Report of the Health Service Commissioner.

Selected Investigations completed
October 1990 - March 1991

London : HMSO

Health Service Commissioner

Second Report for Session 1990–91

Selected Investigations Completed October 1990—March 1991

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

The present selection is taken from a total of 69 cases on which full investigations were completed during the period October 1990 to March 1991. I have not selected for publication in this volume any cases relating to Scotland or Wales (I investigated 4 Scottish and 2 Welsh cases) simply because other cases seemed to me to be more instructive.

When I use the first person singular ('I', 'my' etc) in the reports published in this volume, it includes my predecessor, during whose tenure some of the investigations began. I have not included in my reports every detail investigated, but I am satisfied that no matter of significance has been overlooked.

I have included, as Schedule I at the back of this volume, a glossary of the more commonly used acronyms. Because of the wide variety of job names encountered in my investigations, I have not found it practicable to produce a single, comprehensive glossary. In many cases, therefore, explanation of an acronym will be found in the first reference, within a report, to the post to which that acronym relates.

I have also decided to include as Schedule II the dates on which the investigation of each of the published cases was started and completed, partly for general information and partly as an incentive to reduce time taken to investigate and report on complaints.

June 1991

W K REID
Health Service Commissioner

Contents

Case Reference Number	*Title*	*Page Numbers* *Epitomes*	*Full Text*
W.375/88–89	Deficiencies in nursing care of a terminally ill patient	1	11
W.194/89–90	Inability to provide NHS care for man in need of hospital bed	2	27
W.206/89–90	Expectations of a private patient	3	40
W.212/89–90	Handling of complaint by family practitioner committee	3	45
W.258/89–90	Communications surrounding a decision not to resuscitate a patient	4	50
W.369/89–90	'Patient's friend' at a meeting with a consultant	5	58
W.411/89–90	Delays in handling a complaint under the independent professional review procedure ...	5	62
W.417/89–90	Deficiencies in nursing care and poor communications	6	69
W.478/89–90	Provision of long-term care	7	80
W.599/89–90	Provision within the NHS of long-term care ...	7	90
W.652/89–90	Delay in arrival of ambulance	8	96
W.668/89–90	Failures in provision of ambulance transport ...	9	104
W.25/90–91	Release of confidential information to the press	9	112

Epitomes of Selected Cases

Deficiencies in nursing care of a terminally ill patient—W.375/88–89

Matters considered *Failure by nurses to provide assistance to a patient—loss of property—inability to see the consultant and inadequate explanation of patient's condition—unavailability of National Health Service (NHS) ambulance and condition of patient on discharge—handling of complaint by the health authority (DHA) concerned.*

Summary of case A woman's husband, who had previously undergone major surgery for cancer, was transferred from one hospital to an infectious diseases ward at another hospital for tests. Eleven days later she was told that he was terminally ill and she asked that he be discharged home. The next day a private ambulance took him home, where he died two days later. The woman complained that she had regularly found her husband naked and uncared for; that he had been left food even though he was too weak to feed himself; that two new pairs of pyjamas went missing; that she had been unable to speak to the consultant concerned, nor had she been kept informed of her husband's diagnosis or prognosis; that, because no NHS ambulance was available for her husband's discharge, she had been obliged to arrange a private ambulance at her own expense; and that her husband had been discharged in an inappropriate condition. Finally, she asserted that the DHA's responses to her complaints had been dilatory, unsatisfactory and misleading.

Findings I found that, at times, staffing levels on the ward had been insufficient to give the woman's husband the degree of nursing care and attention that, as a terminally ill patient, he needed—the ward was often left in charge of second level nurses. I was greatly concerned that at such an advanced stage of his illness he should have found himself in an environment which could not accommodate adequately his particular needs. Further, the nursing care plan had not adequately reflected all the care he needed, and it had not been reviewed over a period of 10 days. I did not find that nurses had neglected the husband's dietary needs and, because of a lack of firm evidence on which to make a judgment, I made no finding on the woman's complaint that she had put her complaints about her husband's nursing care to doctors to no avail. I found that two sets of the husband's pyjamas had indeed gone missing, but I was not surprised that her delay in reporting the loss had made attempts to locate them unsuccessful. None of the staff could recall a request from her to see the consultant, and the evidence persuaded me that medical staff had kept her reasonably informed of the progress of tests, and that they had told her of the likely diagnosis and prognosis as soon as they were able to do so. Failure to ask for an ambulance had, I found, arisen from confusion amongst the ward staff over the notice required. I noted that the DHA had agreed a procedure with the ambulance service which should prevent a recurrence. I was persuaded that the nurses had done all that they reasonably could to prepare the husband for his journey home. The DHA had remained in the dark about the bulk of the woman's complaints for about 15 months after her husband's stay on the ward, because two authorities had been involved and the DHA had initially responded through the other authority rather than by making direct contact with the complainant. Even at that stage the complaint had not been treated with due despatch. However, the DHA had attempted, through a meeting and a definitive reply, to give a full answer to the woman's concerns, and there had been no intention to mislead. I noted with approval that the DHA had taken steps to ensure that complaints involving more than one authority were dealt with more effectively.

Remedy The DHA agreed to review ward staffing to ensure that cover was adequate for the needs of the patients, and to remind nurses of the importance of matching the nursing care plan to the patient's needs. Further, the DHA agreed to view sympathetically any reasonable claim in respect of the lost pyjamas and to reimburse the woman for the cost of providing a private ambulance. They apologised to the woman for the shortcomings I identified.

Inability to provide NHS care for man in need of hospital bed—W.194/89–90

Matters considered *Inability of DHA to provide hospital bed or to contribute towards the cost of private care—adequacy of DHA's response.*

Summary of case A man suffering from dementia was admitted to a private nursing home on the advice of a consultant psychogeriatrician, who could not offer him a NHS bed. The man's daughter understood the consultant to have told her that the Department of Social Security (DSS) would meet the full cost of the nursing home's fees—but, as she discovered after her father's admission, his income and the benefits to which he was entitled fell short of the fees by some £50 per week. The woman contacted the consultant and made representations to the DHA in an effort to secure her father's admission to hospital, or to obtain financial assistance. Although she learned that her father would certainly be admitted if a bed was available, the DHA subsequently told her that they were not empowered to help financially by meeting the shortfall; that they did not have the finance available to cover the full costs of her father's care; and that there were others waiting to be admitted to a NHS bed whose need was considered greater. The woman complained that the DHA denied her father a service to which he was entitled, and that their responses were unhelpful and, at times, unsympathetic.

Findings I thought that the woman's expectation that the DSS would cover the financial shortfall probably arose from a misunderstanding, for which I was not disposed to criticise the consultant. In the nursing home the father's condition improved to the extent that, at around the time when the consultant first heard of the difficulty over the fees, he was thought potentially suitable for transfer to local authority (Part III) residential accommodation. However, he was found on assessment to be unsuitable for such a placement. From that time on, the consultant and others concerned were in no doubt that he needed nursing, rather than residential, care—and additional social factors arose from his daughter's own health. Although the consultant considered it most unlikely that the man could be offered a NHS bed unless his condition deteriorated, the daughter was led to believe otherwise. I found it regrettable that the true position had not been explained to her and that she had been left too much to her own devices. It seemed to me that, after the Part III assessment, a multi-disciplinary discussion would have helped all concerned to focus on her predicament and, possibly, to provide some constructive help—although I did not find, generally, that those concerned were unsympathetic to her situation. A letter from a Government Minister to a national charity implied, to me, that the NHS had an absolute duty to provide care in circumstances such as those arising in this case. I took this up with the chief executive of the NHS management executive, who told me that a health authority's duty to provide care was qualified by the resources available, and that 'top-up' payments were not possible. I accepted that, where—as in this case—demand exceeds available resources, there may be some whose clinical priority is such that their needs cannot be met under the NHS.

Remedy The DHA apologised to the complainant and agreed to make her a suitable *ex gratia* payment in recognition of the distress she had been caused as a result of the shortcomings which I found.

Expectations of a private patient—W.206/89–90

Matters considered *Pre-admission information—service and care provided—reimbursement of accommodation charges.*

Summary of case A woman was admitted, as a private patient, to the general practitioner (GP) maternity unit (the unit) of a hospital, having had two previous confinements in the hospital's private ward, which had been closed. Wanting rest after the birth of her child, she had arranged to stay in the unit for three days but, in the event, that rest was denied her because her baby was kept in her room and there were other sources of disturbance. She complained that the service and care had been of a much lower standard than she could reasonably have expected in the light of her two previous private admissions. In accordance with the policy operated by my predecessors and myself, I asked that, without prejudice to the outcome of my investigation, the woman should first pay to the DHA concerned their charges for the accommodation; she agreed to do so.

Findings I established that the unit was an active delivery unit with facilities geared to an admission of 24 hours, and its purposes and practices were fundamentally different from those which had prevailed in the private ward. The Department of Health (DOH) handbook on 'Management of private practice in health service hospitals in England and Wales' requires patients to be fully informed, before they give an undertaking to pay charges, about the nature of the facilities available. I found that, contrary to that guidance, the woman had not been given the relevant information, in advance of her admission, to decide whether she would obtain the rest she sought. She told me that, had she known what to expect, she would have stayed in the unit for the 24 hours for which it was designed.

Remedy The DHA apologised for the shortcomings I identified and, on my recommendation, reimbursed to the woman the charges paid by her for two of the three days of her stay.

Handling of complaint by Family Practitioner Committee (FPC)—W.212/89–90

Matters considered *Handling of, and responses to, a complaint.*

Summary of case A woman concerned about her young son's condition telephoned a deputising service at 7.45 am, and the receptionist first advised her to ring the GP after 9.00 am but then agreed to take a message for him. At 9.10 am another receptionist contacted her to say that she should now telephone the GP herself. Her son was later admitted to hospital, and she complained to the FPC, as it then was, about the deputising service's response to her call. Despite her own enquiries and others made for her by the CHC, she received no response from the deputy administrator (the DA) until nine months later, and she had to wait a further two months for his definitive reply. She complained about that, and that she had not been told whether the GP had been asked about the incident. She was concerned also that the FPC did not appear to have obtained an assurance that receptionists employed by the deputising service would not in future decide what constituted an emergency.

Findings I found that the DA had in fact set enquiries in train on receiving the complaint but had not then followed them up, and I criticised him for that and for not writing to the complainant. What is more, other staff at the FPC had not taken positive action on reminders from the woman and the CHC, nor had the general manager intervened when the complaint was brought to his attention. I did not uphold the complaint about lack of enquiries of the GP, as I was persuaded that the DA had done so and had told the woman, albeit belatedly, about the position. I discovered

that the DA, not being satisfied with the response from the deputising service, had decided to pursue matters through the joint deputising sub-committee. However, he did not tell the woman that, nor did he follow up his approach to the sub-committee—which was satisfied that deputising service receptionists would not decide what was an emergency but would pass calls to the GP concerned—until prompted to do so by my officer. I upheld the complaint about his failure to inform the woman of the final outcome of her complaint.

Remedy The FPC—later FHSA—apologised for the shortcomings I identified.

Communications surrounding a decision not to resuscitate a patient—W.258/89–90

Matters considered *Family not consulted about decision not to resuscitate—DHA's failure to resolve complainant's concerns.*

Summary of case An elderly woman, who was suffering from bronchopneumonia, was admitted to hospital as an emergency. Five days later, her son discovered that her clinical notes stated that she was 'not for the 222s', which meant that, in the event of her requiring cardio-pulmonary resuscitation, she would not receive it. In fact, the woman made good progress and was eventually able to go home. The son complained to the DHA about three issues—why the decision not to resuscitate had been taken; why he had not been consulted or informed; and what the DHA's policy on resuscitation was. He met the district general manager (DGM) and a registrar soon afterwards but remained dissatisfied, so he then wrote to the regional medical officer (RMO). The RMO advised him to discuss the complaint with his mother's consultant which he did some five months after the date of his original complaint. The son continued correspondence with the DHA about their resuscitation policy until he eventually complained to me.

Findings I found that the decision that the woman was not to be resuscitated had been made, on the night of her admission, by a house officer in the exercise of clinical judgment. The consultant said that, by not reiterating the decision at a ward round the next day, he had in effect cancelled it—but his junior staff did not realise that, and no change was recorded in the clinical notes. My investigation also revealed a worrying divergence of view about policy on consulting relatives. The consultant believed their attitude should be taken into account in arriving at a decision, whereas the junior medical staff did not think that was required—or even appropriate. Responsibility lay with the consultant to ensure that a common policy—written or otherwise—was followed. In upholding the complaint, I noted with approval that the DHA had later produced a written policy which called for a non-resuscitation decision to be entered in the clinical records, reviewed daily and time limited; and set out the approach to, and arrangements for, consulting relatives. I found it surprising that a written policy on such a difficult and sensitive issue was viewed as something of a novelty. With regard to the handling of the complaint, I found it regrettable that the DGM had met the son at a time when the consultant was unavailable, as that reduced the chances of resolving the complaint at that stage. The DHA's subsequent handling was confused and unco-ordinated and, while I found that they had gone to some lengths to help the complainant, I upheld the complaint.

