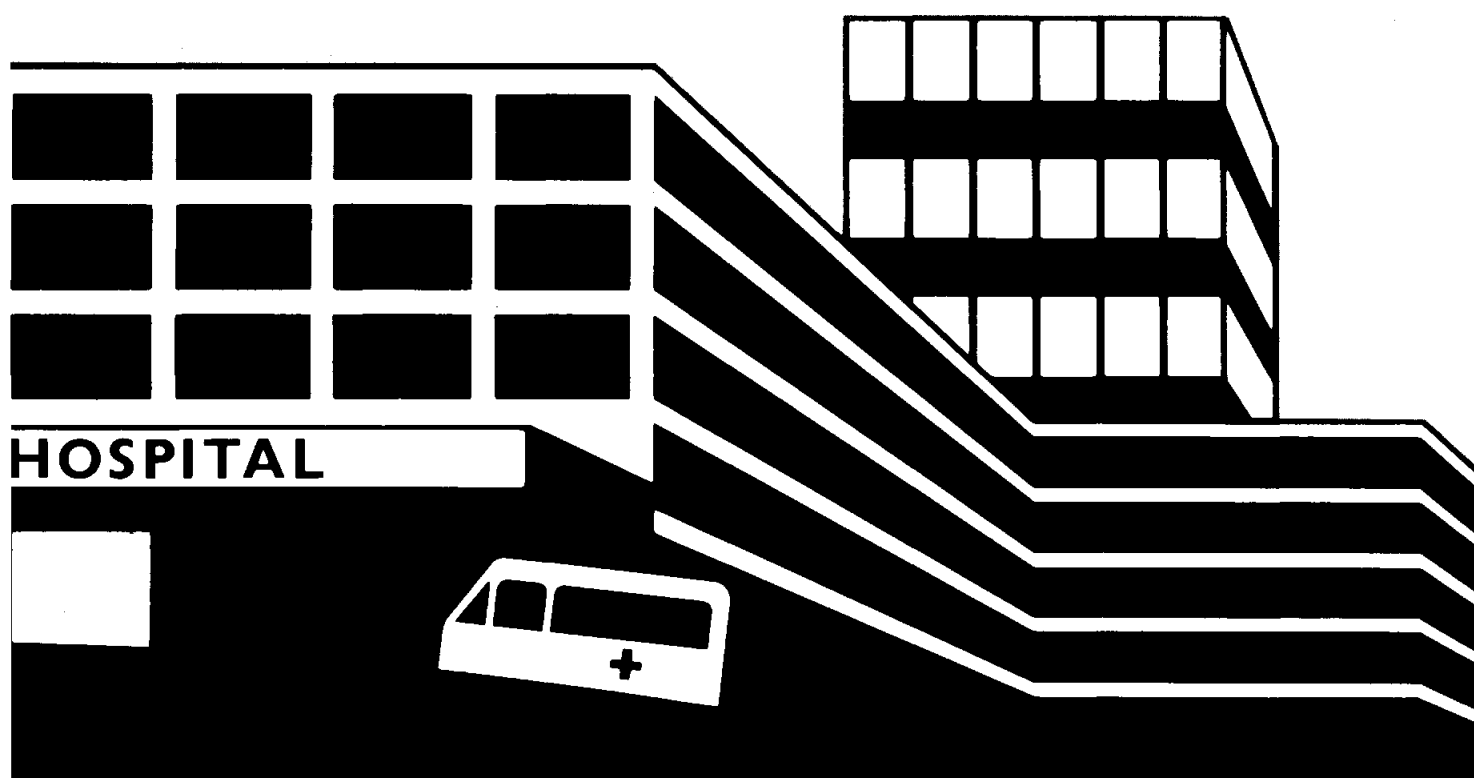


**Health
Service
Commissioner**

**Annual
Report for
1988-89**



Health Service Commissioner

Third Report for Session 1988-89 Annual Report for 1988-89

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

*Ordered by The House of Commons to be printed
12 July 1989*

LONDON

HER MAJESTY'S STATIONERY OFFICE

HC 457

Contents

	<i>page</i>
Chapter 1 — Introduction	1
Chapter 2 — Statistics	2
Chapter 3 — Investigations: main topics	
(i) Clinical complaints procedure	3
(ii) Observation and supervision of patients	9
(iii) Communication with patients and relatives	12
(iv) Handling of complaints	14
(v) Family Practitioner Committees	16
Chapter 4 — Cases of special interest	18
Chapter 5 — Remedies	23
Appendix A — Summary of workload	29
Appendix B — Main reasons for rejection	29
Appendix C — Analysis of investigated grievances 1987/88 — 1988/89	30
Appendix D — Number of grievances investigated and found justified, April 1979 — March 1989	31
Appendix E — Analysis of main categories of grievances 1979/80 — 1988/89	31
Appendix F — Analysis of activity 1973 — 1989	32
Appendix G — Geographical distribution of complaints received for 1988-89	33
Appendix H — Geographical distribution of investigations completed in 1988/89	33

Introduction

Chapter 1

1. My term of office as Health Service Commissioner for England, for Scotland and for Wales expires at the beginning of 1990. It is established practice that a single annual report for the three Offices is submitted to the three Secretaries of State in fulfilment of the duty imposed on me by Section 119(4) of the National Health Service Act 1977 and Section 96(5) of the National Health Service (Scotland) Act 1978. This report covers the year which ended 31 March 1989 and is therefore the last I shall sign.
2. During the year I have submitted to the Secretaries of State two volumes containing the anonymised reports of selected investigations: the first was for the period April to October 1988 and the second for November 1988 to March 1989. These volumes include the full text of 51 investigations completed during the year which were selected with a view to being of interest to Parliament and the public and to help the management and staff of the National Health Service in carrying out their functions. As usual I have provided epitomes of the cases at the front of each volume and these have been circulated separately to the Service.
3. Chapter 2 of the report contains detailed statistics for the year which was again very busy. I completed 123 investigations and issued 139 reports to separate authorities, the highest number of reports issued during a year since the Offices were established in 1973. The number of separate grievances dealt with, which averaged four for every investigation, was also the highest ever total. In previous reports I have expressed concern about the progressive worsening of the time taken from first receipt of a complaint to the issue of my report, which has been due in part to the unusually large number of cases accepted for investigation each year as against the number of investigations concluded in the same period. From 1985-86 to 1987-88 the increase in the average time taken was 11 weeks a year and although the average time taken to conclude investigations last year of 69.4 weeks is clearly unsatisfactory, when set against the time of the previous year of 69.2 weeks it does lead me to hope that the escalation in time taken has been halted and can now start to be reversed. The number of cases accepted this year for investigation, from again a slightly reduced number of complaints received was, for reasons I cannot explain, considerably lower than in recent previous years and this should assist in the efforts to reduce the average overall time taken in providing reports to complainants.
4. My term as Health Service Ombudsman has convinced me of the value of a mechanism which enables the consumers - principally the patients and their relatives - to obtain an independent and impartial investigation when they believe that the care provided by the National Health Service has fallen short of what they were entitled to expect, and the health authority concerned has not been able to dispel their anxieties. It has to be remembered however that the remit of the Health Service Ombudsman covers a good deal less than the entire field of the National Health Service. He does not, for example, deal with complaints against family practitioners. A patient or relative who wishes to complain about the actions of a family practitioner must go to the relevant family practitioner committee (FPC) or health board in Scotland. And unless the FPC or health board is able to dispose of the complaint by informal means the avenue which the patient or relative must follow is the disciplinary - and adversarial - one of a hearing by a service committee enquiring into the question whether the family practitioner has committed a breach of his terms of service. The terms of service, it should be noted, do not cover such matters as rudeness or inefficient surgery procedures, about which there is therefore no formal means of complaining. Moreover even where hospital care is concerned the remit of the Health Service Ombudsman is limited, particularly by the exclusion from his jurisdiction of complaints about actions which were taken in the exercise of clinical judgment. Some part of this excluded area is now covered by the clinical complaints procedure. As I record elsewhere in this report I have continued to receive complaints about the detailed operation of that procedure, and it is my hope that the reports which I and my predecessors have issued on the subject have contributed to improvements in its operation. But again the procedure does not cover the whole ground, applying only to complaints about the actions of hospital doctors and dentists. My predecessors and I have taken the view however that 'clinical judgment' is

not the exclusive prerogative of doctors and dentists. There are occasions when the actions of nurses, midwives and other professionals must be seen as having been taken in the exercise of clinical judgment and therefore as being outside the Ombudsman's jurisdiction. In their case however there is no clinical complaints procedure to fill the gap. It is to be hoped that some way may be found of making good this further lacuna. If that were achieved it would ensure that resort to some form of independent review, albeit in a distinctly fragmented pattern, would be available to the consumers in respect of virtually every aspect of the care provided by the National Health Service.

5. Turning to the rest of my report, in Chapter 3 I highlight five particular topics of which there were several examples in the investigations I have completed this year. A characteristic of complaints I receive is the way in which they present recurring themes, so most of these topics have been referred to in previous years. The operation of the clinical complaints procedure continues to generate a considerable number of complaints of maladministration and this year I refer to a further six examples. Yet again I have found it necessary to illustrate - this year with five cases - how the failure to observe patients properly and to take appropriate action can lead to difficulties and even tragedy. Complaints about failures in communication are among the most common I receive. This year I have selected six cases which show how failures to provide explanations about diagnoses and prognoses can cause unnecessary additional distress to patients and relatives. And all too frequently problems with the provision of care continue to be aggravated by inadequate handling of complaints. This I have illustrated by cases involving both the hospital and the family practitioner services. In Chapter 4 I draw attention to ten cases of special interest chosen to illustrate the variety of subjects I investigate and in Chapter 5 I list the remedies I have obtained during the year. I hope that NHS bodies in particular will find these details helpful in reviewing their own practices.

6. The question of how best to publicise the work of the Office has often exercised my predecessors and myself. I take any opportunity which arises to give interviews to the media and to speak to interested bodies and organisations. But the extent to which I can discuss individual cases is limited, even when they have been published in anonymised form. I cannot add to what I have said in my report, nor can I name names, as the media would like me to. My belief is that it is through organisations such as Citizens Advice Bureaux and Community Health Councils that awareness of my Office can best be promoted. My Deputy has developed an increasing range of contacts with the NHS, lecturing to members of authorities, management, medical and nursing staff on the lessons to be learned from my investigations. In this he has been helped by senior members of my staff. It is gratifying to learn from these contacts and others of the constructive use many authorities and schools of nursing make of the epitomes and, increasingly, my Annual Reports and volumes of selected cases which provide a treasure house of teaching material. The Select Committee on the Parliamentary Commissioner for Administration, which also considers my work as Health Service Commissioner, performs an important role in publicising the Office through its public examination both of individual authorities and of the Health Departments. Not only is that a salutary experience for the individual authorities, but the press interest it sometimes attracts can remind other authorities and the public that my powers derive from Parliament and that Parliament remains interested in what I do and report. I should mention the Committee's recently adopted practice of inviting the complainants in the cases it is considering to attend the relevant meetings. Having spoken to some of the complainants afterwards I know how much they appreciate the work of the Committee and the interest and compassion shown by Members.

7. Although this falls outside the year under review, I should record that on 13 May 1989 the seven years' service of Mr G V Marsh, MA FHSM as Deputy Health Service Commissioner came to an end. I would like to pay tribute to his wide knowledge of the National Health Service and to thank him for his great contribution to the work of the Office. He has been succeeded by Mr R A Oswald, who was appointed District General Manager of Leeds Western Health Authority in early 1985, but had since April 1988 been working on a special project with Yorkshire Regional Health Authority.

8. I am glad of this opportunity, also, to express my thanks to my staff, who are mostly drawn on secondment from the NHS and the Civil Service, for their application and industry. The work of investigating complaints requires the collection of considerable quantities of evidence, both written and oral. Increasingly, in the more complicated complaints and those which relate to events spread over a long period, it is necessary to interview large numbers of staff - sometimes 50 or more. All that evidence has to be analysed and weighed before findings can be arrived at and I can make my judgments.

The investigators, and the senior officers who review their work, need to be meticulous, thorough and absolutely objective, yet without forgetting compassion and, indeed, commonsense. There is, in fact, a quite considerable element of stress in the job, derived from the knowledge that as my judgments are unappealable no effort must be spared to ensure that, so far as possible, they are right. Finally, I must thank the relevant bodies I investigate: health authorities, health boards and family practitioner committees - and their staff - for their ready cooperation and help. Without that my task would be much more difficult. I am grateful, too, for the assistance I, and indeed my clients, receive from secretaries of community health councils and, when needed, from departments of social services and the police. I am also indebted to the Department of Health for the information and help they frequently provide in the course of my investigations. In particular my Office has cause to be grateful for the continuing assistance given by the Department's liaison officer, Mr Philip Chinque.

