Parliamentary and Health Service Ombudsman

Remedy in the NHS

Summaries of recent cases

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Foreword

As Health Service Ombudsman, I conduct independent investigations of complaints about NHS providers and practitioners: the final stage in the complaints procedure. My investigations are carried out in private but I occasionally publish anonymised summaries of selected cases.

This is the first in what will be an ongoing series of published summaries about NHS complaints that I have investigated. My aim in publishing these summaries is to promote better and more consistent complaint handling in the NHS and to demonstrate how I expect the NHS to put things right when things have gone wrong.

The cases have been chosen as apt illustrations of good or poor practice in putting things right when they have gone wrong. They illustrate the variety and scope of my investigations about the NHS and the types of remedies secured as a result. Some of the cases focus specifically on complaint handling (by the provider, the practitioner, the Healthcare Commission or a combination of two or more of these). Others involve failings in service provision – ranging from poor record keeping and poor communication with patients, relatives and carers to more serious clinical failings and, in one case, an avoidable death.

The cases also illustrate my 'Principles for Remedy'[1]. These Principles (which follow on from my 'Principles of Good Administration'[2]) set out my views on the Principles that should guide how public bodies provide remedies for injustice or hardship resulting from their maladministration or poor service. As well as explaining how I think public bodies should put things right when they have gone wrong, the 'Principles for Remedy' also confirm my own approach to recommending remedies when I have upheld a complaint.

In terms of putting things right, the Principles are:

- If possible, returning the complainant and, where appropriate, others who have suffered similar injustice or hardship to the position they would have been in if the maladministration or poor service had not occurred.
- If that is not possible, compensating the complainant and such others appropriately.
- Considering fully and seriously all forms of remedy (such as an apology, an explanation, remedial action to prevent a recurrence, or financial compensation).
- Providing the appropriate remedy in each case.

In some cases, a complainant might receive financial compensation for direct financial loss. Mrs G (page 33) feared her daughter's life was in danger following poor care and treatment for her eating disorder in an NHS unit. Mrs G took out a loan to pay for private treatment for her daughter. In response to my recommendations, the Trust agreed to reimburse Mrs G the cost of the private treatment and the interest paid on the loan.

Financial compensation for non-financial loss may also be an appropriate remedy in some cases. For example, in the case of Dr D (page 15), the complainant received financial compensation in recognition of the fact that the Trusts' poor

[1] October 2007, http://www.ombudsman.org.uk/improving_services/remedy/
[2] March 2007, http://www.ombudsman.org.uk/improving_services/good_administration/

complaint handling resulted in her early retirement and significantly disrupted her personal and family life. In this case the complainant was a GP, illustrating that the Ombudsman can investigate complaints about the NHS from clinicians as well as those from patients or carers.

Many of the cases in this collection highlight the value of a sincere and timely apology and a well-reasoned explanation for what went wrong. In the case of Mrs N (page 21) I found that she was not given sufficient information about the potential scarring she would have following surgery, and therefore the validity of her consent was undermined. This was a case where financial compensation could have been an appropriate remedy for the injustice suffered, but Mrs N was satisfied with an apology and an assurance that lessons had been learnt and that action would be taken to prevent a recurrence.

For those complained about, there can be reputational risks of complaints to the Ombudsman. Where appropriate, I will not hesitate to draw attention to those NHS providers and practitioners involved so that poor service is identified and lessons learnt.

One case which I wish to highlight is that of Dr Mrozinski (page 37). He refused to take part appropriately in the local complaint handling process and refused to pay the financial redress I recommended for the complainant in recognition of the unnecessary distress he had caused her. Such lack of insight and defensive behaviour deserve to be highlighted. I will not hesitate to use the sanction of publicity and draw Parliament's attention to such behaviour. It contrasts sharply with the cases I see where staff providing NHS services respond openly and promptly to concerns.

I have also included in this digest examples of cases where I have engaged a regulator (pages 15 and 39), whether that is the Healthcare Commission or Monitor, in taking forward my recommendations. In the case of Mrs J, I decided to involve Monitor, the body which authorises and regulates NHS Foundation Trusts, because I was highly critical of the nursing care provided by the Trust but was not satisfied that the Trust had fully learnt the lessons from the events which prompted my investigation. Through the involvement of Monitor, I was assured that there would be an appropriate review of the Trust's progress in learning lessons from the complaint. In this way, the regulator can work effectively with the Ombudsman to achieve service improvements.

The wider backdrop to this publication is the changing landscape of complaint handling. A new system for handling health and social care complaints is due to come into place in April 2009 and a pilot of the new arrangements began in April this year, with support and advice from this Office. The changes also put my role, and that of the Local Government Ombudsman, into sharper focus and give them greater prominence. This publication is therefore part of an ongoing dialogue with the NHS about what the Ombudsman expects of service commissioners, providers and complaint handlers under the new system.

I responded jointly with the Local Government Ombudsman to the proposals for a new system. We specifically welcomed the emphasis on effective complaint handling at local level; effective local leadership; a major cultural shift by the NHS from a defensive application of process to a welcome for the learning from complaints and a will to resolve them; the need for an outcome-based approach to complaints;

and effective governance arrangements across all organisations to underpin and support this approach, and ensure that learning from complaints is shared across the NHS and social care.

There is one other aspect of these proposals that has my strong support: that is, the direct path from local resolution – if that should fail – to an independent Ombudsman.

Currently, the second stage of the NHS complaints procedure is provided by the review function of the Healthcare Commission, with a possible third stage when a case goes to the Ombudsman. (Review by the Local Government Ombudsman actually constitutes the fourth stage in the social care complaints process.) The changes which are planned for April 2009 will mean a simpler system that is less drawn out for both the complainant and the service provider. The regulator, the Care Quality Commission, will be able to focus on its core business of regulation and inspection, without the additional demand of complaint handling which sits uneasily with its primary role. And a strategic alliance between the Ombudsman and the regulator will ensure that any recommendations the Ombudsman may make for systemic change are complied with, and followed up in the inspection regime.

I am working closely with the Local Government Ombudsmen to make sure that there is a fully integrated approach to the complaints that cross boundaries between health and social care. We have already issued our first joint report into a complaint about health and social care and have more such cases in the pipeline.

In the short term, I recognise that the changes will result in an increase in the number of enquiries made to our Office and the number of investigations we undertake. We do not, however, expect to take on the same number of complaints for investigation as the Healthcare Commission has done. As evidence, I note that when the Scottish NHS complaints system moved to a similar model (at the time of the introduction of the Healthcare Commission in England), the number of investigations increased, but not unmanageably so. The Scottish Public Services Ombudsman accounts for this by the focus, during the transition stages, on effective local resolution, coupled with the disincentive of a referral to the Ombudsman, with the potential for adverse publicity which an Ombudsman's finding can bring.

The focus on more effective local resolution is a key to making the new system work in practice. I would like to play my part in assisting NHS bodies to prepare for the changes. My 'Principles of Good Administration' set out the sorts of behaviour I expect when public bodies deliver public services; my 'Principles for Remedy' flow from the 'Principles of Good Administration' and, as noted above, set out my views on how public bodies should approach providing remedies. I have also recently issued for consultation my 'Principles of Good Complaint Handling'.[3]

This latest set of Principles will set out for complainants and bodies in jurisdiction what the

[3] http://www.ombudsman.org.uk/news/pgch_consultation.html

Ombudsman expects by way of good complaint handling. The same six Principles will underpin this document, as they do its two predecessors, but apply them in the complaint handling context. So:

Getting it right will be about getting the right leadership, governance and culture – ownership at the top of the organisation; about equipping and empowering decision makers on complaints; about focusing on outcomes not processes; and about signposting to the Ombudsman in the right way at the right time.

Being customer focused will be about providing an accessible complaints service, with help to make complaints for those who need it: a service that is simple, speedy, joined-up with other providers, flexible, sensitive and tailored to people's needs – not 'one size fits all'.

Being open and accountable will be about publicising complaints procedures clearly and well; about keeping proper records of complaints; and about giving reasons for decisions.

Acting fairly and proportionately will be about decisions being reviewed by someone other than the original decision maker; about natural justice – to all the parties; and about not using sledgehammers to crack nuts.

Putting things right will be about remedy. Not only apologies and explanations – important as they are – and not only changes to prevent a recurrence – important as they are, as well, but, as we have seen, financial remedies where they are justified and appropriate.

Seeking continuous improvement will be about learning. But it will also be about attitude and culture. Is this an organisation which understands and practises learning from complaints?

As with all our Principles, those on complaint handling will not be a checklist to be applied mechanically. I am not in the business of providing a manual of how to stay on the right side of the Ombudsman. Rather, I am providing a framework of Principles. I expect public bodies to use their judgment in applying those Principles to produce reasonable, fair and proportionate results in the circumstances. I will adopt a similar approach.

I hope that my framework of Principles will prove useful to complaint handlers without tying them to precise and possibly unsuitable templates. Over time I will use my experience of them to feed back to the NHS lessons about both good and bad practice in complaint handling.

Finally, I did not think it was necessary to spell out the value of complaints in this foreword; the cases speak powerfully for themselves about the individual and public benefit of effectively resolved complaints. However, I do want to do more to tell the NHS about the Ombudsman's role in the complaints system, and to encourage better and more consistent complaint handling practice across the NHS. This document is a key part of that ongoing process.