Remedy The DHA apologised for the shortcomings I identified. I told them that I intended to refer in my Annual Report, which I present to Parliament, to the question of a written policy on resuscitation, and I have raised the matter in general terms with the Chief Medical Officer of the DOH.

‘Patient’s friend’ at a meeting with a consultant—W.369/89–90

Matters considered *Refusal of consultant to allow a CHC representative to accompany patient at a discussion about clinical matters.*

Summary of case A man who had been admitted several times for treatment of his condition complained to the hospital, through the local CHC, about his treatment and aspects of his stay. He was not satisfied with their reply and sought a meeting with the consultant surgeon responsible for his care (the consultant), saying that he wished to be accompanied by a representative from the CHC. The consultant agreed to meet him but was not prepared to accept the presence of a CHC representative, and the man complained that that was unreasonable.

Findings I found that the main purpose of the proposed meeting, which should have been viewed as part of the man’s concern to resolve his complaint, was to allay his concerns and obtain explanations. The man felt that he would be at a disadvantage on his own and needed support from someone with more experience in such situations. The consultant, on the other hand, was prepared to see the man either on his own or accompanied by a relative, and only if that failed to satisfy him would he then see him with someone from the CHC. However, I was in no doubt that the man wished the secretary of the CHC to act not as a representative of that body but as ‘patient’s friend’. I believed that it was for the man to decide who his friend should be, and that his request to be accompanied at the meeting was both reasonable and consistent with the intentions behind DOH guidance to health authorities on the investigation of complaints; it also accorded with the DHA’s own guidance, in draft at the time of the original request. I upheld the complaint.

Remedy The consultant agreed to meet the man in the presence of the CHC secretary acting as ‘patient’s friend’. The DHA apologised for the difficulties the man encountered.

Delays in handling a complaint under the independent professional review (IPR) procedure—W.411/89–90

Matters considered *Delay in arranging IPR and informing the DHA of findings.*

Summary of case A woman originally complained to the DHA about hospital treatment received in April 1988. They were unable to resolve her concerns, so her complaint was referred in December 1988 to the RMO for consideration of an IPR. On 4 October 1989 the RMO’s clinical complaints adviser (CCA) met the woman and the CHC secretary and agreed to an IPR. Not until three months later was the woman told that independent assessors had been appointed and would like to meet her at the IPR on 31 January 1990. She was notified of the outcome on 7 February, and on 3 April she expressed to the CCA her concern that the IPR findings had still not been conveyed to the DHA, who were therefore prevented from monitoring the implementation of remedial measures which had been promised. The CCA wrote accordingly to the DHA on 18 April.

Findings Some initial delay in obtaining the clinical notes from the DHA had not been of the RHA’s making, but I noted that the RMO had shown no concern about that at the time. After the notes were received, the delay of some eight months in arranging a meeting with the woman was accounted for by three factors, none of which in my view exonerated the regional health authority (RHA) from allowing matters to drift for as long as they did. In particular, it seemed to me that the three months taken by the CCA to arrange a preliminary meeting with the two consultants involved in the woman’s care brought the complaints procedure into disrepute. I strongly criticised the delays in progressing the second stage of the clinical complaints procedure, and I considered the RHA to have been

discourteous in not approaching the complainant during that stage. I noted that the RHA had since introduced a procedure for keeping complainants informed of progress. I was also critical of the CCA for having notified the woman direct of the results of the IPR instead of arranging for that to be done by the DHA, as laid down in the clinical complaints procedure. I considered that the delay in setting up the IPR, the failure to follow nationally-agreed procedures, and the consequent delay in giving information to the DHA constituted serious maladministration.

Remedy The RHA apologised for the shortcomings I found, having already changed their system to comply with the procedures and introduced a system for keeping complainants informed of progress.

Deficiencies in nursing care and poor communications—W.417/89–90

Matters considered *Delay in loosening plaster—inadequate nursing care—deficient and insensitive communications.*

Summary of case A woman was admitted to hospital for knee replacement surgery and, the day after her operation, experienced severe pain in her leg. Some days later part of the wound burst and, after swab tests, she was given antibiotics and a haematoma was evacuated. The woman's daughter asked several times to see a doctor but without success. She repeated the request when her mother returned from another hospital to which she had been transferred for skin graft, and a few days after that she eventually saw the consultant concerned. The daughter complained about delay in loosening the plaster when her mother experienced pain; that the nurses had ignored calls for help and had not provided medication when her mother returned from the other hospital; that the nurses had contravened medical advice in removing all of the sutures; that a sister had not acted on requests to see a doctor; that conflicting information had been given about the existence of an infection; and that, at the meeting with the consultant, four other people had been present without introduction or the daughter's prior knowledge.

Findings I found that the delay in loosening the plaster had arisen from failure to explain to the staff concerned new arrangements for locking away the equipment needed. Inconsistencies in the evidence about calls for help prevented me from reaching a finding about that, but I deplored the absence of nursing records for some three weeks of the woman's stay before she was transferred to the other hospital. I did not uphold the complaints about medication or, because professional judgment was involved, the removal of all of the sutures. I was, however, critical of the nurses' failure to arrange earlier for the daughter to see a doctor—particularly given the complications arising from the operation and the mother's distress about that. I found it understandable that the patient and daughter had been confused by diverging perceptions among the staff as to what constituted an infection—and I noted a paucity of entries in the clinical records. Finally, common courtesy in my view demanded that the presence of others at a meeting should be explained and that consent should be obtained to the involvement of medical students. All in all, I was disquieted by the lack of records which must have made continuity of care difficult and compounded the problems faced by the DHA, and later by me, in investigating the complaints.

Remedy The DHA apologised for the deficiencies I found. They agreed to remind nurses of the need to record and act upon requests to see a doctor; to stress the importance of endeavouring to resolve any difference about the presence and significance of infection; to keep under review practice in making regular entries in the records; to remind consultants of their responsibility to obtain consent to the presence of medical students; and thoroughly to review their methods of investigating complaints.

Provision of long-term care—W.478/89–90

Matters considered *Compliance with DOH guidance—DHA responsibility for provision of long-term care—dilatory handling of complaint by DHA.*

Summary of case A woman who had sustained severe head injuries in a road accident was discharged to a private nursing home after spending 18 months in a NHS neurosurgical unit. The woman's son complained that the DHA had not complied with DOH guidance on the discharge of patients from hospital, and that they had put undue pressure on the family to move their mother to a nursing home. He averred that the DHA were responsible for providing for his mother's needs, and he thought the DHA's handling of his representations about her care to have been dilatory.

Findings I found that DHA officers had regularly discussed with the family their mother's discharge to a nursing home, and that they had had no reason to believe that the family was opposed to it; however, contrary to DOH guidance, they had not obtained the family's agreement in writing to what was planned. Although I was unable to obtain evidence from one key party to the discussions, I was satisfied that no undue duress had been put on the family. I learned that the woman had been an in-patient since her accident, and that, although she no longer required the specialist facilities of the unit, she remained severely incapacitated and was likely to need sustained nursing care for the rest of her life. In the light of the Secretary of State's duties to provide services under the provisions of the National Health Service Act 1977, and the view expressed to me by the chief executive of the NHS Management Executive that NHS care should be provided without charge if in a doctor's professional judgment it was required, I concluded that the DHA had a duty to continue to provide the care the woman required, at no cost to her or her family. I also upheld the complaint about handling.

Remedy The DHA apologised for the shortcomings I identified. They agreed to review their discharge procedures to bring them into line with the DOH guidance, and to meet nursing home costs for the woman for so long as she was deemed, in relation to the provision of care or treatment which it is the function of the NHS to provide, to require such residential care. They also agreed to review their complaints procedures.

Provision within the NHS of long-term care—W.599/89–90

Matters considered *Responsibility of a DHA to provide long-term care for a chronically sick man.*

Summary of case A woman, whose husband suffered from a chronic debilitating condition, could no longer look after him and, through his GP, sought his admission to a NHS hospital. She was told that no beds were available for the chronic sick, so she arranged his admission to a private nursing home. She continued to press for his admission to a NHS hospital and, with influential support, was eventually offered a long-stay place—some nine months after her original request. The woman complained about the DHA's failure to provide, for that period, the continuing long-term care her husband required; and she sought redress.

Findings I established that the woman's request for long-stay care had not been put to the consultant geriatrician then responsible until some five months after her first approach to the GP. However, in the intervening period the consultant had assessed the complainant's husband during a brief admission for respite care. His view then, and later when the request was put to him, had been that the man needed constant nursing care but was not a priority for hospital admission—an assessment in my opinion made in the exercise of clinical judgment which I could not question. The decision later to offer the man a bed was taken by a new consultant whom the DHA asked to review the position, and his conclusion too was in my view founded on clinical judgment. Although I believed that the DHA

had a duty to provide some level of care for persons such as the woman's husband, I established that they had developed, and were keeping under review, policies which they believed made best use of limited resources. I found that the DHA's decision about the allocation of resources for the chronic sick was a discretionary matter, which I could not question unless there was evidence of maladministration in the way the decision was made—and I found no such evidence. Overall I did not find the complaint made out and made no recommendation as to reimbursement of private nursing home charges.

Delay in arrival of ambulance—W.652/89–90

Matters considered *Failure to provide ambulance as arranged.*

Summary of case At 10.18 am a GP telephoned for an ambulance to take a woman from her home to a hospital in another area where she had been receiving specialist cancer treatment. He asked for an ambulance 'the sooner the better' but agreed an admission time of up to 3.00 pm that day. At 12.09 pm the woman's husband telephoned the ambulance service (the AS) and told the control manager (the CM) that his wife was almost unconscious. The CM agreed to see if the woman could be moved earlier than planned. Having heard nothing further, another GP telephoned at 2.45 pm and was told an ambulance would arrive between 3.30 and 3.45 pm. As the woman's condition had deteriorated considerably, he asked if something could be done sooner; he was asked to telephone again if the situation got worse. At about the same time the CM offered the woman's husband emergency transport to a local hospital, but he declined that as it would not meet his wife's particular needs. By 4.05 pm no ambulance had arrived, and the GP told the AS that the woman was by then too ill to travel out of the area and should be taken to a local hospital. An ambulance arrived at 4.30 pm and took her to a local hospital, where she died shortly afterwards.

Findings I found that, contrary to the chief ambulance officer's definition of urgent cases, the initial request was treated as non-urgent. The control officer planned for an ambulance to collect the woman after it had first dealt with a transfer, which my investigation revealed to be non-urgent, of two babies. Those arrangements were destined for failure, not the least because the crew were delayed for one and a half hours while collecting the babies. Although the husband spoke to the AS twice, and the GP did so once, to say that the woman's condition had deteriorated, the CM did not upgrade the call to an emergency or discuss the matter with either a senior officer or the control officer, who remained unaware of the changing circumstances. Furthermore, neither the husband nor the GPs were kept informed of the problems in meeting the agreed admission time. I concluded that there were two main causes of failure. First, there was no common understanding between the GPs and the AS, or more worryingly among the AS staff, as to what constituted an urgent call. Second, the AS staff were not sufficiently trained or experienced to cope with the demands which arose that day. I upheld the complaint. However, some remedial measures had been taken by the AS during my investigation, including the issue of guidance to staff on the definition and handling of urgent calls, creation in the control room of a monitoring post, and display of urgent and non-urgent calls on different computer screens.

Remedy The DHA responsible for the AS apologised for the shortcomings I identified. They agreed to issue guidance to GPs about the information necessary to ensure that a call was dealt with appropriately. They also agreed to review training so that staff were systematically equipped to respond to the demands and pressures arising in the control room.

Failures in provision of ambulance transport—W.668/89–90

Matters considered *Method of carrying patient from home to ambulance—wrong type of ambulance provided—inaccurate and tardy response to complaint.*

Summary of case A woman fell at home and was taken to hospital by emergency ambulance. Two days later she was transferred to a neuro-surgical unit, where she later died. Her daughter complained that the ambulance crew had used a carrying chair rather than a stretcher to take her mother from her home to the ambulance; that the transfer to the neuro-surgical unit had been delayed because the wrong type of vehicle was sent; and that the ambulance service's response to the relatives' complaints was inaccurate and delayed.

Findings I criticised the ambulance crew in that, contrary to what they had been trained to do, they had not examined the woman fully on arriving at her home. However, I looked upon their decision as to how to take her to the ambulance as a matter for their professional judgment, having regard to their training and guidance. Although the training manual concerned required that stretchers should always be used for unconscious patients—and I understood the woman to be so—the chief ambulance officer said that crews were not required to adhere rigidly to that. I thought such ambiguity unsatisfactory, but I could not make a finding on this aspect. I found that initially the wrong type of vehicle had been sent for the inter-hospital transfer because, in the ambulance request, the need for oxygen during the journey had not been made known. I also upheld the complaint that the family had not been fully informed about the ambulance arrangements and probable delays. The ambulance service administrator who dealt with the complaints accepted that there were inaccuracies in his replies because he had misinterpreted reports given to him; and I found that there had been a delay of over six months before a representative of the ambulance service visited the family home where the earlier events had taken place.