Complaints received

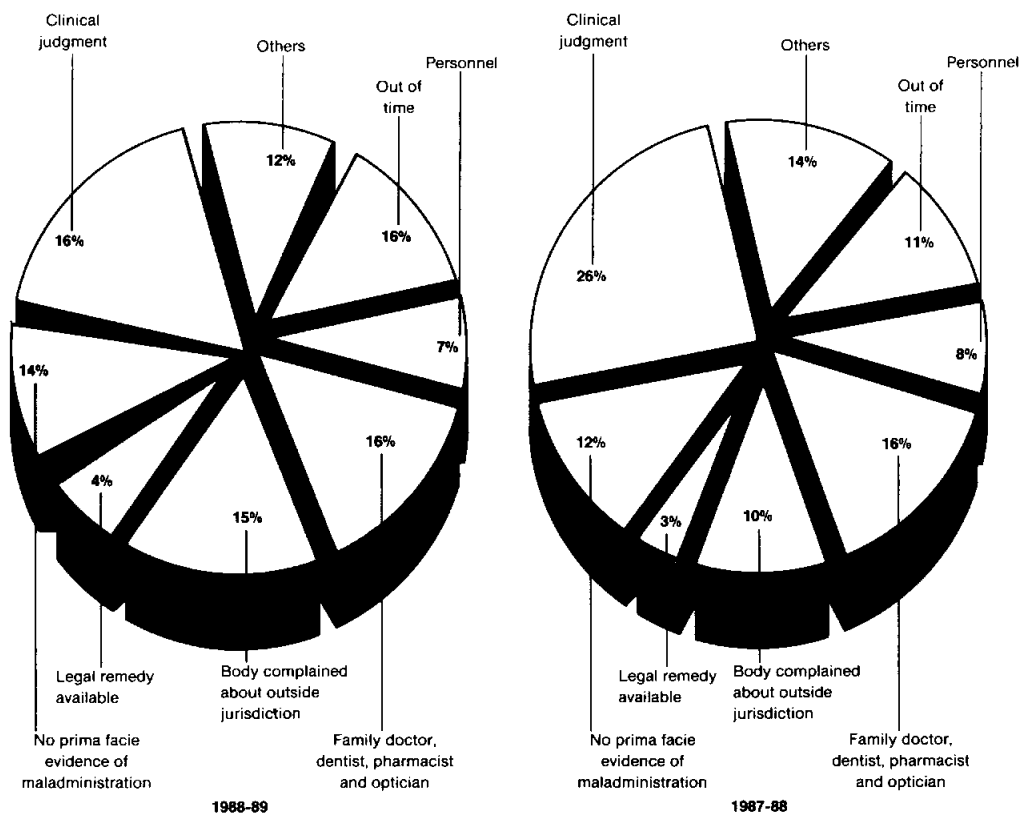
9. The total number of complaints received between 1 April 1988 and 31 March 1989 was 753, a decrease of 5.1 per cent on 1987-88. Since the peak year 1985-86, when 926 complaints were received, successive years have seen declining numbers (see Appendix F). However, there was a noticeable surge in the final quarter of 1988-89, March having the highest monthly intake (95) for over 3 years, although it is not possible to say whether such a sharp upturn has any significance in the longer term.

10. The number of complaints received about the Health Service in England was 641, 4 per cent fewer than in 1987-88. The table at Appendix G shows the distribution of these complaints according to the regions from which they originated and also relates the number of complaints received to the nominal populations of those regions. A little over 43 per cent of all complaints in England came from the four Thames regions, which cover London and the home counties, compared with some 40 per cent in 1987-88. In Scotland 75 complaints were received, 8 fewer than last year; and in Wales the number was 37, compared with 39 in 1987-88. I feel bound to say that, although it may be interesting to speculate on the reasons for the variation between the regions in the incidence of complaints, I doubt whether any firm conclusions can be reached on the subject.

11. In addition to the 753 new complaints, 253 cases were brought forward from the previous year. Of the total of 1006 action was completed on 688 cases (68.3 per cent) during the year.

Cases brought forward from 1987-88	253	Reports issued	139
Cases received	753	Cases discontinued	15
		Cases rejected	342
		Cases referred back and subsequently closed	192
		Cases carried forward to 1989-90	318
	1006		1006

12. Of the 15 cases which I agreed to discontinue 11 complainants asked to withdraw their complaints before I had decided to investigate them and four sought to withdraw after I had commenced my investigation. I describe as 'cases referred back' those complaints which require further action or information from the complainants before I can consider them. The most common reason continues to be that the complaint has not first been put to the health authority concerned, which is a requirement of the Acts of Parliament governing my work. Normally the file is closed if nothing is heard from the complainant within three months. The 318 cases 'carried forward' include 141 which were referred back within the final three months of the year and on which no further action was taken before 31 March and 94 cases which were under investigation at 31 March. The remainder were being considered for investigation, rejection or reference back or were awaiting attention, this latter group being larger than usual due to the exceptionally large number of cases received in March. In addition to the 753 complaints received in the year, 173 written enquiries and requests for advice were received (compared with 107 in 1987-88), together with numerous telephone enquiries. During the year, also, 554 supplementary letters were received about complaints which had either been rejected (ie not accepted for investigation) or referred back for further action or information.



Rejections

13. 342 of the 688 cases concluded during the year were rejected which, with the 15 discontinued cases, represent 52 per cent. This proportion was 7 per cent less than the previous year and was the second lowest in the history of the Office. I have no immediate explanation for this and it certainly does not reflect any change in the screening process when complaints are received or in the criteria which are then applied but, as Appendix F indicates, the proportion of rejections has fluctuated from year to year. The main reasons for rejection are shown in the diagram above and in Appendix B. The figures suggest that there has been a substantial reduction in the proportion of complaints which had to be rejected because of the clinical judgment exclusion. I do not believe that this was the case but rather that the figures and proportions have been affected by recording methods. Accordingly, for the future I have introduced a revised basis for analysing rejections which takes account of individual grievances, which I refer to in the next section, instead of cases.

Investigations

14. The 139 reports issued to separate authorities were the outcome of 123 investigations, a small number of complaints having involved more than one health authority. There was one Welsh case in which I investigated an associated complaint in my capacity as Parliamentary Commissioner for Administration; and I investigated an English case in conjunction with the Commission for Local Administration, although of course separate reports were issued.

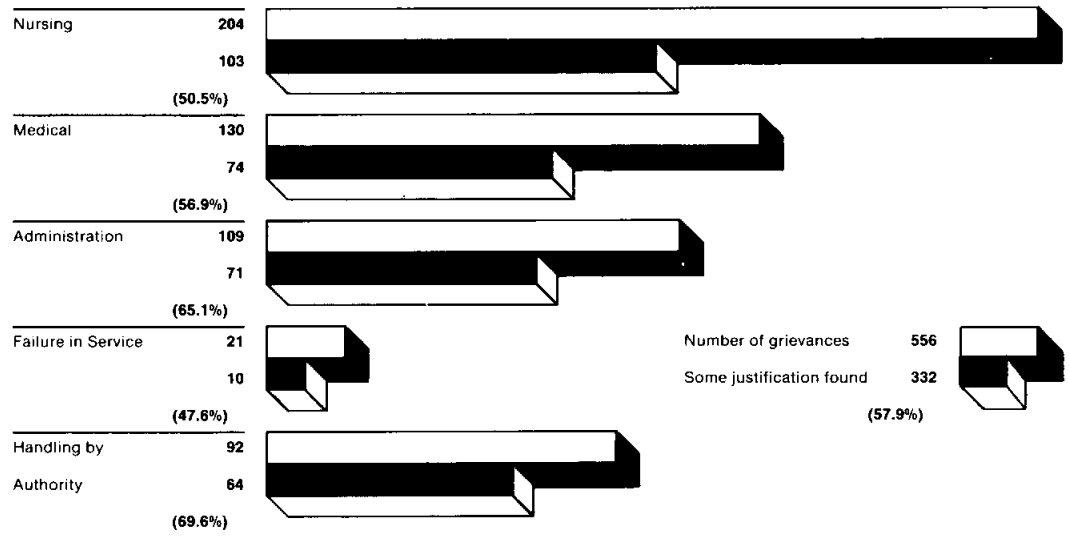
15. There were 556 separately identified grievances within the 139 reports, an increase of 21 over 1987-88 and the highest ever total, giving an average of 4.00 grievances for each report, just short of the peak level recorded in 1981-82 (4.03). The number of grievances in which I found some justification fell back a little to 57.91 per cent from the record level found in 1987-88 (61.04 per cent).

16. Grievances concerning nursing and medical staff totalled 334 representing 60.0 per cent of all those investigated, an increase of 1.7 per cent over 1987-88. The number of grievances about nursing staff (204) was just one less than in the previous year, while grievances about medical staff (130) increased by 28.7 per cent compared with 1987-88 (101). The proportion of upheld grievances about nursing and medical staff increased to 53.0 per cent overall (50.5 per cent and 56.9 per cent respectively) compared with 51.3 per cent overall (54 per cent and 45 per cent respectively) in 1987-88.

17. Grievances about administrative matters totalled 109 (19.6 per cent of the total) compared with 102 (19 per cent) in 1987-88, of which 65.1 per cent were found to have some justification – a fall of 7.9 per cent from the previous year. Investigations relating to failures in service and the handling of complaints by health authorities fell slightly to an overall total of 113 (20.3 per cent of all grievances) compared with 117 (22 per cent) in 1987-88.

18. The grievances investigated within the five main categories and the outcome are as follows:

Grievances received compared with grievances upheld



During the year I accepted 101 cases for investigation, a decrease of 31 (23.5 per cent) compared with 1987-88.

Appendices contain the following detailed information:

Appendix A: Summary of workload, 1987-88 and 1988-89
(England, Scotland and Wales)

Appendix B: Main reasons for rejection, 1987-88 and 1988-89
(England, Scotland and Wales)

Appendix C: Analysis of categories of investigated grievances 1987-88 and 1988-89

Appendix D: Number of grievances investigated and found justified April 1979 to March 1989

Appendix E: Analysis of main categories of grievances 1979-80 to 1988-89

Appendix F: Analysis of activity 1973 to 1989

Appendix G: Geographical distribution of complaints received 1988-89

Appendix H: Geographical distribution of investigations completed in 1988-89

(i) Clinical complaints procedure

19. Under the Acts which govern my work I am not permitted to investigate complaints about actions which, in my opinion, were taken solely in consequence of the exercise of clinical judgment. In 1981 a procedure called the clinical complaints procedure or colloquially the 'second opinions procedure', was introduced to deal with such complaints by means of an independent professional review (IPR), of the clinical action which is the subject of the complaint, by two independent consultants. The decision whether or not there should be an IPR is a discretionary one, taken by the regional medical officer (RMO). I am able to investigate complaints that the RMO's decision has been taken maladministratively, and also complaints about maladministration by the RMO, or the health authority concerned in the procedures leading up to, or following, the decision on an IPR. I can also consider the administrative actions of the independent consultants who conduct the IPR. Each year for the last six years my predecessor and I have included in our reports cases illustrating problems which have arisen with this procedure and this year I mention six such cases.

20. In the first case a woman was dissatisfied about her sister's diagnosis, treatment and care while she was a patient in two hospitals managed by different health authorities. The RMO initiated an IPR and the two independent assessors who conducted the IPR interview with the woman and her sister recommended that a further independent opinion be obtained. The woman complained to me, that among other things, the RMO refused to allow her direct access to the third assessor.

(a) W530/86-87,
W46/87-88 and
W161/87-88
on pages 48
of HC 393

21. I found that the original clinical complaint primarily concerned the specialties of neurology and psychiatry but it was also envisaged that an independent radiologist might be needed to interpret a CAT scan taken in a local x-ray department. The RMO told me that although he had foreseen that possibility it could also have been possible that the neurological assessor might have felt able to comment on the reading of the scan. In the event he had not been able to do so and a third IPR assessor then had to be obtained. I regarded this approach by the RMO as reasonable in itself; for although the guidance provided in the complaints procedure refers only to two second opinions it does not preclude more being used if necessary. However, I considered that the RMO should have allowed the woman to meet the third assessor. The RMO had not considered it necessary to do so because he believed that the third assessor's opinion related to one specific aspect, on which an unequivocal opinion might be expected one way or the other, and that this could be dealt with adequately by correspondence. Although I noted the reasoning behind his decision, I thought the RMO was mistaken for he had not taken account of the fundamental purpose of the IPR procedure, which is to attempt to resolve complaints by providing the complainant with independent expert opinions, the opportunity to meet all the independent assessors personally being an important part of the process. I was glad to learn that in any similar case the Regional Health Authority (RHA) concerned would now expect all the assessors to meet the complainant.