Ann Abraham
Parliamentary and Health Service Ombudsman

June 2008

Complaint about Basildon and Thurrock University Hospitals NHS Foundation Trust (the Trust) and the Healthcare Commission (the Commission)

Complaint about the care and treatment of a critically ill child admitted with breathing problems, and complaint about the Commission's subsequent review

Background to the complaint

Miss A, aged 17, suffered from multiple and severe health problems from birth and her parents were her full-time carers. As she required frequent hospital contact, she had direct access to the paediatric unit. In August 2003 she was admitted to the paediatric unit with shortness of breath and coughing, on the advice of the Paediatric Triage Team, which her parents had contacted. Some hours later, when her condition failed to improve, she was transferred to the Intensive Care Unit; however, sadly, she died an hour later.

The complaint to the Trust and the Commission

In January 2004 Mr and Mrs A complained to the Trust about Miss A's care and treatment and in particular her delayed admittance to the Intensive Care Unit, the failure to call the duty consultant when Miss A was admitted and the fact that the consultant was not on the hospital site. They believed that there had been a failure in care and that Miss A had not been adequately reviewed by a senior doctor. They also believed that, had she been transferred to the Intensive Care Unit more quickly, she would have survived.

The Trust's response to the complaint encompassed three letters and two meetings with Mr and Mrs A between February and August 2004. The Trust acknowledged some shortcomings, apologised and highlighted actions arising from the case including the introduction of individualised illness management plans for children with complex conditions; a system of flagging children with special needs on the patient administration system; and developing summary history sheets at the front of patients' notes. The Trust also subsequently reported improved staffing levels.

In November 2004 Mr and Mrs A complained to the Commission, which reviewed the case having taken clinical advice. In February 2006 it concluded that the Trust had taken steps to reduce the risk of similar problems occurring in the future and that there was no scope to take the complaint further.

What we investigated

Mr and Mrs A complained to the Ombudsman in April 2006 and we investigated the complaint as put to the Trust as well as the Commission's subsequent handling.

We had access to Miss A's medical records for the last five years of her life and copies of all complaints correspondence. We also took clinical advice from a Senior Nurse with paediatric experience and obtained a full report from a Consultant Paediatrician.

What our investigation found

Our investigation found the following significant failings during Miss A's admission:

- Inadequate monitoring.
- Poor record keeping in terms of both nursing and medical notes.
- Failure to recognise the seriousness of Miss A's condition.
- Delays in seeking and obtaining reviews by senior doctors.
- Delay in contacting the on-call consultant.
- Delay in transferring Miss A to a High Dependency or Intensive Care Unit despite clear indications that she needed more intensive care than was available on the paediatric ward.

We found that the standard of care provided to Miss A during her last illness fell below a reasonable standard. This amounted to service failure on the part of the Trust. We concluded that, while it would never have been possible to say for certain whether Miss A would have survived her illness had she been transferred to the Intensive Care Unit at an earlier stage, there seemed little doubt that her chances would have been improved.

We also found that the Trust had not acknowledged or apologised in relation to several key issues from Mr and Mrs A's original complaint.

We also concluded that the Commission's review was seriously flawed because it was not clear that sufficient clinical advice had been taken from a properly qualified adviser and the clinical advice had not been recorded properly on file (the Commission's files contained only a brief note of a discussion with an adviser which gave no indication of the adviser's qualification and did not make clear if the adviser had seen the relevant clinical records).

The investigation, which concluded in September 2006, upheld the complaints against the Trust and the Commission.

Outcome

As a result of our recommendations the Trust wrote to Mr and Mrs A to apologise for the shortcomings identified in our report.

The Trust also drew up a comprehensive action plan in response to our recommendations which included:

- the commissioning of a designated paediatric high dependency facility;
- the implementation of a paediatric early warning system, which has been integrated with an updated monitoring chart for critically ill children;
- staff induction and training programmes, which include the recognition and resuscitation of critically ill children;
- the regular auditing of new joint medical and nursing notes;
- the appointment of a paediatric clinical practice facilitator; and
- the establishment of professional liaison with the regional paediatric intensive care consortium as a resource for advice, training and service strategy.

The Commission wrote to Mr and Mrs A to apologise for the shortcomings in its review and for any distress or frustration that this had caused. The Commission also explained that its policy now required that clinical advice be recorded in appropriate detail (either the adviser's report or a signed record of a detailed discussion).

Complaint about University Hospital Birmingham NHS Foundation Trust (the Trust) and the Healthcare Commission (the Commission)

Complaint about the care and treatment of an elderly patient with Alzheimer's disease and coeliac disease following an admission for planned surgery, and complaint about the Commission's subsequent review

Background to the complaint

Mr L, aged 79, lived in a nursing home and had Alzheimer's disease (he was not able to communicate) and coeliac disease (he required a gluten-free diet). In December 2005 Mr L was admitted to Selly Oak Hospital (the Hospital) for surgery to remove a squamous cell carcinoma lesion (a common type of skin cancer). The referral letter to the Hospital explained about Mr L's medical conditions and that he needed assistance with eating and drinking. The operation, which was successful, took place on the day after Mr L's admission. Eight days after the operation Mr L was discharged and returned to the nursing home by ambulance.

The complaint to the Trust and the Commission

Mrs L, Mr L's wife, complained to the Trust in January 2006 about Mr L's discharge arrangements, lack of adherence to his dietary requirements, the decision to send him for surgery when she was not present, and the administration and prescription of drugs on discharge (medication was prescribed in the wrong form and other medication could not be dispensed due to an error on the prescription). She said that an inexcusable lack of consideration by the Trust had caused Mr L great distress. In February 2006 the Trust offered a number of explanations and apologised for the inconvenience and distress caused and said that in the light of the complaint they had looked at discharge planning in general, with emphasis on older vulnerable adults who might have communication difficulties.

Mrs L complained again, met with the Trust in April 2006 and received a further written response in June 2006. The Trust acknowledged and apologised for several errors, including: the failure to order gluten-free meals; Mr L being unable to take anti-sickness medication as it was prescribed in the wrong form; and failure to dispense medication due to wrong information on a prescription.

In July 2006 Mrs L complained to the Commission which, in September 2006, asked the Trust to provide Mrs L with a response to outstanding issues, which they did in November 2006. Mrs L complained again to the Commission, but it decided to take no further action.

What we investigated

Mrs L complained to the Ombudsman, in February 2007, about the care and treatment provided to Mr L, in particular:

- that the Hospital did not pay sufficient attention to her husband's mental state, allowing him to be taken into theatre for surgery and later discharged back to the nursing home without her being present;
- that Mr L was not provided with gluten-free meals during his time in the Hospital, despite the fact that the staff knew about his nutritional needs, and Mrs L was forced to bring food in for him herself; and
- that Mr L's medication on discharge was wrong, in that he was not given anti-nausea drugs to

prevent travel sickness and that his medication was not provided in a soluble form, despite his difficulties with swallowing.

Our investigation considered Mrs L's complaints against the Trust as well as the Commission's subsequent handling.

We had access to all relevant documentation including Mr L's medical records and the complaint correspondence. We also took clinical advice from an adviser with expertise in the nursing of the elderly.

We also took note of the relevant standards relating to clinical care and the treatment of older people. Of particular relevance were the National Service Framework for Older People (2001) and the NHS Modernisation Agency's benchmarking tool 'Essence of Care'.

What our investigation found

- Mr L was caused avoidable distress by the failure to ensure that his wife was present when he was taken for surgery and when he was discharged. There was a lack of awareness of his needs arising from his Alzheimer's disease, because of the failure to adequately assess him upon arrival, the lack of a personalised care plan, and the failure to begin discharge planning at an early stage.

- The Hospital failed to provide a suitable diet for Mr L, despite being told in advance of his needs. It was unreasonable that Mrs L was placed in a position where she felt she had to bring food in from home for her husband, incurring expense and inconvenience. Hospital staff had then accepted this situation without trying to rectify the failing or provide assistance.

- There was unacceptable confusion over Mr L's medication, which meant that he was given tablets despite his difficulties with swallowing, was prescribed the wrong medication on discharge, and then did not receive the medication because of an error.

- The Commission's investigation of Mrs L's complaint was poor. There was little evidence that an objective investigation was carried out and no clinical advice was passed on to Mrs L about the standard of care and treatment provided to her husband, or about the adequacy of the Trust's proposed initiatives to address the problems.

The investigation concluded in September 2007 and we upheld Mrs L's complaints against the Trust and the Commission.

Outcome

As a result of the Ombudsman's recommendations, the Trust took a number of actions, including:

- the production of 'All about me' (a document aimed at improving communication with patients and those caring for patients with dementia, head injuries and learning difficulties);

- the development of a discharge care plan checklist to ensure safe and timely discharge from hospital with provision of relevant information to patients and families;

- a range of dementia training and the nomination of an 'older people's champion' in each ward or department to review the service in that area;
- a review of the Trust's guidelines about communicating with carers and relatives;
- a successful bid to re-establish the post of Trust Mental Health liaison nurse;
- annual benchmarking of the suitability of wards to care for older people with mental health needs;
- an offer to include Mrs L's experience in the Trust's training programme; and
- nutrition link nurses to highlight the nutritional needs of older people and special diets.

As a result of the Ombudsman's recommendation the Commission wrote to Mrs L to apologise for the deficiencies identified in its review.

Complaint against Medway Primary Care Trust (Medway) and West Kent Primary Care Trust (West Kent)

Remedy for a former general practitioner who retired on health grounds as a result of the poorly handled investigation of a complaint against her

Background to the complaint

In August 2002 Mrs B took steps to register at the Practice at which Dr D worked. A 'new patient' check was required before registration could be completed and was arranged for 3 September. During that appointment an altercation took place between Mrs B and the nurse, which Dr D overheard. She advised the nurse to tell Mrs B that she would not be accepted for registration. Mrs B left the surgery, verbally abusing the nurse as she left. Dr D followed Mrs B into the street, and told her 'You do not call my nurse a bitch, lady'. The same day Mrs B sent Dr D a letter of complaint, to which the Practice Manager replied setting out the Practice's view of events.