Remedy The RHA responsible for the ambulance service agreed to remind staff of the need to examine patients thoroughly, and to ensure that the guidance issued to staff accurately reflected what was expected of them. They and the DHA concerned agreed to examine their administrative procedures to try to ensure that patients and relatives were better informed about non-urgent transfer arrangements. The DHA also agreed to complete a review, then in progress, into the way in which ambulance requests were recorded at ward level, and to issue clear instructions to staff.

Release of confidential information to the press—W.25/90–91

Matters considered *Release of confidential patient information to the press.*

Summary of case Two hospitals (the first and second hospitals) shared a transplant programme, and a girl with a severe disorder was admitted to the first hospital and put on the transplant waiting list. The girl died during transplant surgery, and the circumstances of her case were featured in the national press and in her parents' local newspaper—which also gave her name. The parents complained that the DHA responsible for the second hospital, through a consultant surgeon and others, had acted unethically and against their expressed wishes in releasing information which enabled the press to identify their daughter.

Findings I was left in no doubt that, to heighten awareness of the needs of the transplant programme, the consultant had deliberately released information to the press, on more than one occasion, about the girl's age, location, diagnosis and prognosis,

and that that information had led to the story about her, by name, in the local newspaper. I found that the consultant, apparently unaware that the parents had said specifically that they did not want publicity, had acted in direct contravention of the DHA's policy on confidentiality and, in so doing, had added to the parents' distress. I upheld the complaint.

Remedy The DHA, who had cautioned the consultant about his actions in this case, apologised to the parents and agreed to ensure that all their staff were aware of their responsibilities in respect of confidentiality.

Appendix

Case No W.375/88–89—Deficiencies in nursing care of a terminally ill patient

Background and complaint

1. The complainant's husband was admitted to a hospital (the first hospital), which is administered by a health authority (the first DHA), in June 1987 and underwent major surgery for cancer of the bladder. He was re-admitted in September and, on 2 October, was transferred to the infectious diseases ward (the ID ward) at another hospital (the second hospital), which is administered by another health authority (the second DHA). On 13 October the complainant was told that her husband was terminally ill, and she asked that he be discharged home. The next day a private ambulance took her husband home, where he died two days later.

2. The complainant complained about the standard of medical and nursing care her husband had received while he was a patient on the ID ward, and in particular that:

(a) on every visit she had found her husband lying naked and uncared for with his stoma bag leaking, so that she had had to ask the nurses for clean bed linen, pyjamas and a stoma bag;

(b) the nurses had not fed him even though he was too weak to feed himself, and his food had gone cold;

(c) despite having complained several times to a doctor (the first SHO) about her husband's condition and the lack of nursing care, there had been no improvement to his care;

(d) on 3 October she had discovered that two new pairs of pyjamas she had taken for her husband the previous day had disappeared, and they had never been found;

(e) despite requests she had made to ward staff during the weekend of 2, 3 and 4 October, she had been unable to speak to the consultant physician in charge of her husband's care (the consultant) about the tests or treatment her husband would receive and she had not been consulted or informed about the diagnosis or prognosis of her husband's condition until 13 October;

(f) when she visited her husband on 13 October she had found him on his bed in a semi-conscious state, naked and bleeding;

(g) when she asked on 13 October that her husband be taken home, she had been told that no ambulance was available, and she had had to make arrangements for a private ambulance at her own expense;

(h) on 14 October her husband had been discharged in an inappropriate condition, wearing only an old pyjama jacket and wrapped in white surgical paper and a blanket;

(j) the second DHA's responses to her complaints about her husband's treatment had been dilatory, unsatisfactory and misleading.

Investigation

3. I advised the complainant that my investigation might reveal that aspects of her complaint were about actions taken solely in consequence of the exercise of clinical judgment, which would take them statutorily outside my jurisdiction. I obtained the second DHA's comments and examined all the relevant documents, including the complainant's husband's clinical and nursing records. My officer took evidence from the complainant and from staff of the second DHA.

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(a) Lack of care for the complainant's husband; (b) food not given to him; (c) no improvements to care despite complaints to doctor; and (d) pyjamas lost

4. The complainant's evidence was taken from her written complaint and from her oral evidence to my officer. She said that the ID ward, to which her husband had been admitted late on Friday, 2 October 1987, contained many glass partitions. That evening, and every subsequent afternoon, she had arrived to find him lying naked on top of his bed in full view of staff and visitors. His stoma bag had leaked and he had been left in a dirty condition, so the first thing she had had to do was to clean him. No one had seemed capable of putting on her husband's stoma bags correctly. When she did it herself, there would be no leak. Her husband might well have pulled at his stoma bag, but even so, no one had noticed or changed his bed linen. She had complained to a doctor (the first SHO); as a result she was given clean bed linen to change the bed herself, because the nurses did not have time to do so. That shocked her after the care given at the first hospital.

5. Throughout his stay in the second hospital, her husband had been disturbed and greatly distressed. He had been in much pain and so weak that he was unable to feed himself. On 2 October she had noticed that his food had not been touched and had gone cold. No one had apparently helped him eat. She had taken in two new sets of pyjamas and a milk dessert and had washed him, dressed him in the new pyjamas, fitted a new stoma bag, made him comfortable and then given him the dessert. The next day she had found her husband in the same disgraceful condition, and had complained again to the first SHO. She had been given clean bed linen, a stoma bag and an old pair of hospital pyjamas, because the two new pairs she had taken in the previous day were missing. The nurse in charge had told her that she would be lucky to see them again if they had gone into the wash—they had never been found. Despite her complaints, nothing had changed or improved on subsequent days.

6. In his comments to me on behalf of the second DHA, the district general manager (the DGM) said:

> 'During his investigation of the complaint the Nurse Manager (the NM) indicated that whilst staffing levels on the ward at the time were not ideal due to a combination of factors, in his opinion the nursing profile [I understand that this confusing term simply means the records made by the nurses] showed that in all aspects consistent and persistent nursing care was given. However, throughout [the complainant's husband's] admission he exhibited varying degrees of confusion, wandering about the ward (both during the day and night) and frequently removing all his clothes.
>
> This problem was exacerbated by the fact that [the ID ward] (like all infectious diseases wards at the hospital) consisted of glass cubicles, and were not ideal surroundings for nursing confused patients. However, because of [his] unexplained fever it was essential to nurse him on an infectious diseases ward.
>
> I would add however, that I do accept that due to nursing shortages, nursing care may not have been up to the standard that I would have wished.
>
> The nursing profiles indicated quite clearly that although [his] appetite was extremely poor, a great deal of effort was made to encourage him to take food.
>
> I do however accept that it was totally inappropriate for discarded food to be left at the bedside. Whilst the removal of waste food and crockery is the responsibility of the domestic staff, [the NM] expects his nursing staff to remove it from the bedside and following receipt of this complaint reminded his staff of the need to ensure this procedure was carried out.
>
> [The complainant] stated that two new sets of pyjamas had 'gone missing' on the 2nd October 1987. Unfortunately this particular aspect of the complaint was not known until I received [the complainant's] letter of the 4th January 1989. . . a time lapse of some 15 months made it impossible to locate these items of clothing.'

7. I now set out the relevant entries in the nursing records:

(i) In the 'ASSESSMENT OF PATIENT NEED', the following problems were identified and supported by actions called for in a 'PATIENT CARE PLAN':

2 October — '[The complainant's husband] is confused
[He] has ? [Carcinoma]
[He] suffers from constipation
[He] has an ileal conduit'

12 October — [He] has an abdominal wound from abscess
[He] needs encouragement with diet and fluids
[He] is unable to care for his own hygiene.'

(ii) In the records maintained throughout his stay:

2 October — 'On admission [he] was extremely confused and has refused food. A close watch is needed as he tends to wander off the ward.'

3 October (midday) — 'Slightly confused this morning. Given much assistance with hygiene . . .'

4 October — 'Remains disorientated, keeps wandering up and down the corridor in his birthday suit . . .'

(pm) — 'Assisted with hygiene.
Assisted in the changing of his urostomy . . .
Needs encouragement with his diet [and] fluid. Very poor intake . . .'

5October (am) — 'Fair morning although remains ill and extremely lethargic and weak. Bed bathed and all care given—teeth clean. Pressure areas intact . . .
Intake poor and output reasonable. Bag changed and flange on ileal conduit, due to leakage—patient instructed and mostly did this himself . . .'

8 October — '. . . Has had some lunch and Build-up enjoyed. Much brighter . . .'

9 October — '. . . Diet taken in small amounts and fluids well.
Output reasonable.'

12 October (pm) — '. . . Wound redressed—oozing slightly but it is mainly dried blood, from removal of wick. Not taking diet at all even though he is encouraged, however he has been taking build-up and fluids when prepared and helped.'
and:
'[Seen by] doctor, paralytic ileus, for nil by mouth and IV [intravenous] infusion erected . . . Experiencing much pain in lower sacral area . . . [another senior house officer (the second SHO)] re IM [intra muscular] analgesia.'

13 October (pm) — 'Given bed bath and kept in bed . . .'

14 October — '. . Pulled the catheter and got soaked all over.
Changed and made comfortable in bed . . .'

8. A staff nurse who had been a third year student when the complainant's husband was on the ID ward (the student) told my officer that she had admitted him to the ward on 2 October and had been on duty quite often during his stay. (On the day of admission she completed a patient profile and the needs assessment (paragraph 7(i)) and plan, updating them on 12 October.) On admission he had been very confused, but she had not been aware at the time that he had a problem with his diet and hygiene. Those problems would have become apparent only after he had been cared for and assessed over a few days, and they had featured in the amendments made to the care plan on 12 October. She said that she had fed and

washed the complainant's husband on 2 October. The nurses would occasionally find him naked in the ward corridor, and they would return him to his room and dress him; they would also check his stoma bag because he used to pull at it. He had required constant care and had had to be washed several times a day but, five minutes after being washed and changed, he would be back to the same state. She had never seen him undressing himself but had found him wandering about the ward, and towards the end of his stay he had been nursed in bed. He would be dressed in pyjamas but, to prevent pressure sores, he might not always have worn the pyjama trousers.

9. The student said that, although the complainant's husband had refused solid food, he had been given supplements such as Build-up. A meal would nevertheless be ordered for him in case he could be persuaded to try it. The domestic staff were responsible for removing unwanted meals from patients' rooms, but not food supplements, which were taken away immediately after use. He had probably been fed and washed from the day of his admission, but that had not been recorded because low staffing levels meant that the nurses were too busy to do so. (She made the entry in the nursing records for 2 October and the first of the entries for 12 October (paragraph 7)). She could not recall any of his family complaining about his care, or the circumstances of the loss of his pyjamas.

10. A senior enrolled nurse (the first SEN) told my officer that she had been on duty for much of his period in the ID ward. Had the complainant complained to her—and she could not recall that—she would have asked for extra help. The complainant's husband had been very ill and ideally had required continuous attention. There were never more than three staff on duty in the evenings although the ward could usually cope, even with patients like him; however, during his stay there had not been many staff available. Patients were bathed or bed bathed every morning, after which they were attended to as necessary. Although she had never seen him lying naked on top of his bed he had been restless and inclined to kick off his bedclothes. He was liable to removing his pyjamas, but had never intentionally been left naked. (A statement which she prepared for the DHA on 11 April 1988 recorded that he 'appeared to me to be. . . apprehensive about his illness and embarrassed about occasional. . . incontinence'.) Although observation in the ward was hampered by the glass cubicles, nurses continually passed up and down the ward, and they would have dressed him had they seen him without clothes. She had not been aware of any problems with his stoma bag. The complainant had not asked her for clean linen or complained about standards of care; had she done so, the staff would have been only too willing to clean and change her husband.

11. The first SEN said that, from the day of his admission, staff had offered the complainant's husband alternatives, such as Build-up, to solid foods. Dietary supplement was prepared by the nurses in the ward kitchen, and any which a patient did not consume was taken back to the kitchen by a nurse. However, if food had been left in his room, that was because he had refused it. The domestic staff, who removed meal trays, went off duty at 1.00 pm and returned at 4.00 pm, so if a patient was a slow eater, the food tray might not be taken by the domestic; the nurses would remove it when they had time. She had not known about his missing pyjamas, but she would have expected any nurse told about the loss to check with the laundry. If it had been known that soiled pyjamas belonged to him, they would have been put into a soiled linen bag to give to the complainant.

12. An agency nurse (the AN) told my officer that, although the nursing notes showed (as I have seen) that she had spent a number of days on the ID ward during the complainant's husband's stay and that he had been under her care several times, she could not recall him. (She made the entries in the nursing notes for 5, 8 and 10 October and the second entry for 12 October (paragraph 7).) She was adamant, however, that he had had the best of care from her, and no nurse would have left him naked. As to meals, it could sometimes take up to one hour to feed a patient and, if the patient refused solid food, she would try an alternative. Nurses were usually allocated several patients, and they sometimes needed to leave one patient in order to attend to another. When that happened, the food and tray were collected by domestic staff. A meal would have been ordered for him regardless of

his appetite. No one had spoken to her about improving his nursing care, and it had been impossible to achieve one to one nursing care, which was what he had appeared to require. The ID ward had been no exception in being short of staff. She had no recollection of his pyjamas going missing.