22. I turn now to two cases where excessive delays occurred. In the first a woman complained that she was not satisfied with the treatment she had received in an accident and emergency department. She met the consultant and an administrator but remained dissatisfied and so in March 1986 wrote to the RMO requesting an IPR of the diagnosis and treatment provided. Her letter was acknowledged late in the following month and at the same time the regional postgraduate dean (RPD), acting on behalf of the RMO, wrote to the District Health Authority (the DHA) seeking any relevant notes, a report from the consultant responsible for her care and confirmation that he was willing to co-operate in the IPR procedure. Apparently, neither the complainant nor the DHA received these letters. The Community Health Council (CHC) telephoned the RHA on the complainant's behalf in May, after which the complainant received her letter. In November 1986 she wrote again through the CHC to the RHA to enquire about progress and it was not until this letter was received that the RPD checked with the DHA about the previous request he had made in April. The woman finally received confirmation in

(b) W717/86-87
W235/87-88
on pages 71
of HC 103

March 1987 that the IPR would proceed. I severely criticised a system which allowed a letter seeking action and information from the DHA to go unmonitored for more than six months and which permitted another four months to elapse after the complainant had sought information about progress. I looked to the RHA to make it clear in future cases whether the responsibility for keeping complainants fully informed about the progress of their complaints rested with themselves or the relevant health authority.

(c) W11/87-88
W338/87-88
on pages 88
of HC 393

23. In another case in the same region a woman wrote in July 1985 to the RMO by way of her CHC to request an IPR of the circumstances surrounding the death of her four day old baby daughter. Her letter was acknowledged in August and she then heard in December that preliminary enquiries were continuing and she would hear in the near future about her request. Confirmation that an IPR was to be held was sent to her at the end of January 1986, six months after her request, and it took another five and a half months for the IPR to be arranged, even though she had been told in April who the independent consultants were to be. Although the IPR was held in July the complainant was told in October that it was hoped to have the independent consultants' report within the next month. It was not until January 1987, six months after the IPR had been held, that she received the report. I found it intolerable that the complainant, having suffered the tragic death of her baby, should have her ability to come to terms with such a tragic loss hampered by such serious maladministration on the part of those concerned with her complaint. I severely criticised the RHA for their failure to ensure that the complaint was properly handled, and the independent consultants for their part in delaying the issue of the report. I was pleased to report that a new monitoring system was introduced by the RHA in March 1988 and in this case and the previous one I looked to them to ensure that the unacceptable delays experienced by the complainants were not repeated.

24. The DHSS circular setting out the IPR procedure explains that it is not intended for cases which are likely to be the subject of more formal action either by the health authority or through the courts. The next case I have selected concerned action taken by an RMO to try to establish a complainant's intentions in this regard.

(d) W618/87-88
on pages 389
of HC 393

25. A man had attempted to pursue his grievance about the outcome of medical treatment by way of legal action, and when his efforts by that course failed he asked for his case to be the subject of an IPR. He was then asked to sign a 'Form of Compromise' guaranteeing that he would not take legal action. He complained that the use of the form was most unfair and that by introducing it the RHA had blocked his attempts to obtain information about his case.

26. I upheld the complaint that the use of the form had been unfair. I found that the RHA's legal adviser, who suspected that the man saw the IPR as a way of obtaining a second medical opinion which might enable him to continue his legal action, had advised that the risk of the man pursuing his case through the courts was such that a legally enforceable 'Form of Compromise' should be signed by him to remove any possibility of such future action. I considered that while the RMO, in reaching a decision on whether or not an IPR was appropriate, had to make a judgment as to whether or not the man was likely to pursue the matter by legal proceedings, the use of the 'Form of Compromise' to test the man's intentions went much too far and was altogether inappropriate. This view was supported by the Department of Health who said: 'We do not sanction or approve the use of such forms'. However I did not uphold the complaint that the introduction of the form, which the man had refused to sign, had denied him access to information about his case, because I found that there were several other grounds which led the RMO to his view that an IPR was not appropriate.

(e) C63/86; &
WW23/85-86
on pages 451
of HC 393

27. In a Welsh case, I was not disposed to criticise the line taken by two independent consultants who withdrew from an IPR and refused to give their reasons for doing so, and I did not uphold a complaint that a Medical Officer for complaints (the MO(C)) (who in Wales performs the functions of an RMO in relation to clinical complaints) failed to establish and to tell the complainant those reasons. A woman had been admitted to hospital as an emergency after sustaining bruising and ingesting a quantity of paracetamol. She was discharged the next day but died at her home two days later. Her husband was dissatisfied with the responses he received from the DHA about his wife's treatment and his complaint was referred to the MO(C) who offered him an IPR of her treatment. The evidence showed that the Authority considered that the complaint might lead to legal action but they had never been able to obtain a complete assurance from the husband that he did not intend to litigate and he had changed his mind from time to time. One of the independent consultants told me that when he studied the woman's medical notes he had come to the conclusion that the IPR was

not appropriate because it seemed to him that the woman's husband was very likely to go to litigation. He took the view that he was precluded from continuing with the IPR because the Welsh Office guidance specified that the IPR was intended to deal with complaints of a substantial nature which are not prima facie likely to be the subject of more formal action through the courts. I was conscious of the difficult decision the MO(C) had had to make and I found that he had decided to institute an IPR but with what was in effect a warning to the independent consultants that, if they were disposed to regard the treatment as having been negligent, they should consider terminating the IPR. I saw no reason to take issue with the MO(C)'s approach. I was satisfied that the woman's husband realised that the independent consultants had withdrawn because they thought his wife's treatment had been negligent and that the case was suitable for litigation. The husband then tried to find exactly what it was which had led the independent consultants to their view, but I thought he was going too far when he sought, in effect, precise particulars of the negligence which the independent consultants had identified.

28. Finally in this Section I deal with a case where a man complained that he had been offered an IPR only to be informed, approximately three months later, that it could not proceed.

(f) W98/88-89
on pages 421
of HC 393

29. The man had asked an RMO to institute an IPR to look into his complaint about the decision of a consultant plastic surgeon not to perform surgery on his nose. The RMO had agreed to offer an IPR but the complainant had subsequently been informed that it was not possible to proceed with it because the Joint Consultants Committee (JCC), whose role under the procedure is to nominate the two independent consultants, considered that the complaint was not appropriate for an IPR.

30. The complainant asserted that if his complaint was appropriate for the clinical complaints procedure the RMO should have secured an IPR for him or alternatively, if it was not, the RMO should not have led him to believe that an IPR would be held in his case. I found that as far as the RMO was concerned he had made his decision to offer an IPR in good faith and in accordance with the established criteria. However, both the chairman of the JCC and the president of the Royal College of Surgeons of England regarded the IPR machinery as inappropriate in the case of a patient who was reluctant to accept a clinical assessment.

31. Because I myself believed that the DHSS circular setting out the clinical complaints procedure granted RMOs the sole discretion to decide whether or not to institute an IPR, I pursued the matter with the chairman and the president. The latter was concerned about the number of requests for assessors for complaints which appeared to him to be trivial but he agreed that he should have nominated an assessor in this case. He also accepted that the circular made it clear that the RMO alone could decide whether or not to institute an IPR.

32. The chairman said there were cases which RMOs had referred to the JCC which were obviously outside the terms of the circular. I agreed with him that where cases, such as questions relating to private practice and insurance reports, manifestly fell outside what is specifically a procedure for complaints about the clinical practice of NHS doctors and dentists it was reasonable for the JCC to point that out and to decline to operate the procedure. But when I pointed out my belief that only the RMO had the discretion to institute, or not, an IPR, the chairman agreed to seek independent consultants to carry out the review. I regarded this as a full remedy for the complainant and I concluded, so far as the RMO was concerned, that it was through no fault on his part that the review had not preceded as he had intended.

(ii) Observation and supervision of patients

33. When patients are put in the care of a hospital the expectations are that all reasonable steps will be taken to save them from harm. It is understandable therefore that where, due to apparent failures in supervision or observation, patients die or suffer injuries from which they later die questions may be asked about the care provided. I have selected five such cases, in three of which patients were able to take actions which led to their deaths.

34. In the first case a 27 year old man was readmitted to a hospital as an informal patient following a suicide attempt. Five days later he left the hospital without permission and travelled to his previous place of employment where he jumped to his death from the roof of the building. His mother complained to me that among other

(g) W114/87-88
on pages 137-156
of HC 103

things, the hospital had failed to provide adequate supervision for her son and that on the morning of his death his absence had gone unnoticed by the staff for about an hour.

35. A charge nurse (CN) who was responsible for the ward that morning said he could not recall any discussion with a doctor as to the level of supervision the man required and that he had instructed all the nurses to 'keep an eye' on him. He also could not remember whether the man's supervision had been allocated to a particular nurse, but he explained that all the staff were present for the ward report and would therefore have known about each patient. Although the CN, and the other staff who were on duty, maintained that the man was seen shortly before 8.55 am, when his absence was first noticed, I found the evidence on that issue imperfect and conflicting and on the balance of probabilities I believed that he had left the ward at around 8.20 am. Furthermore, I found that his absence was not noticed as quickly as ideally it should have been and to that extent I upheld this complaint. I commented that while I knew, from other cases, how difficult it was to prevent a patient who was intent on leaving a hospital from doing so, health authorities had a duty to protect patients who were known to have suicidal tendencies, and in this case I was concerned that it had proved all too easy for the man to leave the ward due, I suspected, to a combination of its layout and the number of exits, and the level of observation which was given.

36. The DHA apologised to the mother for the shortcomings I identified and as a consequence of my recommendations agreed to establish a monitoring system for patients with a tendency to suicide or self-harm and to adjust the existing arrangements for the management of such patients as circumstances dictate. They also moved the ward to what they considered was more appropriate accommodation for this type of patient.

(h) W515/87-88
on pages 321
of HC 393

37. The second case concerned a man with a history of schizophrenic illness. One day when he became agitated and disturbed his brother took him to a hospital where he had previously been treated. Later the same morning the brother telephoned the ward and was told that everything was under control but the same afternoon the man jumped out of a window and died as a result of the injuries he sustained. His brother complained that communication between medical and nursing staff had been unsatisfactory and that the level of nursing supervision had been inadequate, especially as it was known that the man had a history of jumping from windows.

38. My investigation revealed that considerable time had been spent that morning considering how best to care for the man, that his history of self-harm had been discussed and that his consultant had emphasised the degree of risk he presented. Consequently I did not uphold the complaint that communication between medical and nursing staff had been at fault. I learned that the consultant had asked for the man to be supervised discreetly and that he had decided that the enforced administration of drugs should be avoided if at all possible. I could not question these decisions because, in my opinion, they were taken solely in consequence of the exercise of clinical judgment. I found that additional nursing staff had been allocated to the ward and that two staff nurses had been responsible for the man's supervision. I also found that although he had exhibited threatening behaviour to staff and aggression towards property during the morning, he had asked for and had been given medication during the early part of the afternoon and I saw no grounds to criticise the way he had been supervised at that stage. However, my investigation showed that the man had damaged a window in his room and that when one of the staff nurses checked it the entire frame fell to the ground below. The staff nurse had then left the man in the room while he went to arrange for the window to be repaired and for the man to be transferred to another room. Although the staff nurse was away from the room for only a short time the man was able to jump from the window and died as a result.

39. The staff nurse maintained that while the man often tampered with or broke windows he had not always jumped from them and that at the relevant time he had appeared to be calm. Moreover, the staff nurse had believed that the medication the man had been given, which normally had a strong sedative effect, would by then have taken effect. I did not accept that the staff nurse's actions had been taken solely in the exercise of clinical judgment and I concluded that he had made an error of judgment in leaving the man, despite his history of having jumped previously from windows, without professional supervision after the window had fallen out. I therefore upheld the complaint and the DHA readily agreed to apologise to the man's family. I was pleased to record that they had also taken steps to provide a more secure and safer environment in which patients at risk could be nursed.

40. I investigated another distressing case in which an elderly mentally ill woman was found to be missing from the psychiatric ward on which she had been an informal patient for several months. A search was made by hospital staff and both her husband and the police were informed of her disappearance. Her body was found three days later in a maintenance tunnel beneath the hospital, where building contractors had been working for some time prior to her disappearance. The entrance to the tunnel through which the woman had most likely entered was found to have a broken hasp and a staple. Her son and daughter-in-law complained to me that the staff had failed both to prevent the woman from leaving the ward and entering the tunnel and to conduct a thorough search of the hospital when she was found to be missing.

