved. In his reply to the complainant he explained the reason for the delay in the lift (which in the event the complainant could not accept) and why the complainant had not received an apology at the time. He himself apologised and said that measures would be taken which should prevent a recurrence. I do not criticise his decision not to hold a formal inquiry.

Conclusions

21. I have upheld the complaint that the complainant's wife was unnecessarily kept waiting in the lift on arrival at the hospital. I have not upheld the complaint about the Authority's handling of the complaint. They established the facts; they accepted that the delay took place, explained it and apologised for it. And they said that they were taking remedial measures—they have done so. I do not think they can do more.

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