13. My officer interviewed other trained nurses and nursing auxiliaries. Of those interviewed, only one sister (the first sister), a senior enrolled nurse (the second SEN) and two enrolled nurses (the first and second ENs) could recall the complainant's husband. They all gave similar evidence to that of the first SEN about his condition, his food intake, receipt of complaints from the complainant and his pyjamas. The first sister did not think that, while she was on duty, the complainant had found her husband naked and uncared for and, to her knowledge, staff had fed him although he had needed encouragement. Another sister (the second sister) said that nurses should change beds and care for a patient unless the relative had expressed a wish to do so. She did not think that nurses on the ward would have said that they did not have time to change his bed, but pointed out that nurses had other commitments and might not have been able to respond straight away. The first EN told my officer that he would sometimes remove his pyjamas, but nurses would dress him again. She had not seen his stoma bag leaking, even though she had changed it herself. Had the bag been leaking she would have recorded it in the nursing records. One of the nursing auxiliaries (the NA) told my officer that patients were bathed and dressed and given general care early in the morning. Confused patients were attended to frequently to make them as comfortable as possible. However, because the ID ward consisted of cubicles, it was difficult for nurses working at one end of the ward to keep an eye on patients at the other end. Her duties included feeding patients and encouraging those who were reluctant to eat to do so. Food trays were left inside a patient's room to be collected by a domestic assistant. She knew nothing about his pyjamas but thought that agency nurses in the ID ward might not have been familiar with what was, or was not, a patient's property.

14. The NM told my officer that, at the time of the complainant's husband's admission, there had been problems with staffing levels on his wards (three ID wards and a haematology ward). The hospital had been short of about 30 trained nursing staff, and he had moved staff among the wards and employed agency nurses. All his wards had lost staff through sickness, planned leave and vacancies. The ID ward had ended up with the first and second SENs effectively in charge, which meant that second level nurses had been acting as first level nurses, and that was not ideal. The AN allocated to the ID ward had been employed on a regular basis and chosen because of her known competence. The ID ward consisted of 20 beds and the full establishment should have provided five mixed grade staff on early duty (7.30 am until 4.15 pm) and three mixed grade staff for the later duty (12.45 pm–9.15 pm). The lowest staffing levels experienced during the complainant's husband's admission had been three nurses in the morning and two in the afternoon. Ideally he would have liked seven mixed grade staff on the early duty and four on the later duty.

15. I have seen that, during the 13 days of his stay on the ID ward, the first sister was in attendance on two days (10 and 11 October), the second sister on one day (4 October) and the third sister on two days (5 and 6 October). Reasons for absence were recorded as annual leave (3 days), bank holiday (4 days), day off (9), study day (17) and sick (1). The NM said that, at times of staff shortage, he worked on the ward himself and provided extra help from other wards. That apart, no regular first level cover was recorded on the seven remaining days.

16. The NM said that, during one of his visits to the ID ward, he had found the complainant's husband wandering naked in the corridor. He had dressed him and reported the incident to the nurse in charge. He thought that, because of her husband's condition and his confused state, the complainant would on occasions have found him naked with his stoma bag leaking. Her husband would have been in view of anyone passing, because the ward's glass partitioned cubicles could not

guarantee privacy. Relatives participated in patient care, and it would not have been unusual for the complainant to be allowed to change her husband's bed linen and his stoma bag, if she had so wished. Although the complainant might not have been told that directly, she had assumed that she could help. Nurses had told him about the problem with the leaking stoma bag, which he had thought to be due largely to her husband's restlessness; weight loss had also affected how well it fitted. He had told the nurses to sort it out, and that should have led to an improvement in his care. Attempts had been made to feed him and to give him fluids, otherwise he would have become dehydrated. Patients' property was lost from time to time, and his pyjamas had probably been put by mistake in the linen skip and taken to the laundry.

17. The first SHO told my officer that the second SHO had been directly responsible for the complainant's husband, although they had both been part of the same medical team. He had clearly been unwell and had had moments when he was sleepy, confused, aggressive and tearful. He had often taken his clothes off and wandered around the ward. On occasions the first SHO and his colleague had found him naked, taken him back to his room and dressed him; however, ten minutes later he would be undressed again. Nursing staff levels had been low at that time, and observation of patients on the ward was difficult. Taking that and his condition into account, the ID ward had not been the place to care for him. He tended to pull at the stoma bag in his agitation. Caring for a patient in his condition was very difficult, and such problems had been unavoidable unless someone were to stay permanently with him. He had been too unwell to eat and had required assistance. He could not recall that the complainant had ever complained to him. Had she complained about her husband's nursing care, he would have notified the nurses.

18. The second SHO said that she had once seen the complainant's husband lying naked with his stoma bag leaking: he was being attended to by nursing staff, who were trying to dress him and put his stoma bag back together. The layout of the ID ward was such that nurses would not immediately have been aware that he had undressed himself. She could recall the complainant being anxious about her husband's condition. She had no knowledge of problems with his feeding and no recollection of the complainant having complained to her about the standard of nursing care. Any complaint she would have recorded in the clinical notes.

Findings

Lack of care for the complainant's husband (a)

19. I am left in no doubt that, as the DHA have effectively acknowledged (paragraph 6), at times the staffing levels on the ID ward were inadequate to give the complainant's husband the degree of care and attention that he needed. What is more, the ward was often left in charge of second level nurses: many of the reasons for that (paragraph 15) were within the control of management, and for the NM to try to alleviate the staffing difficulties by working on the ward himself was in my opinion a worthy but inappropriate managerial response. I find it unsatisfactory that, by contrast with the establishment figures—let alone the NM's ideal target (paragraph 14)—cover dropped to as low as three nurses on early duty and two on late duty. It is hardly surprising that the best efforts of the nurses on duty—and I have noted that they did give such care as they could, including changing his stoma bag—were unable to match the needs of at least one of the 20 patients on the ward, the design of which made ready observation of patients difficult. The complainant's recollections of her husband's condition and appearance when she visited him on the ward are borne out by staff evidence, and I do not doubt that she asked for, and was given, clean bed linen, pyjamas and a stoma bag in order to attend to her husband's needs. Participation by relatives in patient care is not of itself a matter for criticism, and it is unrealistic to expect nurses always to be able to respond immediately a patient is incontinent or in a state of undress. I am, however, concerned that her husband's nursing care plan did not adequately reflect all aspects of the care he needed—there was no note of his tendency to undress himself and the action nurses should take to deal with that. I have also noted that the care plan was not reviewed for 10 days. I recommend that the second DHA review their arrangements for staffing wards to ensure cover is adequate for the needs of the patients. Further, I look to the second DHA to remind nurses of the importance of matching the nursing care plan to the patient's needs. I uphold this complaint.

Food not given to him (b)

20. I believe that, when the complainant found an untouched meal in her husband's cubicle on 2 October, he was nourished with a food supplement made up by nursing staff in the ward kitchen. The student's note in the nursing records states that he refused food (paragraph 7), but her recollection (paragraph 8) is that he would have been washed and fed that day. I think it likely therefore that the complainant arrived after her husband had been attended to but before his conventional meal had been removed. I do not believe that nurses neglected his dietary needs, for I have noted several references to them in his nursing records. Although I criticise the delay in updating the nursing care plan to show that he needed encouragement with his diet and fluids, I do not find this complaint made out.

Complained to a doctor (c)

21. Neither of the SHOs can recall any complaint from the complainant about her husband's nursing care. The nurses, too, have said that they do not recall receiving any complaint by the complainant, made either directly to them or through one of the medical staff—because of the passage of time, that is not altogether surprising. I have seen that there was nothing in the clinical or nursing records to confirm that the complainant did complain. In view of the lack of firm evidence on which to make a judgment, I can make no finding on this aspect of complaint.

Lost pyjamas (d)

22. The evidence of her husband's frequent need for changes of clothing leaves me in little doubt that two of his own pairs of pyjamas went missing; I do not doubt either that, had she reported the loss, attempts would have been made to locate them. However, it is not surprising that, by the time the complainant made her formal complaint some 15 months after the event, the second DHA were unable to trace them. None of the nurses can recall such an incident, and there is nothing in the notes about it. The probable explanation is that the pyjamas were not recognised as belonging to her husband but were sent to the laundry with other dirty linen belonging to the second DHA. A mistake appears to have been made, and I recommend that the DHA considers sympathetically any reasonable claim for reimbursement of the value of the pyjamas which the complainant may wish to make. I uphold this complaint.

(e) *Access to the consultant and lack of information about her husband's condition*

23. The complainant told my officer she had been informed at the first hospital that her husband was to be sent to the second hospital for blood tests. However, her husband had been transferred to the second hospital on a Friday, and no one had given him a medical consultation until the following Monday. At the second hospital there had been a total lack of communication. She had asked on 2, 3 and 4 October, to speak to a senior member of the medical staff about her husband's case, on each occasion being referred to the first SHO who said that he was unaware of the tests her husband was to have. She had also tried unsuccessfully to contact her husband's consultant from home by telephone. In desperation, on Monday 5 October, she had asked a consultant at the first hospital about the tests and treatment her husband was expected to receive; he had told her both then and again the next day that he was still trying to contact the consultant in charge of her husband's care. At 5.00 pm on 10 October she had spoken to some doctors, by appointment, in the ward office. The doctors had said that her husband had still to undergo some further tests and a scan, and that until those tests had been completed they could not tell her much, although they suspected that cancer remained in her husband's body. That had been her only meeting with medical staff at the second hospital. Apart from that and an explanation by the first SHO on 13 October that her husband had only two days at most to live, she had never been consulted, interviewed or informed about her husband's condition, his future treatment or the possible outcome.

24. The DGM commented to me:

> 'During the investigation [the consultant] was distressed that [the complainant] had not been able to make contact with him, as it had been clear from his diary commitments that he had been available within the hospital between the 2nd to 14th October, indeed he had seen [her husband] on the 5th and 13th October. In view of his concern he agreed to raise the matter with his staff.

In addition I would add that [the complainant's husband] was seen daily by the Senior House Officer, [named doctor] (one of the other Consultants in Infectious Diseases), Surgical Registrar, Consultant Haematologist and Consultant Neurologist.

. . . the medical staff involved stated, and indeed the nursing profile statement and notes would seem to bear it out, that [her husband's] condition was discussed with [the complainant]. Unfortunately the results of the biopsy confirming disseminated bladder cancer was not available until the 13th October and [the complainant] was made aware of the diagnosis later that day. At this point [the complainant] decided that she wished to take her husband home.'

25. The consultant gave my officer an account of the tests and opinions obtained during the complainant's husband's stay and of his own involvement in his care. By 9 October the medical staff had become pretty certain that there was a recurrence of tumour, and a biopsy had been performed the next day. On 12 October, the second SHO had concluded from bio-chemistry results that his problems were due to malignant disease. The final diagnosis had depended on the result of the biopsy, and that was when the first SHO had seen the complainant (see paragraph 26) and told her that her husband's illness was terminal. The consultant had intended to see the complainant himself when the biopsy result was received, but she had already decided to have her husband discharged. He never refused to see relatives, and it was quite possible that the complainant had approached one of his SHOs who told her that he would see her when the test results were known. He was surprised to learn that she had tried to telephone him, as he had been in the second hospital throughout her husband's stay on the ward. There had been nothing definite to tell her until 13 October, and if he had seen her before then he would have told her that he was waiting for test results.

26. The first SHO told my officer that he had been on duty on the weekend of 3/4 October but could not recall the complainant asking either if she could speak to another member of the medical team, or about the tests or treatment her husband would receive. After checking the clinical notes to see what the second SHO had written, he would have told the complainant that they were awaiting the results of tests taken and that things could not be taken further until those results were known. It was unfortunate if she had interpreted his responses as indicating a lack of knowledge about what was happening with her husband's care—in fact at that time none of the medical staff had known what was wrong with him. If the complainant had indeed asked him to arrange for her to see the consultant, he would have tried to do so because the consultant was keen to see relatives. He would also have recorded such a request in the clinical notes. Investigations had been undertaken from the day of admission to exclude the infective cause for her husband's illness and to establish a diagnosis. The second SHO had spoken to the complainant several times, and he had been present when she told the complainant that investigations were to be undertaken. From 10 October her husband's condition had deteriorated, and on 12 October a high calcium level had been attributed almost certainly to disseminated cancer. At about that time he had heard the second SHO explain to the complainant the possible significance of a large bowel obstruction, but that she was waiting for the results of the biopsy. The complainant could not have been told anything sooner than that, although he thought that the second SHO had spoken to her quite frequently during her husband's stay, in order to 'point her along the way'. Having received the results of the biopsy on 13 October, he himself had spoken to the complainant and had told her he was very sorry that the biopsy had confirmed what the second SHO had told her the previous day about cancer. He had told the complainant that there was nothing further they could do for her husband and that surgery was not indicated because the cancer was so widespread. He had then discussed with the complainant how best to treat her husband for his remaining days. He had known that her husband did not have long to live, but he did not think he would have put a figure to the possible number of days.