(i) W498/87-88
on pages 302
of HC 393

41. I observed that health authorities face considerable difficulties in balancing the need to protect patients without restricting their freedom, particularly when they are informal patients and not subject to legal detention. I was unable to discover how the woman had left the ward but in upholding the complaint about the woman gaining access to the tunnel, I expressed my surprise, given the DHA's policy of free access for patients, that the insecure door had been overlooked by those responsible. I found that the DHA's duty of care to their patients required them to provide a safe environment but in the woman's case they had failed demonstrably to do so. I did not criticise the adequacy of the search except that I would have expected an early check to be made to ensure that all the places in the hospital which should have been locked were in fact locked, for had that been done earlier, and the significance of the broken hasp and staple been appreciated, greater attention might have been given to the possibility of the tunnel concealing the woman's body.

42. The next two cases illustrate a lack of observation and supervision on wards which ended tragically. In the first a family practitioner (FP) telephoned a hospital seeking the urgent admission of a woman whom he had diagnosed as lapsing into a diabetic pre-coma but, although a hospital doctor agreed to admit her, the information about her was not recorded. The sister in charge of the ward was informed that a patient was to be admitted but somehow gained the 'vague impression' that the patient had suffered a stroke. Another nurse on the ward understood this to be the provisional diagnosis and no special arrangements were made in preparation for her arrival. I was told that the nursing care requirements of a patient in a diabetic coma are markedly different from, and more urgent than, those of a stroke patient. The woman was taken to the ward by an ambulance crew but the ward nursing staff failed to check the FP's handwritten referral letter, which included his diagnosis. The woman had arrived in the middle of the day at 'handover' time when there were nine nurses on duty, but no one nurse was allocated to, or assumed responsibility for, her when she arrived. Furthermore, there were four doctors on the ward at the time of her admission but they all left without being told that the expected emergency admission had arrived. Thus, for about an hour, the nurses failed to monitor and record the woman's condition or to ensure that prompt medical attention was afforded her, even though she had been admitted as an emergency. When a staff nurse eventually went to take her history she learned from the family - the woman having become unconscious - that she was diabetic. The staff nurse then tested her blood sugar and finding it high contacted a doctor. But the doctor was at lunch and the call did not precipitate immediate action as the urgency of the situation was still not recognised. After finishing her lunch the doctor attended the woman but she collapsed and died about an hour later.

(j) W240/87-88
on pages 163
of HC 393

43. I criticised the doctor who agreed to admit the patient for failing to record the information he had received and to convey it accurately to the nursing staff concerned. But the failures of the nursing staff on the patient's arrival and subsequently to ensure that medical staff attended the patient promptly were equally the subject of my criticism. The nurses were also at fault in not opening the FP's referral letter which had been available from the time the woman arrived. Sadly neither the nursing nor the clinical staff displayed a sufficient sense of urgency in dealing with the condition of this unfortunate woman and the consultant expressed the view that, if the seriousness of her condition had been recognised and treatment started immediately she was admitted, she might not have had the heart attack which caused her death. Consequently I could not exclude the possibility that had it not been for the failures which I identified the outcome might have been different.

44. In the second case a baby aged nearly eight weeks died in hospital at 8.10 pm after being admitted earlier that day with a respiratory infection which was thought to be bronchiolitis. Her parents complained to me about various matters, in particular that when a student nurse who had been allocated to look after their daughter had been occupied elsewhere at 8.00 pm other staff were not instructed to care for her.

(k) W6/87-88
on pages 78-94
of HC 103

45. I found that there had been a requirement for the baby to be observed at two hourly intervals and that such observations had been due at 6.00 pm and 8.00 pm. The student nurse said that at about 7.05 pm she had reported to the ward sister that the baby was crying but that the sister had told her to go for her meal-break and to feed the baby upon her return. The student nurse explained, however, that when she finished her break at 7.35 pm she went instead to another patient who had vomited and it had taken longer than expected to deal with him. She had then gone to observe the baby shortly before 8.10 pm but had found her unconscious. The student nurse considered that a ten minute delay in the observation had been reasonable and she had not notified the sister because, apparently, it was usual for observations to be completed a little before or after the appointed time. Both the sister and the district nursing adviser (DNA) in their professional judgment supported the student nurse's actions, and in the circumstances I did not criticise her or find the complaint made out.

46. However I shared the DNA's view that the sister's deployment of the staff at the time in question was not satisfactory and that he would have expected the baby to be observed between 7.05 pm and 8.10 pm. Bearing in mind her condition on admission and that her distress had been reported to the sister at 7.05 pm, I found it disturbing that she had then been left without any specific arrangement being made for her observation other than the possibility of being seen by chance by other staff from the corridor through the observation window of her cubicle. The DHA apologised to the parents for the shortcomings I found and in accordance with my recommendations they issued guidelines on the placement of staff and supervision on the ward to try and prevent a recurrence of this most unfortunate event.

(iii) Communication with patients and relatives

(l) W219/87-88
on pages 122
of HC 393

47. In this section I deal with the outcome of six investigations where failures in communication by hospital staff with patients or their relatives caused unnecessary additional distress. The first case involved my investigation into an allegation that a hospital had failed to inform a woman that she had cancer when it was first diagnosed. A consultant surgeon operated on the woman and diagnosed cancer. He remembered telling her shortly afterwards that she had a malignant tumour, the source of which was unknown, and he believed that it had been 'absolutely reasonable' for her to have deduced from that and other things he had said she had cancer. He added that it was not his practice to use the term 'cancer' when, in his view, the diagnosis of malignancy had been understood by a patient. The DHA's view was that the woman would not or could not take on board the explanation she had been given. However I found that the evidence, taken as a whole, raised doubt as to whether in fact the woman had really understood what she had been told; and it suggested that despite her intelligence she might not have connected malignancy with cancer or have recognised the implications of chemotherapy and radiotherapy. The woman's sister complained to me that it was not until over three months later when a doctor explained to her that she had cancer - and specifically used that word - that the woman realised the nature of her condition. She died several months later.

48. It seemed to me that, whatever the true explanation, the woman's difficulties should have been identified and appropriate action taken to help her by means of further explanations or counselling, perhaps with the involvement of her family. And to that extent I upheld the complaint. I also noted that the consultant's failure to record that he had told the woman of her prognosis led to false assumptions on this issue by other consultants also involved in her care; and I drew attention to the fact that the nursing staff had been aware of the woman's uncertainty about her medical condition following the operation. The DHA apologised and in line with my recommendations they agreed to remind their medical staff that they should record at the time a condition is confirmed whether or not a patient has been told of a prognosis, and to remind their nursing staff that a patient's lack of understanding of their condition should be brought to the attention of doctors.

(m) SW19/87-88
on pages 305-317
of HC 103

49. An example of poor communication between hospital staff and relatives occurred in a case where it was found during surgery that a man was suffering from a terminal condition. The surgery was for removal of a growth in his bowel and in the course of it the consultant surgeon found liver metastases which would inevitably prove fatal within three years. The man's relatives complained that they had been given no indication that he was suffering from this condition. They said that when they enquired repeatedly of the nursing staff they were assured that the growth in the bowel had been removed, that the operation had gone well and that the man was fine. Only after the man was re-admitted to hospital nearly nine months later were they told that he was

dying, and he died one month later.

50. The surgeon took the view that it was for the relatives to ask to speak to him if they required information and that had they done so he would have given it willingly. No doubt in many cases relatives will recognise when there is a need to seek further information but in this case they had been unaware of the limitations on the information the nurses could give them. As a result they accepted the reassurances they had been given about the man's condition, failing to appreciate that further information was available from the medical staff. I did not believe that the relatives had been positively encouraged to see the surgeon and in the circumstances I considered they were justified in feeling let down by the hospital staff.

51. In another case concerning poor communication I upheld a complaint that a man had been left unaware that his wife had developed a pressure sore while in hospital and that he had found out about the sore only when he saw it for himself after his wife's discharge.

(n) SW79/86-87
on pages 270-284
of HC 103

52. I found that although the ward staff had thought the man had been aware of the sore nothing positive had been done to bring it to his attention. As it was known that when the woman went home she would be cared for primarily by her husband, it seemed to me that the hospital staff should have ensured that he was made aware of anything which could affect her care, including information about her pressure sore. The Health Board agreed to remind their nursing staff of the importance of providing full information to relatives in such circumstances.

53. Another case involved failures in communication with both a patient and her relatives. A woman suffering from diverticulitis and a narrowing in the bowel was referred to a hospital by her FP. She underwent a number of investigations as an out-patient and was admitted to the hospital to have fluid drained from her abdomen. She was discharged home and was later told by the FP that she had terminal cancer. The woman's son complained that hospital staff had led his mother and her family to believe that she was suffering only from diverticulitis whereas, he later learned, an ultrasound scan carried out prior to her admission had shown she was suffering from a malignant disease. The woman had told her family that a hospital doctor had informed her, after carrying out a procedure, that he was almost certain she did not have cancer but that he intended referring her for a scan to be absolutely sure. I found that the doctor had suspected a malignancy after carrying out the procedure and that he had decided to refer the woman for a scan to provide further information about the location of the tumour. But I found no evidence to suggest that he had made the second part of the statement attributed to him. I established that the woman had been seen by a consultant after the results of the scan were known and that he too had been fairly sure that she had cancer. Although I believed the consultant could have informed the woman of the diagnosis at that stage I found it was his wish to lead up gently to the disclosure that she was suffering from a serious illness and that he had decided this would be best achieved while she was an in-patient at the hospital. I could not comment on this decision since in my opinion it was made solely in the exercise of his clinical judgment.

(o) W249/87-88
on pages 190
of HC 393

54. I found it was the consultant's policy to make his patients aware of their diagnoses by the time they left the hospital but the consultant himself had gone on leave immediately after the woman's admission and neither of the doctors who attended the woman in his absence had discussed the diagnosis with her because they had assumed that the consultant had done so prior to her admission. They had been unable to check with him about what the woman had been told of her illness and although I did not believe that she had been deliberately led to believe that she was suffering only from diverticulitis, I found that there had been a breakdown in communication between the medical staff which resulted in her being discharged from the hospital without having been informed of her full diagnosis: to that extent I upheld the complaint. I also criticised the nursing staff for failing to discover the extent of the woman's knowledge of her condition. I was pleased to report that the consultant had introduced a procedure to ensure that a record is in future made when a patient is told of his or her diagnosis. The DHA apologised unreservedly for the shortcomings I identified.

55. In a further case a man complained to me that he had neither been given an indication of the seriousness of his wife's condition nor been informed that she was undergoing liver tests. His wife had suffered from a liver condition for some years for which she took a special diet, and her mental health was poor. She took an overdose and was admitted to the intensive therapy unit of an acute hospital. A few weeks later she was transferred to a hospital for mental illness but after ten days she was returned to

(p) W382/87-88
W418/87-88
on pages 230
of HC 103

the first hospital where she died three weeks later.

56. I found in this case - as in so many others that I see - that the staff had made the mistake of expecting too much knowledge and understanding from a layperson. The staff at the acute hospital had been well aware of the patient's poor condition and progress and had assumed that her husband, too, had realised its implications. I did not doubt that the staff had talked to the man about his wife's condition but I did not believe that they had taken sufficient care to ensure that he understood the situation fully. The man told me that because of the lack of any indication of how long his wife had to live, he had not summoned his children from abroad and I considered it clear that this showed he had not fully appreciated how critical his wife's condition was. I criticised the inadequacy of an explanation given to him about his wife's liver tests. His wife had declined offers of a liver biopsy on several occasions and he told me he was not informed that liver tests were being taken, nor was he told of their results. A senior house officer told me that he had discussed the nature of the tests with the complainant, but I considered, particularly in view of his wife's serious condition, that the staff should have taken the initiative in explaining to him what was being done and whether or not the tests were regarded as routine.

(q) W236/87-88
on pages 137
of HC 393

57. The final case in this category concerns an elderly man who was admitted to hospital and died there about two weeks later. His niece, who lived some 300 miles from the hospital and who had been named as his next-of-kin, complained that she had not been informed of his admission, that nursing staff were offhand with her when she telephoned and were reluctant to discuss her uncle's condition, and that the consultant in charge of his care did not return her telephone call. She also complained that the information about her uncle's condition she had been given by hospital staff seemed to be at odds with information she was given by one of his friends.

58. Although a ward sister had recorded that an enrolled nurse had informed the man's relatives of his admission some ten hours after the event, the enrolled nurse denied that she had done so. I concluded that no one had been informed that the man had been admitted to hospital and I found it unsatisfactory that efforts had not been made to contact his niece or someone else on his behalf as soon as possible after his admission. I found that the nursing staff were reluctant to discuss a patient's condition in any detail over the telephone and while I was able to understand that attitude in normal circumstances I concluded that special circumstances obtained in the case, given the distance the niece lived from the hospital. I believed that special arrangements should have been made and I upheld the complaint. I found that the niece had telephoned the hospital to speak to the consultant but had been told that he was busy and would return her call when he was available. Her call was not returned but I accepted that the consultant had not received the message that she had telephoned. I concluded that a failure in communication had occurred and upheld the complaint. I found that a senior house officer was of the opinion that the man's condition was stable and that there was no pressing need for his niece to come to the hospital, but I accepted that his opinion had been formed solely in the exercise of his clinical judgment and I did not comment on it. Although the man's niece had been told by nursing staff that all was well and that her uncle was improving, a friend told the complainant that he was extremely concerned about her uncle's condition. Nevertheless I saw that the friend had not been moved to seek medical or nursing help. Even though the man subsequently died I found no evidence to suggest that hospital staff sought to mislead the complainant about her uncle's condition and I did not uphold the complaint. The DHA apologised for the shortcomings I identified and issued guidance to nursing staff about dealing with enquiries from patients' relatives.