On 6 September 2002 Mrs B wrote to the Chief Executive of Medway to complain about Dr D, apparently not having received the Practice Manager's letter. Mrs B wrote to the Practice Manager on 8 September, having by then received her letter, explaining that she had complained to Medway. On 16 September Medway asked Dr D to respond to Mrs B's complaint letter and informed Mrs B that she could request an Independent Review (Review) of her complaint if she was dissatisfied with the Practice's eventual response. Mrs B replied that she had already received a response from the Practice, which she felt was unsatisfactory. Medway told Mrs B that she now had the right to request a Review, but did not say they had already asked Dr D to respond directly to her.

After Mrs B wrote back to Medway confirming her dissatisfaction with the Practice's response, they treated her letter as a request to proceed to the second stage of the NHS Complaints Procedure. Responsibility for arranging a Review was delegated to Kent Primary Care Agency (the Agency) which operated under the management of the then Dartford, Gravesham and Swanley Primary Care Trust (now West Kent). The paperwork relating to the complaint got lost in a departmental move.

On 2 October 2002 Dr D replied personally to Mrs B's complaint, apologising for the delay in responding, caused by her absence on leave, and setting out her view of the events of 3 September. On 11 November Medway realised that the Agency had not received the complaint documentation, and they forwarded the papers again; Dr D's letter to Mrs B was not included. On 15 November Dr D wrote to ask the Agency if they had taken account of her letter to Mrs B when considering the Review request. She pointed out that she had never consulted with Mrs B. Two weeks later the Agency told Mrs B and Dr D that a Convener had decided that a conciliator might help resolve the complaint. They did not answer Dr D's question about her letter to Mrs B, nor address her point that she had not consulted with her.

In January 2003 Mrs B and Dr D were told that the conciliation process had ended, and that Mrs B could still request a Review. She did so. The Practice Manager wrote to ask Medway and the Agency how a Review could be considered when Mrs B was not a registered patient. The Agency responded that Mrs B had the same right to complain as any visitor to the Practice. Medway wrote to Dr D in response to the Practice Manager's letter; they said they understood that a Review Panel had been convened, but did not

answer the question about whether Mrs B was entitled to pursue a complaint. In March Dr D's representative wrote to Medway, repeating that Mrs B had never been a formal patient at the Practice.

The Panel met in June 2003 and partly upheld Mrs B's complaint. They said that Dr D had not breached her Terms of Service for General Practitioners, because Mrs B had not been registered with the Practice. The Panel's report noted that the complaint arose out of Mrs B's attempts to register, but nonetheless said that *'such a complaint falls within the guidelines of the Health Service's Complaints Procedure'*.
Dr D's mental state was such that the day of the hearing was her last day in general practice. She took sick leave and was admitted in September to a psychiatric hospital with bipolar disorder. She retired from general practice on health grounds in March 2004.

Dr D complained to the Ombudsman in August 2003, wanting an investigation into the process that had led to the Panel sitting at all. She felt she had been the victim of a *'witch hunt'* and said that the Trusts' mishandling of the complaint against her had cost her her career, and significantly disrupted her personal and family life.

What we investigated

- The management of the complaint against Dr D, and whether the resulting stress had led to the deterioration of her mental health and resignation from general practice.

- Dr D's allegations that both Trusts had been biased against her in favour of Mrs B, had

failed to treat her objectively, and had not properly supported her.

- The matter of the jurisdiction of Mrs B's original complaint, since this was a factor in assessing the adequacy of the Trusts' management of the investigations.

What our investigation found

- Key documents were not sent to Dr D in a timely manner.
- Medway did not inform Dr D that they had told Mrs B that she could ask for a Review, despite asking Dr D to provide a local resolution letter.
- Dr D's letter to Mrs B was unreasonably dismissed throughout the investigation because it arrived very slightly late, despite valid reasons for the delay.
- The fact that a Review into the complaint had been arranged was inappropriately disclosed to Dr D as an aside in a letter.
- Both Trusts repeatedly failed to answer Dr D's reasonable questions about whether they had considered her letter to Mrs B, and whether Mrs B was even entitled to pursue a complaint under the NHS Complaints Procedure.
- We made no finding, however, on the issue of Mrs B's status as a patient with the Practice at the time of the incident, since the matter turned on technical arguments that could only be settled in a court of law.
- The Trusts' investigation lacked a sense of perspective and proportionality. It was driven purely by process, with an absence of overall leadership and guidance to determine whether the progress and direction of the investigation were appropriate to the nature of the complaint.
- There was no evidence of bias against Dr D, or that the Trusts had given her insufficient support throughout their investigation.

We concluded our investigation in May 2007 and upheld Dr D's complaint. The maladministrative handling of the complaint against her contributed to a significant change in the nature of a pre-existing psychiatric illness. There was extensive and persuasive medical evidence to indicate that that maladministration had led to Dr D's retirement on health grounds.

Outcome

Both Trusts agreed to:

- pay the sum of £25,000 to Dr D to remedy the significant injustice to her;
- write personally to her to apologise for their failings; and
- use our investigation to inform a thorough review of their existing complaint handling procedures, and use the findings of that review to develop an action plan to be agreed with the Healthcare Commission (in its role as regulator).

Complaint about Good Hope Hospital NHS Trust (the Trust) (now Heart of England NHS Foundation Trust) and the Healthcare Commission (the Commission)

Complaint about the care and treatment of a woman who was later found to have pulmonary hypertension and who died following surgery, and a complaint that the Commission did not address the Trust's failure to follow the Commission's recommendations

Background to the complaint

Ms C was 42 when she had a stroke in February 2002 and was admitted to hospital. She had a pulmonary embolus (a blood clot on the lung) and was prescribed Warfarin (an anti-coagulating drug) which was stopped after six months. Tests were carried out to determine her blood clotting levels and to search for a patent foramen ovale (a hole in the heart which would allow blood clots to travel from the right side of the heart to the left side and from there to the brain thus causing a stroke). This test was performed initially using a transthoracic and subsequently a transoesophageal echocardiogram (an ultrasound test that can provide information about the structure and function of the various areas of the heart).

After review as an out-patient, Ms C was discharged from care but was readmitted in August 2002 and was found to have another pulmonary embolus. She was referred for an MRI scan which was due to take place in March 2003 but, before this happened, she moved house. She was subsequently diagnosed elsewhere as having pulmonary hypertension and a large patent foramen ovale. She was transferred to Papworth Hospital for treatment but died shortly afterwards.

The complaint to the Trust and the Commission

Ms C's mother, Mrs C, complained in November 2003 about the failure to diagnose pulmonary hypertension at an earlier stage. She questioned whether the earlier commencement of specialist treatment for Ms C might have prevented her death. The Trust could not find Ms C's medical records. Mrs C had a meeting with Trust staff in April 2004, but this failed to resolve matters.

In September 2004 Mrs C complained to the Commission which took clinical advice from a Consultant Cardiologist, who found a number of failings in the care provided to Ms C. In December 2005, the Commission asked the Trust to provide explanations of those aspects of Ms C's care and to change clinical procedures. The Trust responded in February 2006.

In April 2006 Mrs C complained to the Commission, which said that the Trust had complied with most of its recommendations, but asked them to respond on the issue of the review of guidelines for management of pulmonary embolism. The Trust sent a further reply to Mrs C in June 2006 which made no acknowledgement or apology for the failings identified by the Commission.

What we investigated

Mrs C complained to the Ombudsman in September 2006. The complaints investigated by the Ombudsman were that:

- the Trust had failed to respond adequately to the Commission's recommendations following its investigation; and

- the Commission had refused to take any further action despite that failing by the Trust.

We had access to all relevant documentation including Ms C's medical records and the complaints correspondence. We took clinical advice from a consultant cardiothoracic surgeon.

What our investigation found

We found that the Commission had carried out an appropriate initial review of Mrs C's complaint that identified failings by the Trust and made appropriate recommendations.

We found that the Trust's response to the Commission's recommendations was inadequate. They had failed to acknowledge the failure in care and to explain the reasons for it. Neither had they accepted the Commission's recommendation that reporting procedures or guidelines needed to be reviewed.

We found that the Commission had failed to properly consider Mrs C's subsequent complaint about the Trust's response.

We found that the Trust's actions (through mislaying papers and not responding appropriately to the Commission's recommendations) had caused Mrs C to suffer distress and delay in receiving the explanation and response to which she was entitled.

The investigation concluded in July 2007 and we upheld Mrs C's complaint that the Trust failed to respond adequately to the Commission's recommendations and that the Commission failed to properly consider her subsequent complaint about the Trust's response.

Outcome

As a result of the Ombudsman's recommendations the Trust made a payment of £500 to Mrs C in the light of the serious failings in their complaint handling and to recognise the additional distress caused by their responses to Mrs C following the Commission's review.

The Trust also:

- apologised for the loss of records and explained that they had introduced a tracking system for physical documents, an electronic patient record for clinical data and were moving towards all patient documentation being accessible electronically;

- produced an amended template for recording and reporting echocardiograms to help ensure that clear diagnosis is obtained;

- reviewed their guidelines for the management of pulmonary embolism and implemented those recommended by the British Thoracic Society;

- offered an explanation of the criteria that would have led to onward referral for Ms C, an acknowledgment of the fact that a referral could have been made earlier and an apology that the process was so protracted. They said that training was to be provided to staff to increase awareness of symptoms of pulmonary hypertension and the need for onward referral;

- explained the procedure surrounding transoesophageal echocardiogram tests and the reasons for delays in scheduling the MRI scan for Ms C. They said that transoesophageal echocardiograms that do not provide clear results would be discussed at regular meetings

and that transoesophageal echocardiogram results would be audited for quality of data and accuracy of interpretation. A lead consultant for this work had been identified and staff training had led to British Society of Echocardiography accreditation; and

- acknowledged and apologised for the failure of care towards Ms C.