27. The second SHO told my officer that she had admitted the complainant's husband on 2 October and (as the clinical records showed) written up a plan of action for him, together with requests for investigations. She had not been on duty again until 5 October and had no recollection of the complainant asking her to arrange a meeting with the consultant. It would not have been difficult to arrange such a meeting, because the consultant was on the ward every day. She had had almost daily contact with the complainant during her husband's stay and had had several conversations with her about his condition; she had tried to keep her fully informed about the deterioration in his condition. The complainant's husband had been her patient, and she had had more contact than the first SHO with the complainant. She had spoken to her alone on 12 October in the ward office and had told her in specific terms of her husband's prognosis. At that stage her husband had been deteriorating, which was why she had specifically wanted to speak to his wife. She could not recall how the complainant had reacted to the news. On 13 October she had spoken to the complainant and her daughter before the first SHO did so, because the major decision had been taken to stop giving her husband antibiotics. The first SHO had told the complainant the results of her husband's biopsy.

28. I now set out the relevant extracts from the complainant's husband's records:

(i) in the clinical notes, the second SHO wrote as follows:

12 October	'. . . D/W [discussed with] wife Poor prognosis discussed. She is fully aware of probable diagnosis . . .'
13 October	'. . . Now appears terminal—rels [relatives] informed. Stop Clindamycin [an infection control agent]'

(ii) in the nursing records:

5 October	'. . . Wife to see doctor tomorrow evening . . .'
11 October	'Spoke to [the complainant] re: appointment [with] Drs [doctors] to discuss [his] condition. Will arrange a time tomorrow and then confirm with [the complainant]'
13 October	'. . . Wife [and] daughter came to visit, were very upset have been seen by the doctor

29. None of the nurses on duty on 2, 3 or 4 October recalled being asked by the complainant to arrange for her to see a doctor, but all said that, had they been asked, they would have done so. A sister (the third sister) confirmed that she had made the entry for 5 October in her husband's nursing records. It was possible that she had merely been recording what another nurse had told her, or that an appointment had already been made. Had she been asked by the complainant to arrange for her to see a doctor, that is what she would have done. The first sister recalled that, on 10 October, the complainant had asked to see a doctor and she had taken her to the doctor's office; the first and second SHOs were there, but she did not know which of them had spoken to her. The first SEN recalled seeing the complainant talking to the second SHO during her husband's stay on the ward.

Findings (e)

30. The consultant has said that he would never refuse to see a relative and that he was available throughout her husband's stay, but there was nothing definite to tell the complainant until the result of the biopsy was known. None of the medical or nursing staff interviewed by my officer can recall being approached by the complainant to make an appointment for her to see the consultant. Although there is a conflict in the evidence as to what precisely was said to the complainant by the first SHO, it is not disputed that he spoke to her during the weekend of 3/4 October. My investigation has established that the complainant was seen by medical staff that weekend and, at the very least, on 10, 12 and 13 October. Further, although records were not always made, the second SHO had said that she spoke to the complainant about her husband's condition on an almost daily basis. I am persuaded by the evidence that medical staff kept the complainant

reasonably informed of progress with the tests they were undertaking, and that they told her of the likely diagnosis and prognosis as soon as they were able to do so from results received. I have been unable to establish that any doctor or nurse was approached with a specific request to see the consultant, and I consider it unlikely that any such request would not have been acted upon. I do not uphold this complaint.

(f) *Poor condition on 13 October; and* (g) *no ambulance provided for discharge the next day*

31. The complainant told my officer that, when she and her daughter visited her husband on 13 October, they had found him lying naked on paper sheets on top of his bed; he was in a dazed condition and bleeding. She had demanded an explanation from the first SHO, who had then told her that her husband had only a few days to live and had asked her what she wanted to do. She had said that she wanted to take her husband home. The first SHO had then tried to arrange an ambulance but had been unable to do so because none was available. The first SHO had said that a private ambulance could be arranged and had offered to contact the St John Ambulance Service. She had told him not to bother, and that she would arrange an ambulance herself. When she arrived home that evening, she had arranged for an ambulance to collect her husband from the second hospital the following morning.

32. The DGM offered no comment on complaint (f). As regards complaint (g), he wrote:

> 'When [the complainant] requested to take her husband home on the 13th October it was explained to her that the [local] Regional Ambulance Service required 48 hours notice for a discharge, but that an agency such as the Red Cross or St John's Ambulance would provide a service for a fee.
>
> There appeared to be some confusion over the arrangements since the Ward Clerk, on [the complainant's] behalf had made provisional arrangements with a private agency which then had to be cancelled as it was discovered that [the complainant] had made her own arrangements.
>
> The question of provision of non-emergency ambulance transport was raised with [the ambulance service], and a course of action agreed whereby future requests could be processed via two divisional officers.'

33. The first SHO explained to my officer why the complainant's husband would have been bleeding on 13 October. An abscess in the line of an old wound had been surgically incised by a surgeon and the cavity packed. Rectal bleeding due to the biopsy (paragraph 25) had been expected to last for a few days and could not at that stage have been dressed. However, any bleeding due to the tumour would have been continuous. Paper sheets were used only when no conventional linen was available. Having informed the complainant of the results of the biopsy, he had then discussed with her at length how best to treat her husband for his remaining days. At first she had wanted him to arrange for her husband to be transferred back to the first hospital; he had attempted that twice but without success. The complainant had then decided that she wanted her husband to go home. He thought he had probably told her that it would not be possible to arrange an ambulance until the next day. His offer to contact the St John Ambulance Service had been made because it was in her husband's best interests to get him home as soon as possible. He had informed the general practitioner that he was to go home for terminal care, and he had alerted the district nursing service.

34. The second SHO thought it likely that the complainant's husband had been semi-conscious on 13 October; she had written in the clinical records that he was deteriorating fast. However, he had been conscious enough—as the notes showed—to pull out his naso-gastric tube and his intra-venous line and to complain of backache. She thought that he would also have been sufficiently conscious to remove his clothes.

35. The second SEN told my officer that she had been in charge of the ward from 12.45 pm until 9.15 pm on 13 October. During that time nothing had been said to her about the complainant finding her husband in a semi-conscious state, naked

and bleeding. Normally, paper sheets were used only when for one reason or another there was no stock of conventional linen, but the nurses might anyway have been using incontinence pads for him at that stage in his stay. She had been told, at hand-over, by a staff nurse that something had been said about him going home, but that she could not arrange an ambulance until the biopsy result was available. The second SEN said that it had been too late by that time to contact the ambulance service, because bookings had to be made before midday for ambulances required the next day. At about 4.40 pm she had seen the student looking through the telephone directory. The student had said she had been informed that the complainant's husband was to go home by private ambulance. The second SEN had told the student to leave it until the morning, because it was too late to get the drugs for him to take home and there was no doctor on the ward at the time.

36. Of the other nursing staff on duty on 13 October who were interviewed by my officer, none recalled him being in the condition described by his wife, or that they had attempted to get an ambulance to take him home. The first SEN said that the complainant had definitely not complained to her about her husband's condition. It was possible that he had been bleeding because of the tests but, if so, that should have been reported and a doctor informed. An entry which she had made in his nursing records suggested that she had nursed him at some time during that day, but she had no recollection of seeing him in the condition described by his wife; she would have made a note of any bleeding in his nursing records. The complainant's husband had been bed bathed (paragraph 7) and would have been dressed in pyjamas afterwards. The student drew my officer's attention to her note of 12 October (paragraph 7) that his wound was oozing and that he was lethargic and weak. She suggested that, on 13 October, the complainant might have seen the wound oozing through the dressing site and that, if there was a rectal discharge, he might not have been wearing pyjama trousers. She thought he should still have been covered up.

37. The NM did not doubt that the complainant had found her husband in the condition she had described, but he attributed that to his continued deterioration. Had nurses seen her husband in that condition, his wound would have been cleaned and he would have been re-dressed. He did not know whether nurses had been involved in getting an ambulance for his transfer home, but the complainant had been obliged to get a private ambulance only because, not unnaturally, she had been desperate to get her husband home.

38. A ward clerk (the ward clerk) told my officer that it was part of her duties to book ambulances. At about 4.45 pm on 13 October the first SHO had asked her if an ambulance could be arranged to take the complainant's husband home. She had replied that it could not, because the ambulance service required 48 hours' notice. Normally when booking ambulances she contacted the ambulance liaison officer, but she had not done so on that occasion because she had known what the booking policy was. The first SHO had then mentioned the possibility of a private ambulance, so the ward clerk had checked the telephone directory and had tried, unsuccessfully, both the Red Cross and the St John Ambulance Services. She had been so concerned that she had taken the details home with her and had telephoned again, but without success. She had tried yet again the next morning but, before confirming the booking, she had telephoned the complainant, who informed her that she had already arranged for an ambulance to collect her husband that morning.

39. A principal administrative assistant (the PAA) told my officer that, as a result of the complainant's complaint, the DGM had written to the regional ambulance officer (the RAO) asking for his views on the possibility of providing ambulance transport under circumstances such as those experienced by the complainant and her husband. The RAO had replied that, if the situation had been explained, the ambulance service would have done their best to accommodate the request. The RAO had suggested that, in such circumstances in future, the on-call administrator should telephone the ambulance service divisional officer (the DO) or his assistant (the ADO) to arrange transport.

40. The RAO's letter read:

'. . . I am convinced, if the full details of the case had been explained to the Service (I am assuming we were NOT asked to move the patient), that the request would have been dealt with sensitively and effectively.

You are no doubt aware that the 24 hours discharge arrangement (HC(78)45 [a circular issued by the Department of Health and Social Security, as it then was, refers to 48 hours] is in being, in order for the [ambulance service] to effectively cope with the known patient demand in any one day . . .

For future reference, if a similar situation to that described should arise, then please do not hesitate to advise your staff to contact either [the DO] or [the ADO], who will ensure the request is actioned by the Service.'

Findings

His condition on 13 October (f)

41. This incident seems to have occurred during the early shift when the ID ward was in the charge of a staff nurse who has left the hospital and whom I have been unable to trace. None of the other nurses interviewed by my officer can recall the precise state that he was in when his wife arrived to visit him on 13 October, or any expression of concern about that at the time by the complainant. However, with the evidence of the two SHO's and the NM, I accept her account as reasonable. I have already criticised in paragraph 19 the adequacy of nursing supervision in the ID ward during her husband's stay, and I am greatly concerned that, at such an advanced stage of his illness, he should have found himself in an environment which could not accommodate adequately his particular needs. I uphold the complaint.

No ambulance available (g)

42. The complainant believes that the first SHO was unable to arrange an ambulance for her husband's discharge the following day because none was available. She subsequently declined his well meant offer to arrange a private ambulance, saying that she would do that herself. It seems, however, that the SHO's attempt got no further than the ward clerk, who advised that the ambulance service required 48 hours for a discharge—she was, as I have shown, incorrect in that assumption. Subsequent events have shown that, had the circumstances been fully explained to the ambulance service, transport might well have been provided for her husband the following day. The second DHA have now agreed with the ambulance service a procedure which should prevent a recurrence of the misunderstanding which occurred in the complainant's husband's case. In recognition of the second DHA's failure to arrange a service at a time of a pressing and wholly understandable need on the complainant's part, I recommend that they reimburse her for the costs she incurred in providing a private ambulance for her husband. I uphold this complaint.

(h) *Discharged in an inappropriate condition*

43. The complainant said that the distance from her home to the second hospital was about 30 miles, and the journey had usually taken her about 50 minutes by car. Her husband had arrived home, by private ambulance, on 14 October wrapped in a blanket; he was wearing a 'tatty old pyjama jacket' and had had white surgical paper wrapped around his bottom. His wounds had been covered only with a piece of gauze. His condition, although not dirty, had not been what she was expecting.

44. The DGM commented to me on this aspect of complaint:

'There was some confusion as to whether [the complainant's husband] was transported home in a full set of pyjamas, but it was known that he was wearing a clean hospital pyjama jacket. In view of [his] condition and the fact that he was fitted with a catheter, he was placed onto a stretcher and an incontinence pad placed beneath him (I assume that this was the paper [the complainant] referred to) and then wrapped in a blanket.'

45. The first SEN told my officer that the complainant's husband had been so helpless and ill that both she and the second SEN had needed to prepare him for discharge. He had been bathed and dressed in a pair of hospital pyjamas and had then remained in bed until the ambulance arrived at some time between 9.00am and 10.00am. She had wrapped an incontinence pad around his bottom—she thought inside his pyjama trousers to keep it in place—and had placed a blanket around him. She had helped the ambulance crew to put him on to the stretcher. At that point he had been clean and ready to be discharged. She had accompanied him to the lift because he was restless, and she had been worried that he might fall off the stretcher. When he left the ward he had been appropriately prepared and his wound had been properly dressed. However, he had had a long journey ahead of him. She could not recall the condition of the hospital pyjamas, but she would not have sent a critically ill patient home in tatty pyjamas.

46. The second SEN told my officer that, on 14 October, she had suggested to the first SEN, who was in charge of the ward, that they should get the complainant's husband ready for discharge since they did not know at what time the ambulance would arrive. They had washed him and had dressed him in hospital pyjamas because there were none in his locker. The pyjamas had been near enough a correct fit, and they had been a full set. The ambulance crew had arrived before she and her colleague had finished preparing him, so they had had to wait. When he had been prepared, she had suggested that incontinence pads be placed on the trolley, because he had to travel a long distance and might need them. The pads had been placed on the trolley and not, she thought, inside his pyjama trousers. She and her colleague had assisted the ambulance crew to place him on the trolley on top of the incontinence pads. The ambulance crew had provided a blanket. He had been adequately covered and had been taken down in the lift to the ambulance. His pyjamas had not been tatty.