(iv) Handling of complaints

59. The complaints I investigated during the year included 92 allegations of maladministration by health authorities in the way they handled complaints. I upheld some 70% and include here four examples of these concerning failures in liaison between authorities, inadequate investigations, delay and inadequate procedures.

(r) WW32/86-87
WW14/87-88
on pages 338
of HC 103

60. I investigated two cases, each involving two health authorities, where problems of liaison between authorities was a feature. The first concerned an elderly woman who was transferred by ambulance from a hospital managed by one DHA, where she had had a cardiac pacemaker inserted, to a second hospital managed by an adjacent DHA. The essence of the complaint was a serious allegation that the woman's ankle had been fractured while in the care of one or other of the DHAs, but her son and daughter-in-law also complained that both the investigation by both DHAs had been inadequate. I

upheld this complaint in part. I was surprised to learn that the first DHA had made no attempt to establish the clinical facts of the woman's injury and I criticised them for their lack of close consultation with the second DHA who were caring for the woman at the time of their investigation. As to the second DHA's involvement, I was satisfied that individual staff had tried hard to satisfy the complainants and had arranged two meetings with them, but I concluded that this DHA's investigations had not been extensive enough to provide the complainants with the explanation to which they were entitled. I considered that both DHAs should have co-operated more positively and efficiently so as to reassure the complainants that their complaint had been thoroughly investigated.

61. I have already referred at (p) to a case which concerned, inter alia, the information a man was given about the seriousness of his wife's condition. In commenting on the handling of the case, I said that I had seen few cases more ineptly handled and I severely criticised both DHAs involved. My investigation revealed that the first DHA had mislaid the original letter of complaint and I criticised them for failing to have an adequate procedure for monitoring the progress of a complaint. Once the letter was found and the complaint was revived, I found that both DHAs failed to deal with it adequately and within a reasonable time and that they failed to communicate with each other to provide a coherent response. I remarked upon the persistence of a CHC secretary who performed the role of coordinator between the two DHAs and who on occasions had copied letters from one to the other in order to provoke a co-ordinated response to the points that the complainant was raising. I found also that despite specific requests from the secretary both DHAs failed to arrange a meeting with the woman's husband to discuss the care of his wife. I was glad at least to know that both district general managers concerned subsequently took a positive approach and I was assured that both DHAs would review their procedure for coordinating the handling of complaints in which more than one health authority was involved.

62. In another case which I have mentioned earlier in this chapter (i) where a woman's body was found in a maintenance tunnel, the complainants alleged that the DHA had not conducted an adequate enquiry into the matter and they complained about the DHA's responses to their complaint. I found it a matter for concern, given the serious nature of the case and the unusual circumstances of the woman's death, that the DHA had not instituted a more thorough and co-ordinated enquiry not only at a higher level but perhaps involving one or more of its members. The patient's relatives had expected some such enquiry and had asked about a report which they had been promised, but it took the DHA some time to tell them no such report existed. By then, of course, and given the initial promise which had been made, the relatives were understandably reluctant to accept this explanation. I also criticised the accuracy and adequacy of the DHA's responses and found the way in which this serious complaint had been handled very disturbing. There had been no formal complaints procedure in operation in the DHA at the time of the complaint, but one had been introduced by the time my investigation started and I expressed the hope that its implementation would improve the handling of complaints in the future.

63. Finally in this section I refer to a case in which I found maladministration in the way in which a DHA had handled a woman's complaint. With the assistance of her CHC, the woman wrote to the DHA complaining about her antenatal care and certain events concerning the birth of her baby at a hospital. My investigation revealed that the hospital's unit general manager (the UGM), on receipt of the letter, had decided to seek the views of the consultant involved, but had believed, erroneously, that he was on leave at the time. The file was put to one side and then overlooked and even though the woman sent a reminder letter that too 'vanished'. It was not until the woman's Member of Parliament intervened that the complaint received further attention and a substantive reply was eventually sent. By that time four months had elapsed since the original complaint and it seemed to me that the overall delay had been caused by an ill defined system for dealing with complaints and general laxity. I also found that during part of this period the UGM had failed to return a number of telephone calls from the CHC secretary about progress and that at one stage his secretary had either advised the CHC or given them the very strong impression that the DHA had no knowledge of the complaint.

(s) W446/87-88
on pages 250-260
of HC 103

64. The woman also complained that although the DHA sent copies of their final reply to her, to the Member and to the CHC secretary, she herself had not been sent a copy of an earlier letter which the DHA had written to the Member in response to his progress enquiry. I noted that this response had contained medical details of her case. However, the Member had merely been trying to help the woman by stirring up the DHA and he

had not been acting as her agent in putting her complaint. I saw no reason, therefore, why the information sent to the Member should not have been given to the woman and I expressed concern that confidential medical information had been given to a third party without the woman's express permission.

65. The DHA, who had since taken steps to improve their handling and monitoring of complaints apologised to the woman for the shortcomings I had identified.

(v) Family Practitioner Committees

66. As in previous years I have investigated a number of complaints alleging maladministration by family practitioner committees and I have chosen four cases to illustrate these. The first two concern grievances by pharmacists about payments due to them and the last two cases refer to the actions of family practitioner committee administrators in their informal handling of complaints arising from general medical services.

(t) W141/87-88
on pages 167
of HC 103

67. In the first case the managing director of a pharmacy applied to be included in the Essential Small Pharmacy Scheme but was informed that his application could not be processed as the introduction of the new pharmaceutical contract was the subject of an industrial dispute by the FPC's administrator. When he protested he was told that he would be given advances based on his entitlement to payments in the previous year. He asked for payment to be made in full and was told first, that his request would be submitted to the FPC chairman and later, that the matter would be put before the FPC at their next meeting. However it was not until the industrial dispute was settled that all moneys due to the company were paid. I found that temporarily the income of the company was significantly reduced because of the FPC's failure to pay the man in full the amount to which he had been entitled and on the due dates and that the FPC failed to make themselves fully aware of the possible consequences of the industrial dispute. And while I commended the chairman, who had been left to monitor events, for the attempts he had made to help the man I criticised him for failing to seek advice from the then Department of Health and Social Security and for his failure to report the matter to the FPC. Despite these shortcomings, however, I concluded that, given the industrial action by the administrator, the FPC's failure to make payment at the correct rate on the due dates had not amounted to maladministration and I did not uphold the complaint. The FPC apologised for the shortcomings I identified and with regard to the complainant's loss agreed, subject to DHSS approval, to reimburse him any additional bank charges he had incurred as a result of the delay in making the correct payments to him. I refer to this remedy in Chapter 5.

(u) W656/87-88
on pages 409
of HC 393

68. In the other case involving payments, a pharmacist experienced delays in the payment of his basic practice allowance and rota fees and was moved to complain to me when a substantial month-end payment for prescriptions failed to reach the pharmacy's bank account on the due date resulting in a loss of bank interest. I discovered that the reference number entered for the pharmacy on the payment schedule sent to the FPC's bank was invalid and that the moneys due to the pharmacy had found their way to the account of another pharmacy. I was unable to establish whether the FPC's bank had paid the money to the wrong account as a result of information given to them subsequently by the FPC or whether they themselves had selected the incorrect account from a master list of numbers. But I found that the FPC had held the correct reference number for the pharmacy when the payment schedule was produced and I concluded that the error would not have occurred if the schedule had been checked before it was sent to the bank.

69. The FPC had not regarded themselves as accountable for the bank's error but I took the view that it had been their responsibility to pay the pharmacy and not just to arrange for the pharmacy to be paid; moreover they had had the information needed to ensure that payment reached the pharmacy's account on the due date. I therefore upheld the complaint. The FPC apologised for the shortcomings I identified and agreed to consider making an *ex gratia* payment of the amount of interest lost by the pharmacy. This remedy, also, is referred to in Chapter 5.

(v) SW63/87-88
on pages 443
of HC 393

70. In a case involving the handling of a complaint a man had to wait well over 16 months for a substantive response from a Health Board (HB) about his father's treatment by family practitioners. This case highlighted the dangers inherent in any procedure where someone is left to work unsupervised and without any proper system to monitor the progress of his work.

71. The administrator dealing with the matter on the HB's behalf initially failed to explain to the man either the possibility of dealing with his complaint informally or that for it to be considered under the formal procedure he was required to explain why his complaint had been made outside the statutory time limit. This led to misunderstandings on the man's part which were not cleared up until 16 months later. The administrator also failed to take any action in respect of the complaint until the man visited the HB's offices almost a year after the initial complaint, when he undertook to interview the family practitioners involved. The administrator then found he needed more information before he could reply fully but he took no further action until after the man had involved the HB's chief administrator. Even then it took a further four months before a response was sent.

72. I considered that the administrator's performance in this matter was lamentable and I also criticised the chief administrator for failing to ensure that a response was expedited after he became involved. I was surprised that the HB had no procedure for monitoring the progress of the handling of primary care complaints and the HB agreed as a matter of urgency to establish such a procedure. They also agreed to remind officers dealing with these complaints of their duty to give full and helpful advice.

73. In the final case in this chapter I found that a FPC had failed to provide a complainant with adequate help to enable him to identify an FP against whom he wished to make a formal complaint.

(w) W243/87-88
on pages 219-230
of HC 103

74. The man had complained not only about the actions of his own family practitioner (the first FP) but also about a doctor deputising for her (the second FP) in connection with certain advice the latter had supplied to him over the telephone. Acting on the instructions of the chairman of the medical services committee (MSC), the FPC's administrator asked the first FP for the second FP's identity, but she responded that, although it would have been an FP principal in the practice, without knowing the exact date of the telephone call in question she could not assist further. The administrator therefore approached the man for this information and when he wrote confirming that he could not remember, the administrator merely sent the first FP a copy of this reply. The complaint against the first FP was heard by the MSC, but that against the second FP was not considered because he had not been identified. The administrator subsequently advised the man that it would be necessary for him to supply the date of the telephone call so that the second FP could be identified. Accordingly the man, of his own initiative, wrote to the doctors of the group practice concerned, with the exception of the first FP, and this led to the second FP revealing his identity to the FPC. By that time nearly a year had elapsed since the original complaint.

75. During my investigation the FPC maintained that the onus had been on the first FP to identify her deputy. In the light of this, and bearing in mind that the first FP was under contract with the FPC, I believed that the FPC could have been expected to press her about her responsibility in this regard. Furthermore, I noted that the man had referred to certain records which might have assisted in the identification of the second FP, and I felt that the administrator could also have been expected to take this up with the first FP. I pointed out that under DHSS guidelines the responsibility for giving advice and assistance to complainants rested with the FPC and their staff rather than with the MSC; and to the extent to which the administrator had believed that by simply following the MSC's instructions he had discharged the FPC's responsibility, I considered that he had taken too narrow a view of the FPC's role. I also criticised the administrator for not making it clear to the man at a much earlier stage that his complaint against the second FP would not form part of the original MSC hearing because his identity was not known.

(x) W252/87-88
on pages 222
of HC 393

76. I have investigated several cases previously about the use of benefits for mentally handicapped people, often in connection with the provision of clothing. The first case in this chapter concerns the use of mobility allowance. The mother of a woman who had been a hospital in-patient for 28 years complained that the DHA had failed to provide necessary clothing for her daughter as a result of which she and her husband had had to provide clothing which had caused them considerable financial hardship, particularly since her husband had been made redundant some eight years previously.

77. I found that, because the woman received her daughter's mobility allowance, there was some feeling among the hospital staff that she ought to contribute towards her daughter's clothing purchases. However the woman had used the mobility allowance for what was a perfectly proper purpose, the purchase of a car which was used to take her daughter on outings and visits home. It seemed to me that as the mobility allowance was used in full for this purpose, the daughter, who had no other income of consequence, came into the category of a patient who could not afford to purchase her own clothing and for whom therefore the DHA had the responsibility of providing clothing. I thought that the mother's protestations of financial hardship had gone largely unheeded and that the DHA had expected her to provide the clothing and had failed to give due consideration to their own responsibilities. As a result of my investigation the DHA reviewed the clothing needs of the patients at the hospital.