The Commission wrote to Mrs C to apologise for the failings identified by our report.

Complaint about South Devon Healthcare NHS Foundation Trust (the Trust) and the Healthcare Commission (the Commission)

Complaint about the care and treatment of a patient in relation to a bilateral mastectomy, and complaint about the Commission's subsequent review

Background to the complaint

In December 2004 Mrs N was referred by her GP for a mammogram which showed that she had small tumours in both breasts. A bilateral mastectomy (surgery to completely remove both breasts) was recommended.

In February 2005 Mrs N attended Torbay Hospital where she was provided with information about her condition. Mrs N discussed the issue of scarring with the Breast Care Nurse and emphasised that the position and cosmetic appearance of the resulting scars were both very important considerations for her. Later that month, the Consultant Surgeon who was to perform the operation gave Mrs N a consent form to sign; however, she had yet to decide whether she would proceed with the proposed surgery and did not sign the form immediately.

In March 2005 Mrs N signed the consent form. She was admitted to Torbay Hospital in early April 2005, and underwent a bilateral mastectomy. When the bandages were removed Mrs N was horrified to discover that, rather than two scars below the breast line, as she had been expecting, she had been left with what appeared to be a single horizontal scar across her chest wall, above her breast line. Mrs N was shocked and extremely distressed by the extent, position and appearance of her scarring and raised her concerns immediately with a member of the Trust's staff. Mrs N was discharged the next day.

The complaint to the Trust and the Commission

Two days after her discharge Mrs N complained to the Trust in writing about the appropriateness of the surgery and the consent procedure in relation to the nature and extent of potential scarring. The Chief Executive responded to the complaint in September 2005 and said that the bilateral mastectomy was the correct procedure and that the surgeon had acted appropriately.

Mrs N remained dissatisfied and in October 2005 she complained to the Commission which found that the procedure was appropriate and the scarring within normal range. It did, however, find shortcomings relating to consent and asked the Trust to look at those issues (both in terms of reminders to staff about the importance of ensuring that consent forms were completed fully, and giving patients the opportunity to ask questions when there is a time lag between consent being given and an operation carried out) and to inform Mrs N of resulting changes in policy. The Commission, in two replies (February and March 2006) concluded that, despite the shortcomings identified, consent had been obtained on a properly informed basis.

What we investigated

In April 2006 Mrs N complained to the Ombudsman. Our subsequent investigation looked at:

- the Commission's handling of her case; and
- the standard of care and treatment provided by the Trust in terms of informed consent, and the appropriateness of the procedure.

Mrs N made clear that she had pursued her complaint in order to have it acknowledged that the operation she received was not the one for which she gave consent, not to obtain financial compensation.

We examined all the relevant documentation and obtained specialist clinical advice from a Consultant Breast Surgeon who is also a Professor of Breast Cancer. We also took account of the relevant standards contained in the Department of Health's 'Reference Guide to Consent for Examination or Treatment' (2001) and the General Medical Council's 'Seeking patients' consent: The ethical considerations' (1998).

What our investigation found

We found that the bilateral mastectomy was an appropriate procedure for Mrs N.

We found that some parts of the consent process were reasonable, insofar as different treatment options were described, nursing staff were involved in the consent-making process, and Mrs N was given the opportunity to reflect before and after making a decision. However, we noted that there was no review of the consent at the time of the admission immediately before the operation. We also concluded that, based on the information given to Mrs N pre-operatively, it would have been reasonable for her to expect two separate scars running horizontally across the lower to middle part of her chest. The fact that Mrs N was not given more specific information about the risks of the procedure impacted on her ability to give fully informed consent. We found that, overall, there were sufficiently serious shortcomings in the consent process to undermine the validity of the consent, with the result that Mrs N was denied the opportunity to decide whether or not to go ahead with the surgery with full knowledge of the potential risk of scarring.

The investigation found that, having reviewed appropriate evidence and sourced appropriate advice, the Commission's resulting decision that Mrs N's consent was fully informed was unreasonable, as it did not properly reflect the evidence assessed or clinical advice received. This caused Mrs N additional inconvenience and distress.

The investigation concluded in February 2008 and we upheld Mrs N's complaints against both the Trust and the Commission.

Outcome

As a result of our recommendations the Trust and the Commission agreed to apologise to Mrs N for the shortcomings identified in our report and the injustice she had suffered.

In addition to the action they had taken as a result of the Commission's recommendations, the Trust also agreed to give Mrs N an assurance that lessons had been learnt from her complaint and an explanation of the changes made to prevent such failures being repeated.

Complaint about Southend Hospital NHS Trust (the Trust) and the Healthcare Commission (the Commission)

Complaint about the care provided to an elderly dying man, the attitude of staff towards him and his wife, and about the way a complaint was handled by both the Trust and the Commission

Background to the complaint

Mr V was 86 years old when he was admitted to Southend Hospital in December 2002, complaining of abdominal pain, intermittent vomiting and diarrhoea. He had a history of diverticulitis (a digestive disease caused by inflammation of pouches which have formed on the outside of the colon) and irritable bowel syndrome with chronic abdominal pain. On this occasion, the doctors diagnosed a small bowel obstruction: he was given intravenous fluids as the diarrhoea and vomiting had made him severely dehydrated.

Mr V was cared for in the Intensive Care Unit for two days and, having made an initial recovery, was transferred to a surgical ward and then, 13 days later, to a medical ward. Within a few days of this latter transfer, Mr V became less well. He complained of abdominal and back pain, became constipated and had a poor appetite. His left arm became swollen and pressure sores developed on his elbows; MRSA was detected in the left elbow. He appeared depressed and was given an antidepressant. It seemed that a long-standing thyroid function problem was not being adequately addressed, so his thyroxine daily dose was increased.

Mr V then developed a fever and blood tests indicated an infection, so he was given intravenous antibiotics. Nine days later, Mr V complained of back pain and was prescribed an opiate painkiller. Over the following fortnight, Mr V's chest condition improved. By the end of January 2003, he appeared to be better and was sitting out of bed, although he was still very depressed. Over the next week, his condition fluctuated as he became drowsy and uncommunicative, and unwilling to eat or drink. He refused further intervention and said that he wanted to be left alone. As time went on, he was in more pain; his opiate painkiller dose was increased and given on a regular basis. He became unresponsive, and his condition deteriorated further. He died in mid-February 2003.

The complaint to the Trust and the Commission

Mrs V, Mr V's wife, complained to the Trust in December 2003. She attended a meeting with them in February 2004 at which statements by nurses (which detailed their communications with Mrs V about her husband's care) were read out. Mrs V was extremely upset by those statements; the Trust then wrote to her expressing regret that the meeting had not resolved matters, but gave no explanations about her husband's care. An exchange of letters followed and, in August 2004, Mrs V requested a further meeting; the Trust refused and said that she could approach the Commission.

In May 2005 the Commission referred Mrs V's complaint back to the Trust, asking that a conciliation meeting be held. Neither Mrs V nor the Trust agreed to this. In September 2005 Mrs V complained to the Ombudsman. As the complaint had not been investigated by the Commission, it was referred back for review. In January 2006 the Commission wrote to Mrs V, with their final decision, suggesting that she contact the Information Commissioner if she wished to have medical records corrected. Mrs V contacted the Ombudsman again in February 2006.

What we investigated

Mrs V remained concerned about the care her husband received on the ward and subsequent complaint handling. Her complaints correspondence made clear that she believed that Mr V had been caused undue suffering and stress and that she had been caused unnecessary distress by the way in which her complaints had been handled. The main elements of her complaint were:

- the nursing care provided to Mr V on the medical ward was inadequate;
- staff were unhelpful and unsympathetic to both Mr and Mrs V; and
- neither the Trust nor the Commission had responded adequately to her complaints.

We had access to Mr V's medical and nursing records and all of the complaints correspondence. We also took clinical advice from a Hospital Consultant with experience in the Care of the Elderly and a Senior Hospital Nurse.

In framing the recommendations on this case we made particular reference to the NHS Modernisation Agency's benchmarking tool 'Essence of Care' (2003).

What our investigation found

We found that while there was evidence of reasonable medical and nursing care in most areas, there had not been adequate planning for communication with Mr and Mrs V. Mrs V had also been very concerned to see her husband in pain, and we found that pain relief interventions could have been made at an earlier stage.

There was also evidence in the nursing records and statements made by nursing staff that they had found it difficult to deal with Mrs V. It appeared that they had held negative perceptions of Mrs V and had provided little support when her husband died. We found that junior staff had not been well supported by their seniors in dealing with a difficult situation.

We found that the Trust had failed to address Mrs V's complaint adequately by not responding to her original concerns about Mr V's care and that this served to increase her distress.

We found that the Commission failed to adequately address Mrs V's concerns about the Trust as it misunderstood her complaint, believing it to be about inaccuracies in medical records and therefore advising her to approach the Information Commissioner.

The investigation concluded in October 2006 and we upheld Mrs V's complaints against the Trust and the Commission.

Outcome

As a result of the Ombudsman's recommendations the Trust:

- wrote to Mrs V in October 2006 to apologise;
- said that the Deputy Ward Manager would attend a specialist external training course on record keeping and then facilitate training sessions for staff on record keeping. These elements would also be emphasised in staff induction and in ongoing training;
- put in place a programme to implement the 'Essence of Care' communication standard and all other 'Essence of Care' standards, with the assessment of the medical ward to take place as part of that programme; and
- reviewed and republished their complaints policy and procedure (along with other supporting documentations) with particular emphasis on the support available to staff members in handling 'Difficult situations or complainants', the need to avoid judgmental statements and a designated framework for conducting local resolution meetings.