47. The only other nurse on duty that morning was the student, but she had no recollection of the complainant's husband being discharged. The NM told my officer that he had been satisfied that her husband had been wearing a full set of pyjamas when he was discharged. The pyjamas had been hospital property and had probably looked old because they did not last well in the laundry process. He thought that the white surgical paper referred to by the complainant had been an incontinence pad.

48. The private ambulance service were able only to comment as follows:

> 'We. . . confirm that our company conveyed [the complainant's husband] from [the second hospital] to his home. . . at approx. 1000am on 14th October 1987.
>
> Unfortunately I am unable to furnish any further information because the ambulance crew are no longer in our employ.'

Findings (h)

49. The complainant's concerns stem from what her husband was clothed in, and from the fact that he was not in her view adequately covered. I am persuaded, however, that the first and second SENs did all that could reasonably be expected of them to prepare her husband for his journey, and the use of incontinence pads—for I believe that is what the 'surgical paper' was—and gauze was in the circumstances not inappropriate in conjunction with the ambulance blanket. Although there is some inconsistency in the evidence of the first and second SENs about whether the incontinence pads were placed inside his pyjama trousers or on the trolley, I believe that he was dressed in a full set of hospital pyjamas, probably old ones, before leaving the ward. I do not exclude the possibility that, had her husband been taken home in a fully manned ambulance supplied by the ambulance service—as I have concluded he should have been—he might not have arrived home in a state so distressing for the complainant. However, I do not find the complaint against the second DHA made out.

(j) The second DHA's handling of the complaint

50. The following events and correspondence are relevant:

16 February 1988	The secretary to a local Community Health Council (the CHC secretary) wrote to the acting general manager of the first DHA, referring to complaints by the complainant about aspects of her husband's care at the first hospital and the discharge arrangements at the second hospital. The CHC secretary asked that the complaint be forwarded to the second DHA.
18 February	The first DHA referred the complaint about the discharge arrangements at the second hospital to the second DHA's chief nursing adviser (the CNA).
11 March	The CNA sent the PAA a copy of the correspondence for action.
15 March	The PAA copied the correspondence to an assistant unit general manager (the AUGM) asking for her comments.
26 April	The AUGM replied to the PAA enclosing statements by the nursing staff involved.
18 May	The DGM replied to the first DHA's letter of 18 February.
12 July	The complainant and a member of the Community Health Council (the CHC member) met representatives of the first DHA. During the meeting the complainant made many complaints about her husband's care at the second hospital and was advised to set them out in a revised statement of complaint.
10 November	The CHC member wrote to me enclosing the revised statement of the complainant's complaints, which included those made against the second hospital.
22 December	I wrote to the CHC member explaining that, as her complaints about nursing care at the second hospital had not been put to the second DHA, I could take no action at that stage.
4 January 1989	The CHC member wrote to the DGM enclosing the complainant's revised statement of complaint and asking for an investigation.
17 January	The DGM wrote to the CHC member seeking the complainant's approval for representatives of both DHAs to meet her at the first hospital after investigation of her complaint (that was agreed by letter dated 25 January).
10 February	The consultant provided his statement to the second DHA.
14 February	The NM provided his statement to the second DHA.
23 March	The first SHO provided his statement to the second DHA.
20 April	The second SHO provided her statement to the second DHA.
25 April	A meeting took place between the complainant, her sister-in-law and the CHC member and representatives from the first and second DHAs.
16 May	The director of planning and administration—in the DGM's absence on study leave—signed the DGM's response dated 9 May to the complainant.

21 July	The CHC secretary wrote to me saying that the complainant remained dissatisfied with the outcome of the second DHA's investigation and seeking my intervention.
4 October	My officer visited the complainant to discover the extent of her remaining grievances.
23 November	I wrote to the complainant saying that I had decided to investigate her complaints against the second DHA.

51. The complainant told my officer that she had not received satisfactory explanations from the second DHA, and it had taken them a long time to carry out an investigation. Their responses had made her out to be a liar and had been misleading in that the second DHA had initially said that the ambulance service required 48 hours notice but had subsequently revised that to 24 hours.

52. The DGM wrote in his comments to me:

'Initially [the CNA] received correspondence from [the first DHA] stating that they were investigating a complaint, part of which referred to transport arrangements and [the complainant's husband's] condition upon discharge. This complaint was processed through the appropriate channels and a formal response was forwarded to [the first DHA] on the 18th May. I accept full responsibility that [the complainant] was not sent a copy of the response or indeed contacted about this matter, but would point out that until [the CHC member's] letter of the 4th January I had been unaware of any other complaints against my Authority and indeed had not received any correspondence direct from either [the complainant] or [the CHC].

I would add however, that in order to prevent a re-occurrence of this type of error the Authority's formal complaints procedure has been amended to deal with complaints involving more than one Health Authority, with all parties receiving copies of correspondence and being involved in all meetings.

When I became fully aware of [the complainant's] concerns about her husband's treatment at [the second hospital]. . ., together with representatives of [the first DHA], [the consultant], [the NM] and I met with [the complainant] members of her family, [the CHC member] and [the CHC secretary] on 25th April 1989 to discuss the matter fully and offer our apologies for the obvious sorrow and distress that [the complainant] and her family had been subjected to and continued to experience.'

53. The NM told my officer that his first involvement in the handling of the complaint had been in about March 1988 when he was contacted by the AUGM. The complaint at that stage had concerned the difficulty the complainant had experienced in getting an ambulance for her husband, and his condition upon discharge. He had interviewed the third sister and the first and second SENs, all of whom had subsequently provided statements. The nurses' recollection had been quite clear, and he had had no problem getting the information from them. He had included their statements with his response to the AUGM. He had next become involved in February 1989 when asked by the AUGM for greater detail. He had re-interviewed the nurses and had reviewed the nursing records. Far from forming the impression that the nurses had neglected the complainant or her husband, he had felt that they had had a great deal of sympathy for them. After replying to the AUGM on 14 February, the next he had heard was a request to attend the meeting with the complainant on 25 April. The complainant had not accepted the explanations given to her at the meeting, but he had apologised to her for those areas of her husband's care which she had felt to be deficient. The DGM and the consultant had also apologised along similar lines.

54. The AUGM told my officer that, as designated officer for complaints within the medical unit, she had had the responsibility for co-ordinating investigations. The PAA's memorandum dated 15 March 1988 had been her first involvement with the complaint. She had written to the nurses concerned enclosing a copy of the complaint. She had received their responses but, because of the nature of the complaint, she had wanted to interview the first and second SENs herself. She had replied to the PAA on 26 April. When the complainant complained further in January 1989, a copy of the complaint had been sent to her. She had left the second DHA's employment in March 1989 and believed the DGM had subsequently taken over responsibility for the investigation.

55. The PAA told my officer that she had drafted the DGM's response sent to the first DHA on 18 May 1988. She thought it had been a mistake not to write direct to the complainant at that time. Although she believed the first DHA had known of the complainant's further complaints as a result of the meeting on 12 July 1988, the second DHA had not received full details until January 1989. An investigation had been undertaken and the second DHA had responded by meeting with the complainant on 25 April, and by giving her a written response on 16 May. The PAA would have liked a quicker investigation, but staff interviews had had to be arranged and there had been difficulty in agreeing a date for the meeting. She had drafted the second DHA's response for the DGM and did not consider the reply to have been unsatisfactory or misleading. The letter had not intended to mislead the complainant about the 48 hours' notice required by the ambulance service for handling discharges; it had accurately reflected the second DHA's understanding of the position at that time. Far from making out the complainant to be a liar, the letter had simply set out the second DHA's position as clearly as possible in response to the complaints she had raised. It had, where appropriate, accepted that there had been faults in relation to certain aspects of the complaint.

56. The DGM told my officer that the meeting with the complainant and her relatives at the office of the first DHA on 25 April 1989 had lasted about two and half hours, and all the complaints had been talked through. He had accepted that perhaps the staff at the second hospital had not communicated with her as well as they might have done, and that her husband's nursing care had not been all that it might have been, and he had apologised to her for those failures. He had taken the complainant's complaints seriously, investigated them and tried to remedy any faults found. He had thought they had done all that they could, but he had not been sure that they had satisfied her. He conceded that there was room for improvement in the length of time taken by the second DHA to deal with her complaints, although he believed that, once they had become aware of all her complaints, they had handled them well. He did not think that his letter of 9 May could have misled the complainant. There had been some uncertainty about the notice required by the ambulance service with regard to discharges, and he could understand that she might have been confused by that.

Findings (j)

57. The complaints (g) and (h) were included with others in a statement which, on 16 February 1988, the CHC secretary addressed to the first DHA asking for them to be passed on to the second DHA. The DGM accepts—and I agree with him—that, rather than relying solely on sending a response to the first DHA, he should have made contact directly with the complainant. Had he done so, it might well have been established whether the second DHA needed to be represented at the meeting on 12 July 1988, and they would then have become aware much earlier of the full extent of the complaints against them. As it was, they remained ignorant of the complaints (a) to (f) until the CHC member wrote to the DGM on 4 January 1989. That delay meant that some 15 months had elapsed since her husband's stay on the ward, and the second DHA's task of investigating those complaints had become correspondingly more difficult. However, even at that stage the complaint was not treated with proper despatch, for it should not, in my view, have taken a further three months to obtain statements from the staff involved in the complaint. I must record with complete sincerity that I have found nothing to substantiate the complainant's contention that the second DHA were accusing her of lying, or that

their references to the notice required for an ambulance journey were intentionally misleading. They attempted, through both the meeting on 25 April and the definitive reply of 9 May, to give a full answer to her concerns, but she apparently found their response unsatisfactory. Nevertheless, I uphold this aspect of her complaint to the extent that the second DHA could have acted more positively in mid-1988, and there were avoidable delays early in 1989. I note with approval that, for the future, the DHA have taken steps to ensure that complaints involving more than one authority are dealt with in a more effective way.

Conclusion

58. I have set out my findings in paragraphs 19–22, 30, 41–42, 49 and 57. The second DHA have agreed to implement my recommendations at paragraphs 19, 22 and 42, and they have asked me to convey through this report—as I do—their apologies for the shortcomings I have identified.

Case No W.194/89-90—Inability to provide NHS care for man in need of hospital bed

Background and complaint

1. In March 1988 a consultant psychogeriatrician (the first consultant) from a hospital (the hospital) made a domiciliary visit to the complainant's father who had recently returned from living abroad where he had been diagnosed as suffering from cerebral atrophy. After examining the complainant's father, the first consultant told the complainant that, although her father would benefit from admission to hospital, he was unable to offer him a bed and could not say when a bed might become available. The first consultant advised the complainant to find a place for her father in a private nursing home and gave her the names of four such homes in the area. The complainant subsequently managed to secure a place for her father in a private nursing home (the nursing home), where he was admitted the same day.

2. Following her father's admission to the nursing home, the complainant discovered that his income, together with the benefits to which he was entitled from the Department of Social Security (DSS), fell short of the nursing home's fees by approximately £50 per week. The complainant contacted the first consultant and then made representations, through third parties and direct, to the health authority (the DHA) which administer the hospital, in an effort to secure her father's admission to hospital or to obtain financial assistance. She subsequently learned, from a letter sent by the DHA to her Member of Parliament (the Member), that her father would certainly be admitted to a hospital if a bed were available, and that the DHA were unable to provide financial help. The complainant's father remained in the nursing home, with the arrears of fees mounting, until September 1989 when he was transferred to a residential home in another area.

3. The complainant complained that the DHA, having acknowledged that her father required a hospital bed, had nevertheless denied him a service to which he was entitled, and that their responses had been unhelpful and, at times, unsympathetic.

Jurisdiction and investigation

4. I explained to the complainant that aspects of her complaint might concern action taken solely in consequence of the exercise of clinical judgment, which would be outside my jurisdiction, but that it would be necessary for me to examine the circumstances so that I could decide whether or not this was so. During my investigation, I obtained the written comments of the DHA. I examined the relevant correspondence and related papers, including the clinical records relating to the complainant's father's outpatient care. One of my officers took evidence from the complainant; from her father's general practitioner (the GP); and from members of the DHA's staff. I also obtained the views of the Department of Health (DOH) and the DSS on the situation in which the complainant found herself.

5. The correspondence and other documents show the following sequence of events:

22 March 1988 — Following the domiciliary visit on 18 March, the first consultant wrote to the GP, describing the father's mental and physical condition and concluding that:

'. . . the most important issue in presentation is his immobility. I am glad to hear therefore that he will be reviewed by my colleague [a consultant geriatrician (the second consultant)] to whom I will copy this letter. I will also send a copy to the duty social worker . . . covering his geographical area since there is a possibility that permanent nursing care may not be available under the depleted National Health Service. It may be that private placement will be necessary and I left a list of the specialist homes in [the district] with the relatives as well as the telephone number of [a named organisation in the locality concerned with care for the elderly]. I also advised the family to seek a mobility allowance and an attendance allowance in order to boost their income.

For the moment I have not arranged to see the patient again . . . but naturally would be delighted to take him on board if he were 'up and about' . . .'