(y) SW11/87-88
on pages 284-287
of HC 103

78. Another case demonstrates the difficulties faced by the Scottish Ambulance Service in manning ambulances in remote areas. A man collapsed while visiting a remote village and was taken by ambulance to the nearest general hospital where he died later that day. His wife complained that the ambulance, which was single manned, had been inadequately staffed. She said that during the journey she had had to tend to her husband, who was being sick, in order to ensure that he did not choke, and that the ambulance driver had had to stop the vehicle to look at her husband. She felt that too much had been expected of one man in such circumstances.

79. I found that the ambulance service at the village in question consisted of one ambulance and two members of staff who provided 24 hour cover each day on a shared basis involving standby duties. It was inevitable with those staffing arrangements that at times the ambulance could only be single manned. However the director and staff of the Scottish Ambulance Service shared fully the woman's view that it was unsuitable for accident and emergency vehicles to have a one man crew, and I found that for many years the service had been making efforts to reduce the incidence of single manning. Unfortunately this had been a slow process due to the calls on the limited funds available to meet the growth in other demands on the service. I commended the director for a development programme he had set in motion, which, provided he can obtain the necessary level of funding, should eliminate single manning within the next few years.

(z) SW25/87-88
on pages 328-338
of HC 103

80. I turn now to a case where a woman was caused embarrassment and offence by the attitude and behaviour of a consultant at her first hospital ante-natal appointment. The woman complained that the consultant had not obtained her prior agreement to the presence of medical students at the examination and that he had not introduced himself or spoken to her directly but had merely pushed her into position for the examination and had made remarks about her to the students which she had found both personal and sexist.

81. The consultant took the view that when a patient attended a teaching hospital it should be self-evident that medical students would be present and accordingly he did not normally ask a patient if she objected to their presence. However I considered that the consultant had made too sweeping assumptions in this respect as I found nothing which would have forewarned the woman that she was attending a teaching hospital or that students might be present. I upheld the complaint about the lack of consultation about the presence of medical students and I criticised the HB for failing to provide a satisfactory system to ensure both that patients were aware that they might be involved

in teaching procedures and that their consent to this was obtained. I noted however that as a result of this complaint the HB had reminded consultants of their responsibilities in this respect and were reviewing the wording of their appointment cards.

82. The consultant could not recall the appointment with the woman, but, while he acknowledged that he did not routinely introduce himself to patients, he denied that he would have failed to speak to the woman directly, that he would have pushed her into position, or that he would have made sarcastic or facetious remarks. I did not believe that the consultant had at no time spoken to the woman directly, but the evidence of other members of staff suggested that he had a habit of 'speaking to' patients through third parties while intending the patient to be the recipient of his words. I could see how this approach might have left the woman feeling ignored. I felt that there probably were occasions during the examination when the consultant moved the woman's legs into position rather than asking her to do so herself. From the evidence of others as to the consultant's normal approach I believed that he did make remarks to which the woman took offence and, although I accepted that the remarks were not meant unkindly or with the intention of offending, unfortunately that was their effect. I criticised the consultant for his failure to be sensitive to the need to modify his approach and manner towards some patients.

83. Another case involved a disagreement between a FP, who was the complainant, and hospital doctors as to whose responsibility it was to prescribe a fertility enhancing drug for a male out-patient attending a special clinic. A clinical assistant (CA) at the hospital told the patient, whom he had been treating, that he should try the drug which would be prescribed by the FP. However following correspondence with the hospital, the FP complained to me that the CA's intentions had been contrary to DHSS guidelines in that, as at the material time he had clinical responsibility for the patient's treatment, it had been his duty, and not hers, to prescribe the drug initially. She also complained that as she had no knowledge of the use of this drug for male patients and was therefore unwilling to use it, the CA's action had placed her in a difficult and invidious position.

(aa) W707/86-87
on pages 58-71
of HC 103

84. I found that muddle and faulty communication between the FP and the hospital staff, rather than a matter of principle, lay at the root of this complaint. In his evidence the CA said that he had not been aware of any guidelines on prescribing for out-patients. Indeed, he explained that his decisions on whether or not to prescribe for out-patients turned on such matters as the time he had available and whether or not printed name stickers were provided for the prescriptions. He could not recall why he had not initially prescribed the drug for the patient, but maintained that his decision had not been based on budgetary considerations. The CA added that in fact he would have no objection to prescribing it initially; and that he had subsequently erroneously assumed from information the patient had given him that the FP had positive objections to using this particular drug in his case.

85. Although I could not determine where the fault for this misunderstanding lay, I saw no reason to question the view, expressed in a letter the DHSS had sent to the FP, that the duty of prescribing rested with the doctor who, at the time, had clinical responsibility for the patient's treatment. And I believed that if the CA had been aware of the DHSS guidelines he would have realised that it was up to him to provide at least the initial prescription of the drug. I accordingly upheld this aspect of the complaint and criticised not only the CA, but also the DHA for having failed to ensure that their staff were aware of DHSS guidelines bearing on their work. The DHA apologised and agreed to ensure that their staff were made aware of, and adhered to, DHSS guidance on prescribing.

86. In a Scottish case, the complainant and her husband had been authorised by a HB to open a nursing home. A short time afterwards they had admitted two handicapped patients from a hospital managed by the HB but their action was subsequently questioned by an inspection team, comprising three of the HB's officers, and they were informed that they were not authorised to take such patients. They then sought amendment of the registration, which was eventually granted. The complainant complained that although she and her husband had made plain from the outset their intention to cater for handicapped patients the HB had failed to register the home appropriately. When this had become apparent, there had then been undue delay before the registration was amended, as a result of which they had suffered financial loss as they were unable to recoup the appropriate allowances from the DHSS.

(bb) SW70/86-87
on pages 260
of HC 103

87. I found that under the relevant legislation the proper means of conveying to the complainant and her husband any intention the HB might have had to limit the

categories of patients they were allowed to admit was by imposing and specifying a condition in the certificate of registration. But I saw that the certificate issued by the HB contained no such condition, nor was any condition or limitation, except as to the number of beds, referred to in the HB's communications to the complainer and her husband about the registration. Moreover all the HB's formal proceedings concerning the registration referred only to 'an 18 bed Nursing Home', without limitation as to patient categories. In these circumstances it appeared to me that a statement made on the HB's behalf in a letter to DHSS that the home had been 'registered for 18 geriatric beds' was incorrect. I also considered that the HB had misled themselves - and the complainer and her husband - into thinking that an amendment of the registration was required to regularise the presence of the two handicapped patients in the home. The fact was that the HB had registered the home without any restriction as to categories of patients and the presence of the handicapped patients had not therefore contravened the nursing home registration legislation. I suggested therefore that the HB should enquire of DHSS whether there were procedures by means of which the higher rate of benefit could still be paid from the date when the two handicapped patients had been admitted to the home. Failing that I recommended that the HB should make an *ex gratia* payment to cover any shortfall in the total payments made by DHSS over the relevant period. I was very pleased to hear, after my report had been issued, that DHSS had agreed to pay the complainer the sum of £1,868 in arrears. I regarded this, together with action which the HB had already taken to improve its guidelines and procedures, as a satisfactory conclusion to my investigation.

(cc) W183/86-87
on pages 21
of HC 393

88. In another case I investigated, a woman was admitted to a hospital's mental illness unit following a drug overdose. One morning, when her daughter visited her, the woman could not be located and although the daughter waited her mother did not return. Early that afternoon the family were informed that the woman had been found dead in a bathroom at a time when, her daughter believed, she herself had still been at the unit. The daughter returned to the unit with her father but when they asked to see the body they were told it was not in the hospital. However, after they had threatened to contact the police, they learned that the body was still in the bath. The husband complained that as his wife had expressed a fear of water she should not have been allowed to take a bath unsupervised. He thought that insufficient effort had been made to locate his wife when his daughter visited her and said that the nurses' actions in seeking to conceal the whereabouts of his wife's body had caused him and his family unnecessary additional distress. I was not convinced that the nursing staff had been made aware of the woman's fear of water and accepted that they had no reason to think that she should not be allowed to take a bath unsupervised. I established that an enrolled nurse had carried out a search for the woman and that when he found a bathroom door locked he had failed to satisfy himself who was in the bathroom and whether the occupant was all right. I criticised him for these failures.

89. Although the woman had been discovered dead in the bathroom there was no evidence to support the daughter's belief that her mother had been found before she herself had left the hospital. But, because of the enquiries made by the police, unit staff had been unable to remove the woman's body from the bath before the family arrived on the ward. I recognised the difficulty this had caused for the nurse in charge and accepted that he had wished to spare the family the distress of seeing the woman's body in the bath. But I considered that his decision to tell them that her body was no longer at the hospital was misguided. I was also of the opinion, given the circumstances of the woman's death, that a member of the medical staff should have seen her relatives when they arrived and that it would have been better had a more senior member of the nursing staff been present to support the ward staff. I found that much of the additional stress caused to the family could have been avoided and I upheld the complaint. The DHA repeated the apologies they had already given for the shortcomings they themselves had identified and offered their deepest apologies for the further failures I found.

(dd) W314/87-88
on pages 270
of HC 393

90. I investigated a sad case about events which followed the termination of a woman's pregnancy after the fetus was found to be hydrocephalic. An out-patient appointment had been arranged and it was the woman's and her husband's belief that the results of tests and examinations on the fetus would be discussed on that occasion and that the possibility of genetic counselling would be considered. But they found on attending the appointment that no test or examination had been carried out. My investigation revealed that the basis on which future action was to be determined had not been adequately explained to the woman and her husband. This was particularly unfortunate because it led them to make a comment to a nurse which, in turn, caused her to believe that chromosomal analysis of fetal tissue was intended. But the nurse

had then placed the fetus in an inappropriate solution which rendered it useless for examination. I found that a senior house officer who attended the woman after the fetus had aborted failed to examine it or to record its description in the woman's clinical notes. He also failed to ensure that the nursing staff were aware of the nature of the examination to be carried out on the fetus. I discovered that a revised protocol detailing the action to be taken following a therapeutic termination of pregnancy had been issued but I criticised the DHA for the absence of precise guidance on the ward at the time of the woman's admission. It became clear in the course of my investigation that despite the issue of the revised protocol, staff still had no clear understanding of the steps to be taken when genetic testing was required.

91. I found that another senior house officer provided the husband with a letter stating that the necessary tests had been carried out, and that he had authorised the release of the fetus, even though he knew that no examination had taken place. I believed that the woman and her husband could have been told at that stage that the fetus had not been examined so that they were not left with the erroneous belief that the main purpose of the out-patient appointment was to discuss the results of the fetal examination. I believed also that the possibility of appropriate counselling could have been considered at that time. The DHA apologised for the serious failures I identified and undertook to ensure that the revised protocol was fully understood by all staff who might be called upon to follow it.

92. I investigated another disturbing case in which the complainants alleged that they had been given contradictory advice about the cremation of their baby. A pregnant woman had attended hospital as an outpatient for an ultrasound scan and was told that the baby she was expecting had a severe brain abnormality and could not survive. She was admitted to the hospital later the same day in order that her pregnancy could be terminated and on the following day labour was induced and she gave birth to a baby boy who died shortly afterwards. Two days after she was discharged the parents returned to the hospital and were advised that their baby had been cremated, which was against their wishes. In fact it was found some six weeks later that the baby had not been cremated but was available in the hospital mortuary for burial.

(ee) W651/87-88
on pages 395
of HC 393

93. My investigation revealed that the baby had been recorded as alive at birth by the midwife but that, when the woman returned from the labour ward to her gynaecology ward, the medical and nursing staff there acted as if the baby had been stillborn. I found that this had influenced the subsequent action with regard to the disposal of the baby's body and what the woman and her husband were told. The failure to recognise that there had been a neonatal death as opposed to a stillbirth led to the staff thinking of the baby as a fetus, disposal of which would properly be the concern of the DHA. While I thought it possible that the nurse concerned had not specifically told the parents that the baby had already been cremated, I was in no doubt that they were left believing that the disposal of the body was not a matter for them but would be dealt with by the hospital by means of cremation, despite the mother's wish for a burial. Errors on the gynaecology ward which led to this situation deserved my serious criticism and I also criticised the failure of the DHA to advise the parents earlier as to how things stood.

94. In an unusual case, I investigated a complaint from a woman about an over-amorous male visitor. It was alleged that nursing staff failed to prevent him from having sexual intercourse with his wife while she was a patient on the same ward in a family practitioner hospital. The complainant, who had suffered from a back condition for a number of years, had been transferred to the hospital following an operation for spinal fusion. She complained to me that she had suffered embarrassment and distress because the staff persistently failed to prevent a husband from visiting his wife on the ward when intoxicated and that the ward was inadequately supervised on the particular occasion when the incident occurred. The complainant also complained that although she had felt tense and insecure as a result of these experiences, the staff had failed to transfer her to a side ward or back to the original hospital, and therefore she had discharged herself.