Complaint about Cambridge University Hospitals NHS Foundation Trust (Cambridge) and Hinchingbrooke Health Care NHS Trust (Hinchingbrooke)

Complaints about the assessment and management of an adolescent's scoliosis; the post-operative care and treatment which led to his death; and the handling of complaints about those matters

Background to the complaint

In January 2000 Q, then aged 13, attended a combined Spinal Deformity Clinic at Cambridge (the Clinic), at which Mr M (Paediatric Orthopaedic Surgeon) and Mr H (Visiting Consultant Orthopaedic Surgeon from Hinchingbrooke) assessed children and adolescents with scoliosis (a spinal deformity). Q was assessed as having scoliosis and put on the waiting list for surgery. In January 2001 Q's father, Mr R, asked if the operation could be carried out in early summer. Mr H explained that many parents wanted their children treated at a time that did not interfere with schooling, but he would do what he could.

In September 2001, shortly before the planned operation, Mr H belatedly reviewed an MRI scan taken in April, which had been filed away. The scan indicated a Syrinx (abnormal dilation of the central canal of the spinal cord). The surgery to correct that took priority over the scoliosis surgery, and was carried out at Cambridge in April 2002. The procedure markedly decreased Q's neck mobility. It was noted that Q's parents preferred the scoliosis care to be continued at Cambridge, but Mr M had no access to appropriate beds there.

Mr H and Mr M carried out the scoliosis surgery at Hinchingbrooke on 17 June 2003. Before the operation, the Consultant Anaesthetist at Hinchingbrooke (Dr Y) discussed with Dr P – the Consultant Anaesthetist and Intensive Care Unit (ICU) lead – the difficulty of placing a breathing tube in Q's throat because of his rigid neck. It was decided to pass a flexible fibre optic scope through Q's nose to visualise the opening of the windpipe and to pass a breathing tube over the scope and into his windpipe. That was accomplished and the operation went according to plan. Dr Y and Dr P decided to keep Q on a breathing machine for 24 to 48 hours after the surgery, by continuing to ventilate him through the nasal tube. After surgery Q was transferred to the ICU, where he was placed on volume controlled ventilation and received fluids. There were unexpected problems with Q's care: he developed Adult Respiratory Distress Syndrome (ARDS – a severe form of acute lung injury) from which he did not recover. He lost fluids and his blood pressure dropped. A central venous pressure line was inserted and a tracheostomy was performed, allowing the nasal tube to be removed. Secretions on the tube from sinusitis cultured positive for MRSA. Steroids were started as treatment for the acute lung injury but Q's condition continued to deteriorate. He died on 27 July, aged 17.

The complaint to the Trusts

In August 2003 Mr R asked both Trusts to review Q's treatment to find out what had contributed to his son's death. He also raised concerns, including the management of Q's scoliosis and his care in the ICU. Hinchingbrooke's report to Mr R contained explanations from the clinicians concerned. It concluded that Q's *'untimely death was not the result of a single or even several specific incidences of carelessness, neglect or inadequate care'*. Cambridge apologised for the failure to either forward Q's MRI scan results to Hinchingbrooke or for them to have been read and acted upon at Cambridge. Mr R's subsequent

request for an Independent Review was refused by the Convener, despite a Consultant Anaesthetist's report identifying shortcomings in Q's care and treatment in the ICU. Mr R complained to the Ombudsman in December 2004.

What we investigated

In terms of the assessment and management of Q's scoliosis we investigated the following concerns:

- the nature of the scoliosis was not adequately assessed;
- investigations were not undertaken with sufficient promptness and regularity;
- there was a delay in reviewing the MRI scan;
- Q was not prioritised appropriately;
- there was no reassessment about where the scoliosis surgery should take place; and
- whether the organisation of the Clinic had any detrimental effect on Q's assessment and surgical treatment.

On Q's post-operative care and treatment we investigated:

- the management of ventilation and fluid volumes;
- the MRSA infection; and
- the standard of nursing care.

We also investigated the Trusts' complaint handling.

In considering Mr R's complaints, we sought advice from a Consultant Orthopaedic Surgeon, a Consultant Orthopaedic and Spinal Surgeon, a Consultant in Paediatric Intensive Care, a Consultant Anaesthetist and a Nurse Consultant in Critical Care. We also considered evidence provided by Mr and Mrs R at interview and in writing, the documents relating to the Trusts' response to Mr R's original complaint, relevant clinical records, and the testimony of Mr M and Mr H. We also discussed the management of Q's anaesthesia and post-operative care with Dr Y and Dr P. We gathered information from the Trusts about planned changes to the Clinic and took account of the 'British Scoliosis Society Guide to Practice' (2001).

What our investigation found

Assessment and management of the scoliosis
There should have been a paediatric assessment for Q because of the length of time since his previous assessment (in 1995). Mr H now ensures that all younger patients go for paediatric assessment.

It was not common practice in 2000 to request an MRI scan of a scoliosis patient until surgery was clearly indicated, unless there were additional factors. In Q's case there were no abnormal signs and surgery was not indicated until December 2000. Although it would have been best practice to order regular X-rays every six months, the length of time between X-rays (December 2000 and September 2001) was not unreasonable.

Clinicians must take responsibility for ensuring that test results are reviewed; in this case there was a failure to review an MRI scan promptly.

Mr H was limited to six sessions a year to undertake scoliosis surgery requiring two surgeons and was faced with conflicting demands from his patients. Problems with waiting times and prioritisation for scoliosis patients were not uncommon in 2000-01; therefore it was unreasonable to hold Mr H individually responsible for the pressures on the service.

Because of his rigid neck and the degree of spinal curvature, Q would have benefited had a multi-disciplinary pre-operative discussion taken place in order to assess the risks of the anaesthesia and the most appropriate site for scoliosis surgery.

The combined Clinic arrangements did not provide the necessary infrastructure to support all scoliosis patients referred to it. Adolescent scoliosis patients entering the Hinchingbrooke 'stream', such as Q, were disadvantaged because they did not access the advice and support of paediatric anaesthetists and paediatric intensive care staff that was available to Mr M's patients.

Post-operative care and treatment

The management of Q's post-operative ventilation was poor and, in all likelihood, had contributed to the damage to his lungs. The ventilatory parameters used immediately after surgery were too high for a patient of Q's age and build, and the ventilation strategy used was not consistent with accepted practice in 2003. The management of Q's fluid balance was deficient and the excessive fluid transfusion contributed to the rapid onset of ARDS. We were satisfied that MRSA did not contribute to Q's deterioration and we found no deficiencies in the nursing care provided.

Complaint handling

The Trusts' responses to Mr R's original complaints were inadequate and did not answer his questions. Neither Chief Executive explained about the arrangements at the Clinic which led to some patients entering a different care pathway from other patients with similar clinical needs. Hinchingbrooke's response to Mr R's complaint was effectively provided by the clinicians concerned, and their failure to thoroughly review the factors which contributed to Q's unexpected death was unacceptable. We were highly critical of the decision to refuse Mr R's request for an Independent Review. While the ICU team undertook a clinical review of Q's death, Hinchingbrooke did not take the opportunity to analyse the failings which contributed to the problems with Q's care and treatment and to learn lessons.

We upheld most aspects of Mr R's complaints. Individual and organisational failings resulted in the assessment and management of Q's scoliosis falling below a reasonable standard. Although these shortcomings were unlikely to have impacted on the correction of the scoliosis, they led to unnecessary delays and increased discomfort and distress for Q. The organisation of the combined Clinic had a detrimental effect on Q's assessment and surgical treatment, as Mr H's patients did not have the benefit of the multi-disciplinary support and assessment available to Mr M's patients. There were avoidable factors which led to the development of ARDS and Q's subsequent death. Mr and Mrs R had a right to expect a thorough, joint investigation of the arrangements at the Clinic following the devastating loss of their child, but the Trusts' responses to their complaints and concerns were inadequate.

Outcome

We made 14 recommendations aimed at bringing about systemic improvements to services for adolescents with scoliosis, and assisting both Trusts in addressing the very serious issues raised by our investigation. All our recommendations were accepted.

Both Trusts agreed that:

- each Chief Executive would send a letter of apology to Mr and Mrs R for the shortcomings identified and the failure to investigate their son's death adequately; and provide them with details of the action taken in response to our recommendations and of the changes to the Spinal Deformity Service.

Among the recommendations we made to Hinchingbrooke were that they:

- revise their management of ventilation and fluids in intensive care and their management of intra-operative fluid balance during any major operation with risk of significant blood loss or prolonged surgery. In doing so, we recommended that they revisit the published research and rewrite their guidelines in line with current knowledge and expert opinion from the local Network and the Royal College of Anaesthetists; and

- ensure that the Chief Executive and the Medical Director receive assurance that current anaesthetic and ICU practice is safe and that they consider the further steps needed to understand the factors that contributed to Q's death.

Our recommendations to Cambridge included that they:

- provide evidence that the arrangements for the transfer of the results of investigations, correspondence and other records for Mr H's patients from the Clinic to Hinchingbrooke have improved.

In addition, both Trusts agreed to address the arrangements for pre-operative cardiopulmonary assessment.