19 April — The first consultant wrote again to the GP following a visit to the nursing home on 15 April. He commented that he had found a 'remarkable' improvement in the father's mobility and general condition.

17 May — Following a further visit to the nursing home, the first consultant informed the GP that the father was continuing to make good progress and that some of the earlier symptoms had almost disappeared. He said that he proposed to see him again in six months time and he sent a copy of his letter to the second consultant.

1 June — The complainant wrote to the first consultant to request a medical report on her father with a view to her obtaining an enduring power of attorney.

8 June — The first consultant replied:

'. . . There is no persisting damage to his short term or immediate memory store and, as far as I could see, no evidence now of social decline. It therefore appears that the syndrome of 'dementia' is now quite in abeyance and he is certainly in a position to sign an Enduring Power of Attorney . . .'

I have seen that this letter contained no reference to the availability, or otherwise, of NHS facilities for her father although, commenting on concern which the complainant had expressed about her father's entitlement to DSS benefits, the first consultant had offered to secure advice from a social worker if she could provide further details of the problems she was facing.

18 November — The complainant's father attended an outpatient appointment at the hospital, where he was seen by a clinical assistant (the CA).

28 November — The CA wrote to the GP saying that she had advised the father to continue on the same medication and that she would review the situation again in six months.

The first consultant recorded, in the clinical notes, that the complainant had told him that the nursing home's fees had increased, and that he had advised her to look for a cheaper home.

14 December — The social worker wrote to the CA saying that he had heard from the complainant that the nursing home had put up its fees to a level she could no longer afford. He suggested that the father should, in view of the general improvement in his condition, be assessed to see if he was suitable for admission to a local authority Part III residential home (a Part III home).

17 January 1989 — The complainant's father was seen by the CA to assess his suitability for a Part III home.

The complainant wrote to the first consultant expressing her extreme concern that a decision on the matter of her father's transfer to a Part III home was unlikely to be made until March of that year. Her letter continued:

'. . . I don't think anybody realises just how desperate the family situation is . . .

. . . The Social Work Department have furnished me with lists upon lists of old folks homes which after making enquiries into every single one, I find they have either no beds available, or charge £250 plus per week or they are not suitable or cater for people such as my Father. Believe me, I have researched every avenue!

. . . are [my parents] not entitled to some assistance and care? Nobody seems to want to know. If I lose my job through all this, . . . who is going to help? Do I have to take my father & 'dump' him off in a casualty department somewhere and forget about him or is there somebody prepared to give him the assistance to which he is entitled?'

20 January — The first consultant replied:

'. . . You pointed out the current charge of £250 a week plus chiropody and haircut bills [and that] . . . your father had no savings and that mother too was ill and might well require nursing home nursing when she returns to Britain. You felt unable to meet the [nursing home's] charges and my suggestion is that, having already contacted [the named organisation in the locality], that you discuss the financial problem with the proprietor or matron at [the nursing home] and point out your inability to pay.

On the other hand I was pleased to tell you that my colleague [the CA] saw your father in her out patient session yesterday and deemed him medically well enough to be cared for in a local authority Part III accommodation and I will copy this letter to [the social worker] involved for his information.

. . . you . . . wondered who would fund their care if you were no longer earning for any reason. I do not see any situation wherein you would be required to pick up your father and take him to a local casualty unit though I extended my sympathy to you because of the anxiety such penalties of care have produced.'

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23 January — Following her assessment of the father on 17 January, the CA wrote to the social worker indicating that she considered him suitable for transfer to a Part III home.

25 January — The complainant wrote again to the first consultant about the outstanding fees at the nursing home, and expressed her hope that something could be done.

4 February — The complainant sent the first consultant further correspondence concerning the outstanding fees at the nursing home and wrote:

'. . . I hope my father's plight will be 'sorted out' soon. . .'

15 February — The first consultant replied:

'. . . I have passed your letter and the enclosure on to our senior social work colleague at [another hospital] who. . . is preparing a paper on this local and national issue with a copy to our own District Health Authority.'

15 February — The first consultant also wrote to the GP to inform her that a local authority panel (the panel) would be considering the complainant's father's suitability for transfer to a Part III home. His letter continued:

'. . . if he is deemed not fit for local authority care but requires more nursing, then he is the responsibility of the [DHA] and a bed would have to be found for him within the [district]. . .

. . .

. . . her father should by rights be housed in an NHS long stay bed if he requires nursing though this latter point does not seem to apply if [the CA's] opinion of the 23rd January still holds good as I think it must in view of the original diagnosis.'

3 March — The complainant updated the first consultant on the situation regarding the outstanding fees at the nursing home and expressed her concern lest the panel consider her father unsuitable for transfer to a Part III home. Her letter ended:

'I realise you have all been most helpful so far. . . but I really do hope my father's case will be in his favour.'

12 and 13 April — The complainant's father attended the assessment at the Part III home. One of the assessment reports ended:

'. . . To enable him to function adequately, [he] would be far better suited to a more secure environment, where structure is part of the everyday pattern of things. Trained staff would assist him with anti-social behaviour and aggressive outbursts.'

7 May — After hearing that her father was not considered suitable for a place in a Part III home, the complainant wrote again to the first consultant:

'. . . The matter I believe is to be passed back to [the CA]. As you know, I have researched fully, alternative places for my Father to go to. . .

. . .

It was in March '88 when [the GP] referred my father to [the hospital] Psychogeriatric department. He was only housed in a private nursing home as there was nothing the NHS could do for him then and I was not able to

nurse him myself. It has taken a whole year for the matter to go round in one circle, return to its original position without getting precisely anywhere.

I have done the best I can, I have researched the problem fully, my mental health has suffered, I have got myself into debt with the nursing home arrears, I cannot afford to supplement my Father's fees. . . .

. . . Can anyone help?'

8 June — The Member wrote on the complainant's behalf to district general manager (the DGM). He said that the complainant had to find £63 a week for her father's upkeep, and that she earned £500 a month.

12 June — The secretary of the community health council (the CHC secretary) wrote on the complainant's behalf to the DGM.

4 July — The CHC secretary wrote again to the DGM explaining that the complainant was being sued for approximately £2,500 by the nursing home and that her GP was concerned that her pregnancy might be affected.

7 July — A note on the DHA's file recorded that the complainant telephoned to enquire what progress had been made in dealing with her father's case.

7 July — The first consultant wrote to the DGM:

'. . . My opinion is that [the complainant's father] will require constant nursing care for the rest of his life as I do not think there will be much more improvement hereafter.

He is not so damaged as many of my demented patients in the community and even if we had NHS beds we would not give first choice to this patient. It would not even be fair to say that, his name being on the waiting list, he would eventually be given an NHS bed though this is possible if he became much more damaged and 'came to the top of the priority list'.'

10 July — The DGM replied, in almost identical terms, both to the Member and to the CHC secretary:

'. . . I have now discussed [the complainant's father's] situation in detail with [the first consultant] who is fully aware of his circumstances. [The first consultant] is in full agreement that [he] should be provided with nursing home care and because of his circumstances would like to be able to offer him a hospital bed instead. Unfortunately, as you will be aware there is a shortfall of dementia beds in the District and even though a new 24 bed dementia ward has just been opened the majority of these beds are occupied by patients who have been transferred from [another hospital]. Some time will elapse, therefore, before the beds in the new ward will be of benefit to the local population.

. . .

In view of the problems which [the complainant's father] and his family are facing he would certainly be admitted to a dementia bed if one was available, although as I believe his daughter is aware, there are several patients waiting for a bed who have greater priority and who are ahead of [her father] on the waiting list.

I understand that the Nursing Home have threatened to sue [the complainant] with regard to the unsettled bills which have accrued there. Unfortunately, there is nothing that the Health Authority can do with regard to this as we are not empowered to make top-up payments to cover the difference between private nursing home rates and DHSS benefit rates, nor is the finance available to enable the Authority to meet the costs of his care. [The first consultant] has suggested a number of voluntary sources to which [the complainant] may apply for help including the local Council and [the named organisation in the locality] ([telephone number]). So far, however, she has not been successful.'

11 July — The complainant wrote to the DGM:

'As a result of the shortfall [in nursing home fees], I have been forced to liquidate all my Father's assets and have been unable to meet this shortfall for the last two months. I have received a letter from the nursing home's agents informing me that if they do not hear from me in the next few days they will sue me for the arrears. Yesterday, I received a telephone call from [the DHA's planning and patients' services manager (the PPSM)] advising me that there was no money left for the Local Authority or NHS to help with this situation.

I am at my wits end having unsuccessfully tried to obtain further funds to cover the shortfall from the DSS. . . I have approached everyone I can think of for help. No one is willing to accept any responsibility. . . If you cannot help or cannot afford to fund this situation, surely you must know who to contact in the NHS in these circumstances so that one or the other of you takes responsibility.

. . .

Please tell me what you will do to help me.. . .'

20 July — The DGM replied:

'. . . I understand that you have been sent a copy of the letter which I wrote to [the CHC secretary]. Although I have the utmost sympathy for the position in which you find yourself, I am unable to add anything further to the comments which I made in that letter.'

19 July — The PPSM's assistant made the following note of a conversation between the PPSM and the complainant:

'File Note re: [the complainant's father]

1) [The PPSM] spoken to [the complainant] on 19.7.89. She told him that she has received from the CHC a copy of [the DGM's] letter dated 10th July 1989. [The PPSM] said that there was nothing he could add to this.
2) [The complainant] informed [the PPSM] that she has referred the case to the Health Service Commissioner.
3) [The complainant] also noted that she had referred the case elsewhere including [the named organisation in London, and another organisation] etc.
4) [The complainant] was v[ery] reasonable bearing in mind the nature of the problem.
5) [The PPSM] advised [the complainant] that in his opinion she was not legally liable for the bills.'

6. The complainant told my officer that, at the domiciliary visit in March, the first consultant had told her that her father should be provided with nursing home care, but that no NHS beds were available in the district. In giving her the names of the four homes, he had given her the impression that the DSS would meet the fees, although he might not actually have said as much. The first consultant had continued to see her father as an outpatient but she had not contacted him again until her letter of 1 June. By November 1988, it had become clear that the DSS would not meet the full cost of the fee shortfall. She had telephoned the first consultant about the situation and, because he had expressed surprise, she felt certain that he had not explained in March that nursing home fees varied and might sometimes exceed DSS financial assistance. The first consultant had told her that he could not admit her father to a NHS bed, as all beds were occupied, and that since her father's condition had stabilised, there was nothing more he could do for him. He had suggested that her father might be considered suitable for a place in a Part III home and had told her that he would refer his case to a social worker at the hospital (the social worker). The first consultant had in her view 'passed the buck', as she had felt certain that, owing to her father's aggressive behaviour, he would not be considered suitable for a residential home.

7. The complainant said that the social worker had arranged an assessment, which had consisted of a medical examination (on 17 January 1989) and a series of one-day introductory day care sessions in a Part III home. She had been advised, towards the end of March or early in April, that her father was not considered suitable for residential care. Thereafter she had spoken to the first consultant on a number of occasions, but had not been able to obtain any information as to when her father might be offered a NHS bed. He had told her several times that he wished he could offer her father a bed, but that none was available. He had given her the names of a number of organisations and individuals who might be able to help, including the Member, the CHC secretary and the DGM. She had pursued all the first consultant's suggestions, and subsequently both the Member and the CHC secretary had written to the DGM on her behalf.

8. Although the complainant had not written to the DGM until 11 July, she had telephoned his office on a number of occasions during June and July, leaving messages with his secretary and expecting him to telephone her back; he had not done so. On 10 July her call had been put through to the PPSM. Although the PPSM had known of her father's situation, he had not been able to offer any helpful advice. His manner had been brusque and unsympathetic; she had gained the impression that he thought that she was wasting his time. She had asked the PPSM whether he was able to give an indication of when a bed would be found for her father; he had replied 'He will just have to wait until somebody dies' or words to that effect. The complainant later said that she had asked the PPSM what he would do in her situation, and he had responded along the lines of 'You're an intelligent enough person, you've done your research, you should know what to do'. She was certain that the PPSM's reference to patients dying had been directly related to her father's case and that he had also mentioned something about filling 'dead man's boots' or 'dead man's shoes'. When my officer subsequently put to the complainant the PPSM's view that their discussion had been conducted in a pleasant and cordial atmosphere (paragraph 22) she responded that that had certainly not been the case. It would have been clear to the PPSM that she was annoyed by his remark about her being an '. . . intelligent enough person . . .', as she had commented on his attitude and said 'in my job I would not speak to anyone like that on the 'phone'. The PPSM had acknowledged that her father was in need of a long-stay bed, and the complainant thought that he might also have told her that there were other patients ahead of him on the waiting list. She could recall speaking only once to the PPSM.

9. The complainant said that the DGM's reply to her letter of 11 July had been both polite and sympathetic but had merely referred her to a copy of the letter he had sent to the CHC secretary. The CHC secretary had already given her a copy of that letter and of the DGM's almost identical reply to the Member. Both replies had acknowledged that her father should be provided with nursing home care and

that, because of his circumstances, the consultant would have liked to offer a NHS psychogeriatric bed if one had been available. She had also understood from the letters that there were patients ahead of her father on the waiting list, and that he would have to wait his turn before being admitted.