(ff) W478/87-88
on pages 290
of HC 393

95. I did not uphold the complaint about the failure to prevent the man visiting his wife when drunk both because I was not convinced that the complainant had voiced her fears about him to the staff sufficiently forcefully and because I accepted the staff's view that he was never so drunk as to justify barring him from visiting the ward. While I found that the man had indeed had sexual intercourse with his wife on the ward, I did not uphold the complaint that staff had failed to prevent him doing so because I believed they could not possibly have anticipated the incident and they had acted promptly when it was discovered. And I saw that the complainant had been offered, but

declined, a side ward and that by then the acute hospital in which she had had her operation was inappropriate for the stage of treatment she had reached.

(gg) W569/87-88
W322/87-88
on pages 374
of HC 393

96. The final case in this chapter features a worrying failure in the arrangements between two hospitals for the transfer of an elderly woman patient. The woman had suffered from severe heart disease for a number of years and had been admitted to hospital following a deterioration in her condition. A consultant cardiologist from a hospital managed by another DHA agreed to accept her for urgent transfer with a view to cardiac surgery and arrangements for this were made by junior medical staff from the two hospitals. The woman's husband complained that after having travelled a considerable distance by ambulance, his wife found that she was not expected at the second hospital and consequently no bed was available for her from her arrival at midday until the evening. He also complained that during her wait she was left sitting in a wheelchair without medical attention and was given no adequate sustenance.

97. I discovered failings on the part of both DHAs which led to the woman waiting an unacceptable time for the bed. The first DHA accepted their staff should have checked the availability of a bed with the second hospital and they suggested to me that the responsibility for making the arrangements lay with a house physician who appeared to have assumed that nursing staff would check the bed availability. But I believed that that might not be entirely fair to the house physician as he had been new in post and the DHA appeared to have had no established policy that it was the responsibility of medical rather than nursing staff to make such arrangements. The DHA agreed to ensure that in future all staff concerned understood who was responsible for checking the bed availability for patients referred to other hospitals. As to the second DHA, they left it to their medical staff to tell referring doctors in other hospitals whenever a transfer was agreed that the availability of a bed should be confirmed at the beginning of the day of transfer. I thought this an unsafe procedure and accordingly the second DHA agreed to notify referring hospitals formally what is expected of them. I also upheld the complaints about the lack of medical attention and adequate sustenance while the woman was waiting and the second DHA undertook to improve their facilities at the hospital for the reception of patients and to ensure that adequate clinical assessment is available for the reception of patients transferred in such circumstances.

98. I am pleased to record that the remedy I regarded as appropriate was agreed by the authority in every case before the year's end. However in February 1989, following revised guidance by the Treasury, the Department of Health asked health authorities and family practitioner committees to refer to the Department all cases, including those falling within delegated limits, where I had recommended a financial remedy, before the authority or committee committed itself to payment. At the end of the year Departmental approval was outstanding in three cases where the relevant FPCs or DHA had already shown themselves prepared to pay.

99. In 109 of the 123 cases (involving 139 authorities) I investigated and reported on in 1988-89, I thought that an apology from the authority was required. In a few particularly serious cases I may ask the chairman of the authority to write personally to the complainant but in the majority of cases I convey the authority's apologies to the complainant through my report – a practice begun by my predecessors and which I continue to follow to ensure that the apologies are given promptly and are not couched in terms which might call their sincerity into question.

100. I list below procedures which have been introduced, improved or reviewed by authorities following the investigations I have completed in 1988-89. For convenience they are grouped in four broad categories:

(i) Administrative practices or procedures associated with medical activity

- W707/86-87 Action to be taken to ensure that medical staff are aware of guidance issued by the then Department of Health and Social Security as to responsibilities for prescribing.
- W114/87-88 Monitoring system introduced for patients at risk of suicide or self-harm and arrangements revised to ensure that such patients' management is appropriate in all circumstances.
- W168/87-88 Written instructions to junior doctors to be revised to ensure that patients' allergies and drug-sensitivities are identified in medical records.
- W569/87-88 (a) Arrangements made to ensure that doctors in a referring hospital know that they are expected to check on the day of a patient's transfer the availability of a bed in the receiving hospital.
- W332/88-89 (b) Arrangements made to ensure that adequate clinical assessment is available for patients arriving from other hospitals.
- SW43/87-88 Instructions issued to medical staff to ensure that changes in patients' discharge dates are recorded in writing.
- W95/88-89 Guidance to junior medical staff regarding the handling of complaints to be reviewed.

(ii) Administrative practices or procedures associated with action on the ward

- W764/85-86 Diets reviewed and arrangements introduced to ensure that appropriate food is selected for those patients who cannot make their own choice.
- W313/86-87 Procedure reviewed to ensure that relevant information about patients' pain and the need for its relief is conveyed to medical staff.
- W705/86-87 (a) The respective responsibilities of medical and nursing staff regarding some aspects of treatment to be clarified.

- (b) The functioning of a nurse call system to be monitored closely.
- SW79/86-87 Staff instructed about the need to take note of complaints even though at first they seem to be insignificant.
- W6/87-88
 - (a) Precise instructions issued to nursing staff about how and when infant feed charts should be completed.
 - (b) Guidance issued on the placement and supervision of babies on a ward.
- W137/87-88 Nursing staff to be made aware of a hospital's facility to lend money to patients for travel expenses.
- W233/87-88 Staff training to be introduced to improve oral communication with other ward staff and relatives.
- W236/87-88 Instructions issued to nursing staff on dealing with enquiries from relatives who are not recorded as next-of-kin.
- W240/87-88 Instructions to be revised regarding the admission of patients direct to a ward.
- W252/87-88 The clothing needs of all patients at a mental handicap hospital reviewed.
- W314/87-88 Action to be taken to ensure that all staff are fully aware of the procedures to be followed when tests or examinations of aborted fetuses are called for.
- W382/87-88 Procedures reviewed for communicating information about patients who are transferred between hospitals.
- W418/87-88
- W569/87-88 Arrangements introduced to ensure that all the staff concerned understand who is responsible for checking that a bed is available for a patient about to be transferred to another hospital.
- W332/88-89
- W635/87-88 Review of procedures for showering and hair-drying.
- SW19/87-88 Nursing staff advised to encourage relatives to seek clinical information in appropriate cases.
- SW43/87-88
 - (a) More formal procedure to be adopted in dealing with transfer of patients between two hospitals.
 - (b) Instructions issued to improve oral communication between nursing staff and relatives.
 - (c) Introduction of a new written procedure for discharge arrangements.
- W3/88-89 Procedure for discharge letters reviewed.
- W110/88-89 Lessons learned from a complaint about poor communication on a ward to be brought to the notice of staff.

(iii) Administrative practices or procedures associated with action in other hospital departments

- W313/86-87 Procedures reviewed to ensure that medical records are available at clinics.
- W737/86-87
 - (a) Communication between clinical departments and the medical records department to be improved to assist in identifying the location of medical records.
 - (b) Arrangements for out-patients transported by ambulance to be reviewed in an attempt to reduce waiting time at clinics.
- W1/87-88 Signposting at a hospital to be reviewed to ensure it is clear, comprehensive and visible.

- W219/87-88 Procedure for making clinical appointments to be reviewed in cases where
W395/87-88 a patient transfers to another hospital with his medical records.
- W233/87-88 Entries in patients' handbook on the subjects of pensions and laundry to
be reviewed.
- W303/87-88 Procedure for tracing relatives of patients who die in hospital to be
reviewed.
- W314/87-88 Procedure for ensuring that the results of tests and examinations are filed
promptly in clinical notes to be reviewed.
- W644/87-88 Procedures improved in connection with communication with patients on
long out-patient waiting lists.
- SW19/87-88 Patients' handbook revised to reinforce section about seeking medical
advice.
- W62/88-89 Waiting times in accident and emergency department to be monitored.

(iv) Other administrative practices or procedures associated with record-keeping, correspondence or complaints

- W717/86-87 Arrangements introduced to ensure that both the RHAs and DHAs are
W235/87-88 aware of their respective responsibilities regarding communication with complainants in independent professional review cases.
- W117/87-88 In respect of their informal procedure for the investigation of complaints, an FPC undertook to ensure that:
- (a) the monitoring of complaints would be followed more vigorously;
 - (b) the practice of copying a complainant's letter to his FP would be reviewed; and
 - (c) the circumstances in which their office informal procedure was used would be reviewed.
- W124/87-88 Revised arrangements introduced for progressing complaints considered by an FP under their informal procedure.
- W236/87-88 Complaints procedure revised to ensure full and detailed investigation by the authority.
- W239/87-88 Nursing notes patient summary sheet to be reviewed to provide for a record of notifying relatives of a patient's admission.
- W240/87-88 Complaints procedure reviewed.
- W249/87-88 A codified complaints procedure introduced.
- W252/87-88 Instructions issued to staff regarding the handling of complaints and claims about patients' lost property.
- W266/87-88 Review of the period for which the work rota records of junior medical staff are retained.
- W309/87-88 Wording of a standard letter from an RMO to complainants in IPR cases to be reviewed.
- W362/87-88 Complaints procedure to be reviewed.
W542/87-88
- W382/87-88 Procedure for co-ordinating the handling of a complaint involving two
W418/87-88 authorities to be reviewed.
- W402/87-88 Complaints procedure revised.
- W513/87-88 Wording of document issued to assessors in IPR. Cases to be reviewed so
W70/88-89 that they are not led to believe that only medical staff can be interviewed.

- SW14/87-88 Comprehensive review undertaken of nursing records.
- SW63/87-88 New procedure introduced regarding the monitoring of complaints.
- SW64/87-88 Procedure for recording patients' details in hospital records to be reviewed.
- W80/88-89 Arrangements for identifying misdirected medical records and for the
W151/88-89 reception of mail to be reviewed by two FPCs which share the same premises.
101. On occasion my investigation shows that although a procedure is already in existence staff have forgotten it or have not been fully mindful of it. In such cases it is often necessary to do no more than ensure that the staff are reminded of the procedure. Some examples in 1988-89 were:
- W596/86-87 Staff reminded of need for diligence in implementing the complaints procedure.
- W669/86-87 Medical staff reminded of the need to ensure that discharge notes and summaries are prepared and issued promptly.
- W705/86-87 (a) Midwifery staff reminded of obstetricians' opinions on pain relief.
(b) Staff reminded of the need for accurate documentation.
- SW79/86-87 Staff reminded of the importance of being alert to the needs of relatives and of providing them with full information.
- W114/87-88 Medical staff reminded of the need for clear and precise instructions to nursing staff.
- W137/87-88 Staff to be reminded of the risk in giving a generalised assurance to a worried patient.
- W168/87-88 (a) Junior doctors to be reminded of the importance of asking about, and recording details of, a patient's allergies and drug-sensitivities.
(b) Nursing staff to be reminded of the need to enquire about such sensitivities and to record them in the nursing records and drug sheet.
- W179/87-88 Nursing staff reminded that they should ensure that drugs are actually taken by patients before the drug record chart is noted to that effect.
- W197/87-88 Staff reminded of the procedure to be followed when recording patients' property, particularly in the case of those who are confused.
- W211/87-88 Nursing staff reminded of the need to record instances of incontinence and to bring them to the notice of nurse in charge.
- W219/87-88 (a) Medical staff to be reminded of the need to record, at the time a condition is confirmed, whether or not the patient has been told of the prognosis.
(b) Nursing staff reminded of the need to bring a patient's uncertainty about his condition to the attention of medical staff.
- W233/87-88 Staff reminded of importance of adhering to accepted financial procedures and regular monitoring.
- W236/87-88 (a) Staff reminded of the need for care to be taken with primary documents.
(b) Nursing staff reminded of need for regular and sufficiently-detailed entries in nursing notes.
- W239/87-88 Nursing staff reminded of the importance of accurate and detailed record-keeping.
- W240/87-88 Staff to be reminded of the importance of filing securely medical documents and related correspondence in casenotes.