Complaint about Cambridgeshire and Peterborough Mental Health Partnership NHS Trust (the Trust) and the Healthcare Commission (the Commission)

Complaint about a decision to withdraw an anti-dementia drug, Aricept, from an elderly patient, about the care and treatment provided to him subsequently, and about the Commission's review

Background to the complaint

Mr S was referred to the Trust by his GP in May 2002 because of poor memory and was seen by a Consultant Psychiatrist for Older People in June 2002. It was thought that Mr S had mild cognitive impairment but that dementia might be developing and an anti-dementia drug, Exelon, was prescribed. In July 2002 Exelon (which had made Mr S unwell) was replaced with a prescription for Aricept. Mr S attended further appointments in September and November 2002. At that stage it was intended that he would continue taking Aricept and that his mental state would be assessed by a Community Psychiatric Nurse.

By May 2003 Mr S's GP considered that his mental state had deteriorated and asked for him to be reassessed. When Mr S was reassessed in July and November 2003 it was noted that his memory was continuing to deteriorate, that he would continue to be monitored and that the Community Psychiatric Nurse would keep in touch with his carers to discuss any concerns.

In January 2004 Mr S was seen by a Staff Grade Psychiatrist for Older People, with the result that the Aricept was stopped and Mr S was discharged to the care of the Community Mental Health Team. At this time Mr S was living in his own home and his day-to-day care was provided under a private arrangement, largely by neighbours. Mr S had been recently widowed, but he had two adult sons who monitored his situation closely. In March 2004 Mr S's condition had deteriorated and he was admitted to hospital. Mr S remained an in-patient until September 2004 when he was discharged to a nursing home.

The complaint to the Trust and the Commission

In July and August 2004 Mr S's son, Mr T, complained to the Trust about a number of issues relating to Mr S's care including: the failure to inform Mr S's family and those caring for him about the stopping of Aricept; the lack of a care plan following that; and the fact that Mr S's condition had been allowed to deteriorate. The Trust replied in September 2004 and provided a number of explanations as well as several apologies relating to communication with Mr T and the provision of information to him.

Mr T complained to the Commission in October 2004. In November 2005 the Commission told Mr T of its decision to refer matters back to the Trust to provide details about the guidelines used to discontinue Aricept.

In December 2005 Mr T complained to the Ombudsman. However, as the Commission had not sought independent clinical advice, we recommended that it look at the complaint again. The Commission sent its revised decision to Mr T in February 2006 advising that the clinical care given to Mr S was appropriate, that guidelines had been followed but that the Trust could have provided more information to Mr T.

What we investigated

In March 2006 Mr T complained to the Ombudsman. Our investigation covered the following concerns:

- the Trust withdrew Aricept from Mr S in January 2004 without informing Mr T, his carers, or the local social services department;
- following the decision to withdraw Aricept no care plan was devised and implemented, and the Trust failed to monitor Mr S to avoid deterioration;
- Aricept was not re-prescribed to Mr S despite the opinion of a member of Trust staff that it should be, and despite Mr T's repeated requests;
- the Trust applied the National Institute of Clinical Excellence (NICE) guidelines strictly and without thought or consideration for Mr S's individual circumstances;
- the Trust denied Mr T's request for a change of consultant for his father;
- the Commission's handling of Mr T's complaint was inadequate.

We examined all relevant documentation concerning the case, including complaint correspondence, Mr S's medical records, and the Commission's papers. We also obtained clinical advice from an experienced Consultant Psychiatrist. We also took into account the relevant NICE guidelines in place at the time, 'Technology Appraisal Guidance No 19: Guidance on the Use of Donepezil [Aricept], Rivastigmine and Galantamine for the Treatment of Alzheimer's Disease'.

What our investigation found

Our investigation found that the Trust failed to communicate significant changes in Mr S's treatment plan (that is, the withdrawal of Aricept) to those most closely involved in his care.

We found that the Trust did not identify and plan for the risk of Mr S's deterioration following the decision to discontinue Aricept and also failed to ensure that Mr S was adequately monitored after January 2004.

We found that there would have been no benefit in re-prescribing Aricept to Mr S, even though this was recommended by a member of the Trust's staff.

We found no documented evidence of any consideration of Mr S's individual circumstances in the application of the NICE guidelines.

We found that Mr S was given the opportunity of review by an alternative Consultant Psychiatrist for Older People.

We found that the Commission did not take steps to understand Mr T's complaint fully; failed on two occasions to take independent medical advice from an appropriately qualified person with the necessary expertise; did not provide Mr T with an adequate explanation for its decision; and failed to respond in a timely manner.

Our investigation concluded in March 2007 and partly upheld the complaint against the Trust and fully upheld the complaint against the Commission.

Outcome

The Trust had, before our investigation concluded in March 2007, already taken some action in response to Mr T's complaints including: apologising for the lack of communication over the withdrawal of Aricept; revising their care plan approach which includes the identification and management of risk; undertaking to remind senior staff of the need for monitoring and follow-up where medication is discontinued; and a structured format for consensus meetings (which should result in proper recording of the decision-making process and factors taken into account when medication is discontinued).

As a result of the recommendations made in our final report the Trust also agreed to:

- apologise to Mr T and provide him with evidence that senior medical staff have been reminded of the importance of careful monitoring and follow-up of patients where medication is discontinued; and

- conduct an audit of consensus meeting documentation (to ensure that this format is used and that the requisite level of information is recorded).

The Commission agreed to apologise for the failings identified in our report.

Complaint about Berkshire Healthcare NHS Trust (the Trust)

Remedy for poor treatment of an adolescent girl suffering from anorexia nervosa

Background to the complaint

Miss G was 15 years old when she was referred to the Berkshire Adolescent Unit (the Unit), because of weight loss and self-induced vomiting, in November 2002. She was assessed at the Unit in January 2003, and admitted to a re-feeding programme in February. Miss G used laxatives and diuretics and made herself sick in order to lose any weight gained. She left the programme in March, and a week later took an overdose, having felt guilty about eating something at a barbeque.

In May 2003 Miss G was readmitted to the programme, but continued to lose weight. On 14 May the Consultant Psychiatrist, Dr Z, met Miss G for the first time. Because of Miss G's poor progress at the Unit, her mother asked about a transfer to a specialist unit within the NHS or to the private sector. Following this meeting Miss G attended the Unit as an in-patient on weekdays, but she still felt distressed if she put on weight.

Miss G absconded from the Unit four times in June 2003. On the first occasion she telephoned her mother to let her know that she had left the Unit; Unit staff were unaware that she had gone. Miss G took another overdose in July, following which Mrs G asked Dr Z if her daughter could be transferred to a named private clinic (which specialised in treating anorexia nervosa in children and adolescents) as an NHS patient because she felt that her daughter had deteriorated. In mid-July, at a time when Miss G was in a poor state, Dr Z and others who might have advised Mrs G about her daughter's ongoing care were all on leave. Feeling she had no alternative, she asked her GP to refer Miss G to the private clinic.

Mrs G took out a loan of £45,000 to pay for the treatment. All the other patients at the clinic were said to be NHS-funded. Miss G put on weight and was discharged in December.

Complaint to the Trust

Mrs G complained to the Trust in August 2003 and received the Chief Executive's response in November. Amongst other things, the letter said that the matter of Miss G having absconded would be followed up in the Unit. Mrs G was dissatisfied with the response and approached the Independent Complaints Advocacy Service for help. They referred her complaint to the Ombudsman in May 2004.

What we investigated

We investigated Mrs G's allegations that the Unit had not provided adequate care for Miss G; that there were failings in the care provided by the Unit, in that she was able to abscond from there; and that Miss G was not seen personally by the Consultant Psychiatrist until May 2003. Mrs G told us that she did not want any other family to have the same experience. She had sought help from the private sector, when she thought her daughter's life was in danger, and wanted to be reimbursed for the loan.

A Consultant and Professor of Adolescent Psychiatry and two Psychiatric Nursing Assessors provided us with advice on clinical issues and nursing matters.

As the National Institute for Clinical Excellence (NICE) did not issue its guidelines about eating disorders in adolescents until 2004, we relied on our clinical advisers to indicate the care standards

that Miss G and her family could reasonably have expected in 2003. We were advised that the response to treatment of young people with anorexia nervosa is very variable and tends to be poor when laxative and diuretic misuse and self-harm are involved. Some aspects of progress would be expected within six months, however, and it would be of concern if none of these were apparent. These include some engagement with treatment aims and development of good relationships with one or two key staff; and some containment of the young person's maladaptive eating and associated non-eating behaviours.

We expected the Unit to have policies on observation and assessment, and an approach to the planning of care consistent with the Care Programme Approach (CPA). Further guidance was set out in 'Modernising the Care Programme Approach', issued by the Department of Health in 1999, which noted that risk assessment and management are integral components of CPA, and that contingency planning should be an element of risk management as a means of preventing and responding to crises. Arrangements for handling crises are expected to be included in care plans.

What our investigation found

We found that the Unit had no adequate systems in place for care planning, communication, risk assessment and risk management to provide Miss G and her parents with a sense of engagement and containment, nor did it give them a clear sense of direction about Miss G's care. She lost weight and her health and safety were compromised by a lack of effective arrangements to manage the risk that her behaviour presented. Miss G and her parents were not offered other choices, nor given a clear sense of direction when all local options seemed to be ineffective, inappropriate or unavailable.

Although the Chief Executive told Mrs G in November 2003 that the issue of Miss G having absconded would be followed up in the Unit, the letter was dated some five months following the event. It was not apparent that an urgent investigation had been carried out immediately following Miss G's undetected absence.

The gap between Miss G's admittance to the Unit and being seen by Dr Z was unacceptable, given her clear lack of progress, a moderate to high level of risk and high parental concern.

We concluded our investigation in November 2007, and upheld Mrs G's complaint. The service failures described above, together with the fact that she was left without any clear guidance about when a decision might be made about referring Miss G elsewhere left Mrs G fearing for her daughter's life.