- W266/87-88 (a) Staff reminded of the need to treat primary documents with care and to ensure that they are not separated from record folder.
- (b) Staff reminded that patients' relatives need to be made aware that oxygen should be administered by ward staff, or others only after training and with prior agreement.
- W314/87-88 Medical staff to be reminded of the need to record accurate clinical details on histopathology request forms.
- W436/87-88 (a) Nurses reminded of the need for special vigilance to ensure that elderly patients do not become cold.
- (b) Staff reminded of the importance of keeping the next-of-kin informed of significant changes in patients' condition.
- W438/87-88 Nursing staff to be reminded of need to maintain adequate records.
- W498/87-88 Staff reminded of security procedures relating to building contractors working on hospital site.
- W518/87-88 Medical staff to be reminded of the importance of checking all relevant documents before replying direct to patients or their families.
- W543/87-88 Medical staff to be reminded to complete discharge summaries properly.
- W544/87-88 (a) Staff reminded of the stages included in the authority's complaints procedure.
- (b) Clinical staff to be reminded of the need to co-operate fully and willingly in any investigation of a complaint.
- W547/87-88 Staff to be reminded of the need to ensure that patients awaiting
W597/87-88 discharge or transfer are cared for appropriately and if necessary are allowed to rest in bed.
- SW19/87-88 Staff reminded of a procedure for readmitting patient out 'on pass'.
- SW20/87-88 Accident and emergency department staff reminded of the importance of responding constructively to requests for assistance.
- SW63/87-88 Staff reminded of their duty to provide advice to complainers.
- W3/88-89 (a) Staff reminded of the care which needs to be taken when prescription sheets are amended.
- (b) Medical staff reminded of the need to make appropriate arrangements for a patient's follow-up, at time of his discharge.
- W78/88-89 (a) Medical and nursing staff to be reminded to record in the notes events such as the repeated cancellation of an operation and the reasons for this.
- (b) Staff to be reminded of the importance of recording decisions to discharge patients.
- W97/88-89 Medical staff to be reminded of the importance of keeping FPs adequately informed about their patients' treatment.
102. Other remedies which were obtained following investigations completed in 1988-89 included:
- W705/86-87 Alterations to be made to ward fittings.
- W726/86-87 Procedure document for the acquisition of property reviewed.
- W114/87-88 Ward moved to a more appropriate location.
- W249/87-88 Nurse staffing levels to continue to be reviewed.

- W285/87-88 An extract from my report to be included in a patient's casenotes.
- W438/87-88 Authority to consider how a complainant might be assisted in obtaining explanations of certain clinical matters which she had sought previously.
- W547/87-88 Ambulance service to discuss with users the form of written guidance or
W597/87-88 information about their working arrangements which should be issued to persons responsible for ordering transport.
- W639/87-88 Authority to satisfy themselves about the level of staffing on a ward and the training and supervision available there.
- W98/88-89 Assessors to be nominated to conduct an IPR in a case where a request for them had been refused previously.
- SW2/88-89 Board to clarify arrangements with a local hostel to which patients are discharged.
103. Finally, there were five cases in which I thought a financial remedy appropriate.
- SW70/86-87 A Health Board agreed to find out whether arrears of benefit could be paid by what is now the Department of Social Security and if not to consider making an *ex gratia* payment to cover any moneys outstanding. In the event the Department agreed to pay £1,868 arrears to the complainant.
- W197/87-88 A DHA agreed to pay a daughter £3,000 for the loss of a ring belonging to her mother while she was a patient in hospital.
- SW2/88-89 A DHA agreed to pay £5 to a patient in respect of a taxi fare.
- W141/87-88 In two cases involving FPCs, the committees agreed to pay small sums
W656/87-88 under £50 each to chemist contractors whose payments had been delayed.

Anthony Barrowclough
Health Service Commissioner

July 1989

Summary of workload

Appendix A

England		Scotland		Wales		Totals		
88/89	87/88	88/89	87/88	88/89	87/88	88/89	87/88	
220	271	22	30	11	16	253	317	Brought forward from previous year
641	668	75	87	37	39	753	794	Add received in current year
861	939	97	117	48	55	1006	1111	Total considered
281	220	24	22	13	11	318	253	Deduct carried forward to next year
580	719	73	95	35	44	688	858	Concluded
299	421	38	60	20	24	357*	505	Complaints rejected or discontinued
158	187	23	20	11	13	192	220	Complaints 'referred back'
123	111	12	15	4	7	139	133	Results reports issued
580	719	73	95	35	44	688	858	Totals
155	88	13	15	5	4	173	107	Written enquiries/advice sought

*This figure includes 15 discontinued cases of which 11 were discontinued at the request of the complainant before a decision was taken on whether or not to investigate.

Main reasons for rejections

Appendix B

England		Scotland		Wales		Totals		
88/89	87/88	88/89	87/88	88/89	87/88	88/89	87/88	
41	38	6	7	5	3	52	48	Body complained of outside jurisdiction
46	62	7	9	1	5	54	76	Complaint against FP, dentist, pharmacist, optician
6	13	1	-	-	1	7	14	FPC Service Committees and Tribunal Regulations
45	106	5	11	4	7	54	124	Clinical judgment
10	14	2	1	2	-	14	15	Legal remedy available
19	34	2	6	1	-	22	40	Personnel matter
46	46	7	7	1	1	54	54	Out of time
1	1	-	-	-	-	1	1	Right of appeal to tribunal
-	-	5	1	-	-	5	1	Action subject to the protective functions of the Mental Welfare Commission (Scotland)
45	48	1	6	3	3	49	57	No prima facie failure/maladministration
4	5	-	2	-	-	4	7	Contractual/commercial transaction
15	18	-	6	3	2	18	26	General discretion
7	9	-	1	1	-	8	10	Complainant not aggrieved or acceptable as complainant
-	3	-	-	-	-	-	3	Complaint from local authority, other public body or nationalised industry
285	397	36	57	21	22	342	476	Totals

Analysis of categories of investigated grievances, 1987/88 and 1988/89

Some Justification	No Justification	Sub Total	Total 1988/89	1987/88	
					Nursing
59	55	114			failure in care
23	17	40			lack of or incorrect information
21	23	44			attitudes
-	6	6			maltreatment
103	101		204	205	Total
					Medical
32	15	47			lack of or incorrect information
21	18	39			attitudes
21	23	44			failure in non-clinical procedures
74	56		130	101	Total
					Administration
25	8	33			policy decisions (manner in which reached)
25	19	44			day-to-day (hospital in-patient)
8	5	13			day-to-day (hospital out-patient)
1	-	1			day-to-day (hospital casualty)
11	2	13			day-to-day (family practitioner services)
1	4	5			day-to-day (community health)
71	38		109	102	Total
					Failure in service
5	5	10			ambulance
-	-	-			community
5	4	9			laboratory/technical/house-keeping
-	2	2			paramedical
10	11		21	27	Totals
64	28		92	90	Handling by authority
322	234		556	525	Totals

Year	Number investigated		Number found justified	
	Total	No of grievances per report issued	No	% of (ii)
(i)	(ii)	(iii)	(iv)	(v)
1979/80	344	3.25	150	43.60
1980/81	399	3.53	125	31.33
1981/82	407	4.03	152	37.35
1982/83	368	3.20	160	43.47
1983/84	350	2.94	167	47.71
1984/85	443	3.54	209	47.18
1985/86	526	3.84	302	57.41
1986/87	483	3.69	290	60.04
1987/88	525	3.94	321	61.14
1988/89	556	4.00	322	57.91
Totals	4401	3.62	2198	49.94

Analysis of main categories of grievances, 1979-80 to 1988-89

Year	Total number of grievances	Nursing		Medical		Administration		Failure in service		Handling of complaint	
		No	%	No	%	No	%	No	%	No	%
1979/80	344	114	33%	97	28%	50	15%	16	5%	67	19%
1980/81	399	125	31%	94	23%	79	20%	27	7%	74	19%
1981/82	407	107	26%	136	33%	73	18%	26	6%	65	16%
1982/83	368	103	28%	101	27%	59	16%	36	10%	69	19%
1983/84	350	136	39%	61	17%	101	29%	15	4%	37	11%
1984/85	443	153	34%	101	23%	87	20%	32	7%	70	16%
1985/86	526	236	45%	111	21%	76	14%	36	7%	67	13%
1986/87	483	179	37%	112	23%	108	22%	19	4%	65	13%
1987/88	525	205	39%	101	19%	102	19%	27	5%	90	17%
1988/89	556	204	37%	130	23%	109	19%	21	4%	92	17%
Totals	4401	1562	35%	1044	24%	844	19%	255	6%	696	16%

Analysis of activity 1973-1989

Appendix F

Year	1973/74 from 1.10.73	1974/75	1975/76	1976/77	1977/78	1978/79	1979/80	1980/81	1981/82	1982/83	1983/84	1984/85	1985/86	1986/87	1987/88	1988/89	Totals			
287	402	418	483	494	590	484	556	586	658	770	711	807	752	668	641	9307	E	Complaints rec'd		
53	40	43	56	49	70	47	49	62	107	76	67	85	87	87	75	1053	S			
21	51	43	43	41	52	31	42	38	33	49	37	34	44	39	37	635	W			
361	493	504	582	584	712	562	647	686	798	895	815	926	883	794	753	10995	Total			
187	405	422	457	421	594	482	579	603	657	761	686	761	715	719	580	9029	E	Cases concluded		
44	42	48	47	43	66	54	56	54	94	90	67	80	76	95	73	1029	S			
11	59	35	43	35	52	34	41	42	35	38	45	32	40	44	35	621	W			
242	506	505	547	499	712	570	676	699	786	889	798	873	831	858	688	10679	Total			
155	239	248	285	267	426	334	398	419	460	520	387	407	338	421	299	5603	E	Rejected or dis- continued	D I S P O S A L	
39	23	34	27	23	47	33	35	38	76	50	38	43	40	60	38	644	S			
7	31	26	29	29	35	24	29	27	23	22	21	15	24	24	20	386	W			
201	293	308	341	319	508	391	462	484	559	592	446	465	402	505	357	6693	Total			
14	64	60	69	59	67	58	83	95	96	145	195	238	262	187	158	1850	E	Referred back		
2	9	6	12	10	12	10	11	10	10	20	17	24	25	20	23	221	S			
2	12	3	4	1	9	5	7	9	6	13	15	11	11	13	11	132	W			
18	85	69	85	70	88	73	101	114	112	178	227	273	298	220	192	2203	Total			
18	102	114	102	94	101	90	98	89	101	96	104	116	115	111	123	1574	E	Results Reports issued		
3	10	8	8	10	7	11	10	6	8	20	12	13	11	15	12	164	S			
2	16	6	10	5	8	5	5	6	6	3	9	6	5	7	4	103	W			
23	128	128	120	109	116	106	113	101	115	119	125	135	131	133	139	1841	Total			
83	58	61	62	64	71	68	68	69	71	67	56	53	48	59	52	62	Rej/Disc	Average % 'Disposal' of cases concluded		
7	17	14	16	14	13	13	15	16	14	20	28	31	36	26	28	21	R/B			
10	25	25	22	22	16	19	17	15	15	13	16	15	16	16	20	17	Inv			

Geographical distribution of complaints received for 1988-89

Region of origin	Number of complaints received	Proportion of total (%)	Nominal population (000s)	Population (000s) per complaint
Northern	21	2.8	3080	147
Yorkshire	46	6.1	3601	78
Trent	44	5.8	4634	105
East Anglia	20	2.7	1992	100
London and Home Counties:				
North West Thames	70	9.3	3488	50
North East Thames	62	8.2	3761	61
South East Thames	85	11.3	3619	43
South West Thames	60	8.0	2965	49
Wessex	31	4.1	2876	93
Oxford	12	1.6	2476	206
South Western	27	3.6	3178	118
West Midlands	66	8.8	5181	79
Mersey	41	5.4	2414	59
North Western	56	7.4	3990	71
Total for England	641	85.1	47255	74
Scotland	75	10.0	5112	68
Wales	37	4.9	2836	77
Overall Total	753	100.0	55203	73

Geographical distribution of investigations completed in 1988-89

English Regions	Investigations Completed
Northern	3
Yorkshire	11
Trent	1
East Anglia	4
London and Home Counties:	
North West Thames	13
North East Thames	12
South East Thames	12
South West Thames	7
Wessex	6
Oxford	1
South Western	7
West Midlands	15
Mersey	8
North Western	8
Total: England	108
Add: Scotland	12
Wales	3
Overall Total	123

Notes: 1. 31 investigations of complaints about English health authorities were conducted by the Investigation Units in Edinburgh (10) and Cardiff (21).

2. 78 investigations were conducted by the London based Investigation Units; 44 (56%) related to the four Thames Regions of which 36 (82%) involved health authorities within the Greater London area.

HMSO publications are available from:

HMSO Publications Centre

(Mail and telephone orders only)

PO Box 276, London SW8 5DT

Telephone orders 01-873 9090

General enquiries 01-873 0011

(queuing system in operation for both numbers)

HMSO Bookshops

49 High Holborn, London, WC1V 6HB 01-873 0011 (Counter service only)

258 Broad Street, Birmingham, B1 2HE 021-643 3740

Southey House, 33 Wine Street, Bristol, BS1 2BQ (0272) 264306

9-21 Princess Street, Manchester, M60 8AS 061-834 7201

80 Chichester Street, Belfast, BT1 4JY (0232) 238451

71 Lothian Road, Edinburgh, EH3 9AZ 031-228 4181

HMSO's Accredited Agents

(see Yellow Pages)

And through good booksellers

ISBN 0 10 245789 1