Outcome

The Trust agreed to apologise to Mrs G for their failures and for the distress caused to her, and to pay her compensation of £500; to reimburse Mr and Mrs G the full cost of the private treatment and to pay the interest on the loan; to ensure that they have a clear policy on out-of-area treatment that can be shared with parents and patients; and to implement the NICE Clinical Guideline 9 ('Eating disorders – Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders').

Complaint about Peterborough and Stamford Hospitals NHS Foundation Trust (the Trust) and the Healthcare Commission (the Commission)

Complaint about a decision to discharge from hospital an elderly vulnerable patient, who died shortly after readmission, and complaint about the Commission's review.

Background to the complaint

Mr E, aged 88 years, went to live in a nursing home in September 2004. He suffered with severe dementia. In January 2005 he was admitted to Peterborough District Hospital with signs of internal bleeding and a chest infection, and, 17 days later he was discharged back to the nursing home. Three days later he was readmitted to the hospital where he died at the beginning of February.

The complaint to the Trust and the Commission

Mr E's son, Mr F, complained to the Trust in February 2005. He raised concerns about the discharge decision and its planning, and their communication with the nursing home and Mr E's GP.

The Trust replied in March 2005 that Mr E had been properly assessed and discharged safely. They apologised for the fact that the Ward Manager had failed to inform the nursing home that Mr E was no longer diabetic and for a lack of information in the discharge letter to Mr E's GP.

Mr F remained dissatisfied and in June 2005 the Commission confirmed that it would look at his complaint. The Commission then looked at Mr F's complaint and replied in November 2005. It referred to a breakdown in communication between the hospital and the nursing home but said it was not apparent that this was the fault of the Trust's nursing staff. It referred to the gaps acknowledged by the Trust in their discharge letter and said that the Trust were being asked to explain what action they had taken on that point.

In December 2005 the Trust sent a further response to Mr F. They apologised for any distress caused and explained that they were trialing an electronic discharge letter. They said also that a letter used for inter-hospital transfers was being extended to transfers to nursing homes in complex cases and that the importance of providing complete and legible information in discharge letters was being emphasised in training and in staff meetings.

In December 2005 Mr F complained to the Ombudsman but as the Commission had not sought independent clinical advice during its review it was asked to look at the complaint again. In February 2006 the Commission sent its revised decision to Mr F and said that, having taken clinical advice, it took the view that the Trust's documented actions, including the recommended follow-up actions, appeared appropriate.

What we investigated

In March 2006 Mr F complained to the Ombudsman. The investigation covered the following concerns:

- the Trust should not have discharged Mr E from hospital in January 2005;
- the Trust did not discharge Mr E with a care plan. Instead, the hospital left it to the staff at the nursing home to devise a care plan but did not provide them with sufficient information with which to write one;

- neither the nursing home nor Mr E's GP was properly informed about his condition and treatment on discharge from hospital. Proper procedures for the discharge of vulnerable patients were not followed;

- the Trust refused to provide the nursing home with information about Mr E's condition;

- the Commission's handling of Mr F's complaint was inadequate.

We examined all relevant documentation including complaint correspondence, copies of Mr E's medical records and the Commission's papers. We also obtained advice from a geriatrician and from a nurse with significant experience of older people's care.

We took account of the prevailing standard which in this case was the Department of Health's 'Discharge from hospital: pathway, process and practice' (2003).

What our investigation found

We did not find evidence to support the Trust's decision that Mr E was ready to be discharged from hospital. This is not to say that, had he remained in hospital, the outcome for Mr E would have been any different. Rather, the Trust should have carried out a more thorough assessment of his needs at that time and of the ability of the nursing home to care for him. Because the acute illnesses that Mr E was suffering from had improved and his vital signs were within normal limits, it was assumed that Mr E was fit for discharge. Instead, the totality of relevant factors should have been considered. The Trust agreed that Mr E should have remained in hospital until a full assessment was made before discharge and they apologised for the fact that Mr E was discharged without more investigation into his discharge requirements.

We found that the Trust were under no obligation to discharge Mr E with a care plan.

We found that the Trust's discharge letter was inadequate, that the use of a telephone call from the Trust to the nursing home to provide additional information was not an appropriate way to handle this complex discharge and that good practice would have involved a higher level of pre-discharge liaison with the nursing home.

We did not find any evidence to support the complaint that the Trust refused to provide the nursing home with information about Mr E.

We found that the Commission's handling of Mr F's complaint was inadequate as it failed to obtain independent clinical advice from an appropriately qualified person with the necessary expertise and did not give an adequate explanation for its decision.

Our investigation concluded in March 2007 and we partly upheld Mr F's complaint against the Trust and fully upheld his complaint against the Commission.

Outcome

The Trust agreed to review their documentation on pre-discharge planning and their procedures to ensure compliance with Department of Health guidance on the proper discharge of complex elderly patients.

The Commission agreed to apologise to Mr F for the shortcomings identified in our report.

Complaint about Dr Mrozinski, a locum GP

Complaint that a GP unreasonably prescribed amoxicillin to a patient recorded as being allergic to penicillin, and mishandled the patient's subsequent complaint

Background to the complaint

Mrs K's history of penicillin allergy, based on her account of a previous reaction, was marked on her medical summary card, on her Lloyd George (paper) folder and on her computer records. On 3 June 2004, shortly before her honeymoon in Mexico, Mrs K had an appointment for vaccinations at the surgery. The Nurse was concerned about vaccinating Mrs K, who was congested, and arranged for her to see Dr Mrozinski. By Mrs K's account Dr Mrozinski asked her if she was allergic to antibiotics, to which she replied: not that she was aware of. (Mrs K was aware of her penicillin allergy but did not associate antibiotics with penicillin.) Dr Mrozinski prescribed a five-day course of amoxicillin, an antibiotic of the penicillin family.

Mrs K flew to Mexico on 9 June 2004. The next day a rash appeared on her back and arms. Her body became red, swollen and hard to the touch, covered in lumps and blisters. She assumed she had been prescribed penicillin. Mrs K spent the last days of her holiday in her hotel room, and she described the flight home as *'painful and frightening'*. She immediately saw her regular GP, who told her that Dr Mrozinski had written on her notes that he had asked her if she was allergic to penicillin, to which she had answered that she was not. Mrs K disputed that account of the consultation.

The complaint to Trafford North/South Primary Care Trust (the Trust) and the Healthcare Commission (the Commission)

On 28 June 2004 Mrs K complained to the Trust, asking for an apology and compensation for her ruined honeymoon and the distress Dr Mrozinski had caused her. After Dr Mrozinski failed to attend a local resolution meeting arranged by Mrs K's GP, she told the Trust that she wanted a full written response to her complaint from Dr Mrozinski. His eventual reply did not provide an account of his actions nor explain why he had prescribed antibiotics. He said that if Mrs K was questioning his clinical competence or claiming gross professional misconduct she should contact the General Medical Council (GMC). If she was claiming medical negligence she should expect a possible counterclaim. The Trust made several attempts to engage Dr Mrozinski in the complaints process, and reminded him of his responsibilities under the GMC guidance and NHS Complaints Procedure. When no substantive response was forthcoming, Mrs K took her complaint to the Commission, which began an investigation.

The Case Manager visited the surgery, where Mrs K's GP demonstrated the warning notice displayed on the computer when an attempt was made to prescribe a drug to a patient with a recorded sensitivity or allergy. It was noted that the warning could be manually overridden. The GP pointed out Dr Mrozinski's computer entry, prescribing amoxicillin for Mrs K. The Commission wrote to Dr Mrozinski three times asking for a response to Mrs K's complaint, but received no reply. With Mrs K's agreement the Commission referred her complaint direct to the Ombudsman in April 2005, as we have powers to obtain evidence from witnesses.

What we investigated

We investigated whether Dr Mrozinski had unreasonably prescribed amoxicillin to Mrs K and whether he had appropriately handled her complaint about that. We took account of the GMC's 2001 publication, 'Good Medical Practice', which stated that clinicians must explain fully and promptly what has happened if harm has been suffered. It also stated they should appropriately apologise and that patients who complain about care or treatment they have received have a right to a prompt, open, constructive and honest response. We also bore in mind the NHS Executive's Guidance on the NHS Complaints Procedure for General Practices which reminds GPs of the need to *'listen carefully and understand the person's perspective – empathise'*.

What our investigation found

We concluded, on the basis of clinical advice from the Ombudsman's GP Adviser, that it was not certain that amoxicillin was the cause of Mrs K becoming unwell: although Mrs K was not aware of it, she had twice been prescribed penicillin (in 1994) with no ill effect.

Mrs K's penicillin allergy was clearly recorded; although Dr Mrozinski did not totally disregard the need to check if she was allergic before writing a prescription, he should not have disregarded the allergy warnings, or overridden a computer alert, without discussion with her. He should also have recorded that Mrs K's understanding that she was not allergic to antibiotics was inconsistent with her medical records. There was conflicting evidence about what Dr Mrozinski had asked Mrs K during the consultation, which could not be resolved.

Dr Mrozinski's initial response to Mrs K's complaint was unhelpful, negative and belligerent in tone, and his threat of a counterclaim did not comply with NHS complaints regulations and GMC guidance. It was only after we contacted Dr Mrozinski about Mrs K's complaint, that he provided a response to the substance of it, but there was no explanation of why he had not provided an earlier explanation and no apology. Dr Mrozinski's refusal before then to explain his actions showed a blatant disregard of GMC guidance and the NHS Complaints Procedure.

We concluded our investigation in September 2006 and upheld Mrs K's complaints. Although it was not clear that she had suffered as a result of Dr Mrozinski's prescription, he should not have prescribed antibiotics without further discussion, and should have told her that it was recorded that she was allergic to penicillin. Dr Mrozinski's handling of Mrs K's complaint was totally unacceptable; his repeated refusal to respond to the substance of her complaint put her to unnecessary time and trouble, and added to her distress.

Outcome

We recommended that Dr Mrozinski send Mrs K a written apology and pay her £250 compensation for the unnecessary distress he had caused her. He refused to do so and wrongly questioned the Ombudsman's authority to investigate clinical matters. At our suggestion, the Trust made the payment to Mrs K themselves, on the basis that *'the patient is more important than the principle'*.

Complaint about Gloucestershire Hospitals NHS Foundation Trust (the Trust) and the Healthcare Commission (the Commission)

Complaint about the care and treatment of an elderly patient who died during an in-patient admission, and complaint about the Commission's subsequent review

Background to the complaint

Mr W, aged 74, was admitted to Gloucester Royal Infirmary as an emergency in August 2002 for treatment of an infective exacerbation (pneumonia) of chronic obstructive pulmonary disease. He was treated in the Intensive Treatment Unit until the end of August when he was transferred to a respiratory ward. Mr W then had episodes of confusion, difficulty with oxygen intake and some bleeding from a catheter site. He later contracted MRSA, developed diarrhoea and was found to be infected with C.difficile. Mr W was transferred to Standish Hospital at the start of October, where he suffered with recurrent C.difficile infection. Mr W died in November 2002, with the cause of death noted as respiratory failure.

The complaint to the Trust and the Commission

Mrs J, Mr W's daughter, questioned whether the Trust's actions had contributed towards his deterioration and death. She had specific concerns about the care and treatment that he had received, including: his transfer from the Intensive Treatment Unit; the timing of medical reviews following that transfer; the general standard of hygiene and nursing care (Mr W had been found by his family with bloodstained pyjamas and bedclothes and there was a delay in providing continence pads when he suffered from diarrhoea); effectiveness of communication (both between staff members and with the family); the management of MRSA and C.difficile and the accuracy of the death certificate. Mrs J believed that Mr W had been caused undue suffering and stress during his admission and that their family had been caused unnecessary distress.

Mrs J complained to the Trust in March 2003; they responded in July 2003. A local resolution meeting was held in August 2004. Mrs J was unhappy with the action taken by the Trust and complained to the Commission in October 2004.

In November 2005 the Commission referred some aspects of the complaint back to the Trust for action (requesting an update on improvements to record keeping and communications between staff and families) and asked them to look at the timing of Mr W's transfer from the Intensive Treatment Unit. Mrs J complained, again, to the Commission in December 2005, which said, in May 2006, that it would take no further action as it was satisfied with the Trust's actions and responses.

What we investigated

Mrs J asked us to investigate all aspects of her complaint against both the Trust and the Commission.

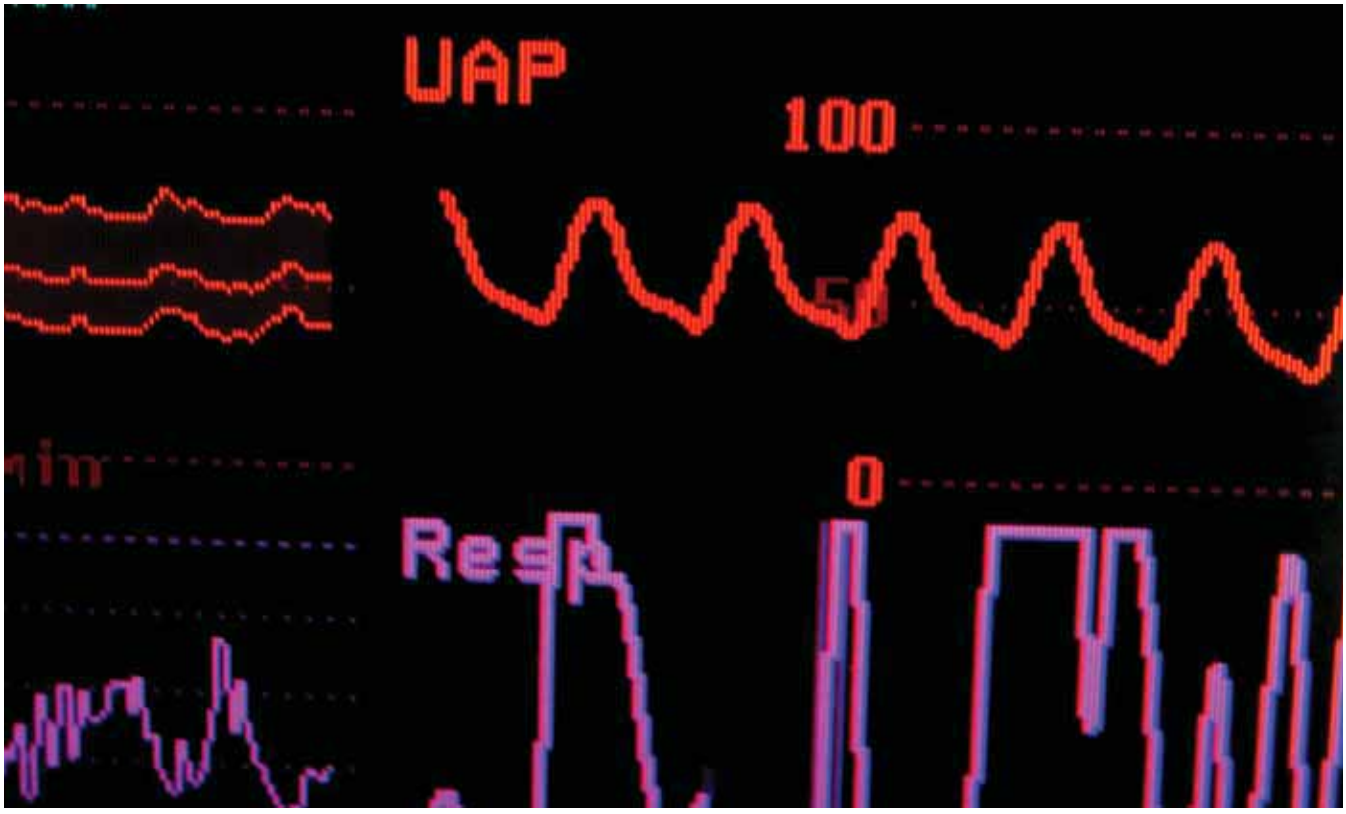
We considered all the available evidence and took clinical advice from an experienced General Physician (who is also a Consultant in Elderly Care Medicine) and an experienced Nurse. We also took account of the relevant standards and guidelines including the Department of Health's National Service Framework for Older People (2001), the British Society of Geriatrics' 'Standards of Medical Care for Older People' (revised 2003), the Nursing & Midwifery Council's 'Standards for Records and Record Keeping', the NHS Modernisation Agency's benchmarking tool

'Essence of Care' and the March 2001 guidance about resuscitation decisions published jointly by the British Medical Association, Royal College of Nursing and the Resuscitation Council.

What our investigation found

We found that the timing of Mr W's discharge from the Intensive Treatment Unit was appropriate; that the medical care in late August/early September 2002 was generally reasonable; that there was no objective evidence of MRSA being implicated in Mr W's death; that the medical management of C.difficile was appropriate; and that the Trust's response on the accuracy of the death certificate was reasonable. However, when taken in the round, the evidence we saw pointed to serious failings in the Trust's service to Mr W and his family which were:

- a lack of monitoring while Mr W waited to be transferred from the Intensive Treatment Unit;
- a delay in carrying out a medical review;
- extremely poor nursing care in relation to care planning, communication, pain management, infection management, patient privacy and dignity, and monitoring fluid intake/output;
- a lack of multi-professional working and senior medical review;
- poor record keeping; and
- poor end-of-life care (including lack of a care plan and no discussion with the family about resuscitation and the seriousness of Mr W's prognosis).



We concluded that, irrespective of the poor practice identified, the final outcome for Mr W would not have been different, but that the failings identified would have significantly affected Mr W's quality of life and the level of distress he suffered. We also found that Mr W's family were caused undue distress due to the condition in which they sometimes found Mr W and because they had no opportunity to come to terms with the fact that his life was ending and to make suitable arrangements.

We acknowledged the time and effort the Trust took in attempting to resolve Mrs J's concerns and that they readily acknowledged several failings and took action to address them. However, we concluded that Mrs J's complaint should have prompted a wider review of nursing care which may have led to a more co-ordinated approach to implementing improvements and, in turn, provided reassurance for Mrs J that her complaint was being taken seriously.

We found maladministration in the Commission's handling of Mrs J's complaint (including failure to seek clinical advice, not providing her with regular updates and failure to assess the priority of the case) which had exacerbated her worry and distress.

The investigation concluded in March 2008 and we upheld Mrs J's complaints against both the Trust and the Commission.

Outcome

In this case we decided to involve Monitor, the body which authorises and regulates NHS Foundation Trusts, because we were highly critical of the nursing care at the Trust and were keen to ensure that there was an appropriate review of the Trust's progress in learning lessons from the complaint.

The Trust agreed to:

- write to Mrs J and her family to acknowledge and apologise for the failings identified;
- review the areas where we had identified serious failings in order to ensure that their practices were in accordance with current guidance and standards;
- provide Monitor with information to demonstrate that their practices (in the areas where we had identified serious failings) are in line with current standards; and
- report back to Mrs J on the action taken in response to our recommendations.

The Commission agreed to write to Mrs J and her family with an apology and pay £250 compensation in recognition of the worry and distress caused by its poor complaint handling.

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