10. The complainant felt very dissatisfied with the manner in which the DHA had handled her queries to them concerning her father. Her father had first been assessed in March 1988, and not until July 1989, after much persistence on her part, had the DHA acknowledged in writing that he required a NHS bed. Each person she had spoken to had referred her to another. She had gained the impression that nobody really wanted to take responsibility for helping her to resolve her problem. Any information she had been given had been the result of her own perseverance.

11. The first consultant's evidence to my officer is contained in this, and the five paragraphs following. The complainant's father had, in March 1988, been suffering from symptoms of dementia, poor memory and social decline. He had been unable to stand, walk, or focus his eyes, and had required total nursing care. Because immobility had been the most important issue, and the hospital's psychogeriatric unit was not equipped for patients who could not walk, he had decided to refer him to the second consultant. He thought he had asked the GP to make the referral, although it was possible that he had done so himself.

12. He acknowledged that he had given the complainant a list of private homes, there being four in the area which were especially good for psychogeriatric patients. Although he could not remember the details of his discussion with her in March 1988, he did not believe that he would actually have recommended that she should find a place for her father in a private nursing home. As he had intended referring the father to the second consultant, there was a possibility that a bed would become available. He thought that he would have explained the situation regarding the availability of long-stay beds in the district and mentioned the possibility of finding a place for him in a private nursing home. He would have explained that the difference in the fees charged by the various homes was quite marked, and that the DSS allowance would meet the fees in total for some of the homes, but certainly not for all.

13. He had next seen the complainant's father on 15 April. Although he had noted a significant improvement in his general condition and his mobility, he had still been in need of total nursing care. The improved mobility had made a psychogeriatric (as opposed to a geriatric) placement more appropriate. However he had not considered the father for a bed on a long-stay psychogeriatric ward at the hospital, as adequate care was already being provided in the nursing home. By 15 May, his condition had improved to the extent that he would not need as high a level of care as that available on a psychogeriatric ward at the hospital. Referring to his contemporaneous clinical notes, he thought he would have required a level of care similar to that provided in a local authority residential home. However, he had not arranged for him to be assessed for transfer to residential care because, at that time, he had not been aware of any problem with the nursing home's fees.

14. In November or early December, after the complainant had told him of her problem with the nursing home fees, he had suggested to the social worker an assessment for local authority residential care. By that time he had not considered the complainant's father to be in need of a hospital bed. He had been surprised to learn, in May 1989, that he had not been found suitable for a Part III home. To diagnose dementia he tested only the memory parts of the brain, which in the father's case had been in good order, and he concluded that the area of the brain that controlled his social functions had been damaged (and hence the lack of suitability for the Part III home). However, that did not indicate a need for a hospital bed; the father's condition might have appeared worse, had he not been in a nursing home. The first consultant accepted that his letter of 15 February to the GP seemed to indicate that, at the time, he had considered that the father would require a hospital bed if deemed unsuitable for local authority residential care. In his opinion he had needed a level of care between that provided by a long-stay psychogeriatric unit and the facilities of a local authority residential home.

15. He confirmed that he had spoken to the complainant on a number of occasions after the assessment, but he did not think he would have told her that her father was not in need of a hospital bed. He had probably told her that her father was not as bad as many of his patients and that no beds were available in the district. He had suggested that she should try to find a less expensive home for him and had offered to help in that respect. He had also advised her to contact the CHC and the Member in order to highlight the problem.

16. He wrote to my officer following his interview with her:

> '. . . you asked whether I had told [the complainant] her father's name was or was not on our waiting list . . . I cannot recall that the question ever arose, and nor would it when one considers the other points hereunder . . .
>
> . . .
>
> At first presentation [the complainant's father] suffered the syndrome of dementia (a " dysmnesia " or poor memory, plus a social decline) and, as the " dementia doctor " I felt some responsibility to the patient and the family. Technically speaking this responsibility would draw to a close as early as May 1988 in view of the patient's dramatic improvement but I was not anxious to relinquish responsibility for someone who had been so ill and in any case I told the daughter on the telephone that I did not feel that there was any other professional who would act as an advocate for her in her distressing social predicaments so contact was established which continues to the present . . .
>
> You twice asked me to confirm that I had not turned his name down for a vacant bed because he was already in a nursing home. I twice gave you this reassurance and would add that a similar much more crippled patient . . . was actually admitted from one of the four nursing homes mentioned above because she could not meet the fees. She is still under our NHS care. I made the point that [the complainant's father] was so much recovered from his original illness that he would not have stayed in any hospital bed in our unit had I been able to offer admission because of the deteriorated condition of the others. On the other hand . . . he was still sufficiently damaged as to need some degree of nursing care and more than could be secured in a standard old folks home or local authority 'Part III home'. This sort of placement would have required much professional input from a social worker in conjunction with the family (our team had no such professional until a few weeks ago) and hence my attempts to seek out extra help from other social work colleagues . . .'

17. The CA told my officer that, at the outpatient clinic on 18 November 1988, she had observed that the complainant's father's mental and physical condition had improved significantly since March; however, he had still required some level of nursing care. She had next seen the father on 17 January and had found him well-orientated. His mobility had improved significantly, and he could walk without the aid of sticks. The matron of the nursing home had reported that he was no longer incontinent and that he was more independent. The CA had considered that he would be suitable for a placement in local authority residential accommodation and she had subsequently written to that effect to the social worker and to the panel. She had not seen the father again after 17 January.

18. The CA said that, following the decision of the panel in May 1989, the father would have been considered for a bed on a dementia ward at the hospital. However, his priority would have been lower than that of other patients with a greater need, both medically and psychologically. It was doubtful whether he would have been offered a bed, even if one had been available. However, she had not informed the complainant of her father's low priority when speaking to her on the telephone shortly after she had been notified of the panel's decision, as she had thought that that might upset her. She had simply told the complainant that no bed was available, and had suggested that she might be able to find a cheaper

nursing home outside the area. She had also given her the telephone numbers of the local citizens advice bureau and social services department. She had encouraged the complainant to contact her again if she had any difficulty in finding her father a cheaper home.

19. The second consultant's secretary told my officer that the complainant's father had been referred to the second consultant by the GP, on 14 March 1988. However, an out-patient appointment made for 22 March had been cancelled by the complainant, who had explained that her father was in an old people's home, and that the GP had been unable to arrange transport.

20. The second consultant told my officer that he had not considered it appropriate to accept responsibility for the father's care as, generally speaking, he did not see patients under the age of 75 (the father was 70) and patients with psychological or psychiatric problems were usually cared for by a consultant psychogeriatrician. However, he had agreed to see the father and the complainant on 22 March as he had wanted to explain in person the reasons why he felt unable to help. In the event, the complainant and her father had not been able to attend, and he had subsequently learned that the father was being cared for by the first consultant.

21. The PPSM told my officer that the DGM had passed to him the letters he had received from the Member and the CHC secretary, asking him to make enquiries into the case. He had in turn passed the letters to the manager of the hospital, for investigation. Following receipt of the CHC secretary's second letter, he had on 6 July discussed the case at length with the first consultant, over the telephone. The first consultant had said that he was unable to find a bed, and that even if that had not been the case, the complainant's father was not near the top of the waiting list, and it would be wrong to give him priority. The first consultant had explained that the list was not static, but stressed that it would be wrong to allocate the father a set number on the list as that might unreasonably have raised the complainant's expectations. The PPSM said that, after that discussion, he had asked his assistant to draft letters to the Member and the CHC secretary for the DGM's approval. He thought the letter had been sent before the DGM had received the consultant's letter of 7 July (paragraph 5).

22. The PPSM thought he had telephoned the complainant on 10 July, in response to her call to the DHA's offices on 7 July. He had not kept a formal record of the conversation but was able to recall much of the detail from rough notes which he had made at the time. The conversation had been quite lengthy and repetitive. The tone had been cordial throughout and he had been impressed with the manner in which the complainant was coping with the situation. He had been frank and open with the complainant about her father's situation. He had acknowledged that the father was in need of a long-stay bed and had told the complainant that no bed was available and that, even if there had been, there were other patients ahead of her father on the waiting list. The complainant had expressed concern about the outstanding fees at the nursing home, and he had told her that he did not believe the home would evict her father. At the end of their discussion, he had told her that she should speak to him again after she had seen the letter which the DGM was sending to the CHC secretary.

23. The PPSM was most concerned that the complainant had found him brusque and unsympathetic. He had had much sympathy and respect for her and had not been aware that she had been upset by his manner although she had clearly been unhappy about the information which he had had to convey. (The PPSM's assistant said, in separate evidence to my officer, that that accorded with her own recollection of the PPSM's sympathetic attitude to the complainant's complaint while work on the complaint was proceeding.) He denied that he would have said her father would 'just have to wait until somebody dies' or anything similar. He might have said something like 'the only way beds are released is through patients dying'. Referring to his conversation with the complainant on 19 July, the PPSM said that this had also been cordial although he had had to repeat much of the information which he had already given her. He had not treated the complainant's case unsympathetically; it was not his normal practice to discuss a complaint with a consultant direct, but he had done so in this case because of his concern for her situation.

24. The DGM told my officer that he had had little personal involvement with the case. He had seen copies of all the correspondence and signed the outgoing replies to the Member, the CHC secretary and the complainant. Although he had not spoken to the complainant himself, he would certainly have done so if he had been available when she telephoned, or if he had received a message specifically asking him personally to telephone her. He was frequently out of the office, and he suggested that her telephone call or messages might therefore have been directed to the PPSM. Moreover his secretary might have considered that the PPSM was in a better position to advise the complainant, as he had actually been dealing with her case. (The DGM, at a late stage of my investigation, had second thoughts, and said that he did recall speaking to the complainant about the complaint but could not remember the details of what was said.) He explained that the DHA had insufficient funds to pay for beds in private homes, and that they were expressly prevented from 'topping up' DSS grants to pay fees.

25. In his reply to me about the complaint, the DGM commented that he was a little surprised that the complainant considered no-one had been sympathetic to her problem. He said that everyone involved had understood the position she was in but had been unable to resolve the problem, and that the PPSM's assistant recalled that the PPSM had expressed to her several times during the DHA's investigation his utmost sympathy for the complainant's predicament. In his later evidence to me, the DGM wrote (but I saw no supporting documentary proof) that the consultant had informed staff at the DHA about the case in January or February 1989, and that, at the time of the decision that her father could not be accepted for Part III accommodation, there had been no social worker in his department and no community psychiatric nurse with whom he could discuss the complaint.

26. I have seen a letter dated 14 March 1988, from the Minister of State for Social Security and the Disabled (the Minister) to a national charity, dealing in general terms with this type of case:

> 'Decisions about the discharge of people from hospital are for the consultant in charge of the patient's care to make and must be made on clinical grounds. Financial considerations should not enter into the decision. Where it is decided that a patient requires continuing in-patient medical or nursing care, it falls to the NHS to supply it at no cost to the patient. The on-going care can be provided either by the patient remaining in an NHS hospital bed or for example by transfer to a private nursing home under contractual arrangements, with the NHS meeting the full cost and retaining the ultimate responsibility for the patient's care. It is of course for individual health authorities to decide the levels of contractual arrangements. In making such decisions a variety of factors have to be taken into account; cost is an important factor but it is not the overriding consideration.
>
> . . .
>
> . . . supplementary benefit cannot meet all charges. In the last analysis, where a person in a home can no longer meet his fees but still requires nursing home or residential home care it will fall to the NHS or local authority as appropriate to provide that care if it is not otherwise available to the person.'

27. Because it seemed to me that the Minister's letter implied that the NHS had an absolute duty to provide care for the complainant's father once it became clear that he could no longer meet the nursing home fees, I asked the DOH for clarification of the legal position and invited their general views. The chief executive of the NHS Management Executive (the chief executive) replied:

> 'There are, undoubtedly, real problems in the area which you are examining but it is difficult to be prescriptive about particular local circumstances. The position set out in the [Minister's] letter is quite correct, although it refers largely to the situation where a patient has already had a spell in hospital and consideration is being given to their discharge. Nevertheless, the same general principles apply. If in a doctor's professional judgement a patient needs NHS care, then there is a duty upon the Health Service to provide it without charge (except for items where there is a specific power of charging).

In the case of a patient such as you describe, this can be done by providing community nursing care to the patient's own home, by providing in-patient care or by a contractual arrangement with an independent sector home (ie paid for in full by the health authority). The level of service provided overall is a matter for individual health authorities in the light of local circumstances and priorities.'

28. Subsequently, the chief executive was good enough to provide me with a more detailed response, as follows:

'. . . there are four key points . . .

a. there is no general duty on a health authority to provide inpatient medical or nursing care to every person who needs it. Legal precedents have established that the Secretary of State's duty under Section 3 of the Act is qualified by an understanding that he should do so 'within the resources available' . . . Thus

b. in any particular case the provision of such care may be deferred so that cases may be dealt with, in order of clinical priority, within the resources available; and

c. consideration of clinical priority may mean that a particular patient may never be provided with in-patient nursing care. *Further*

d. Where a person is receiving private care, in a nursing or residential home, the Health Authority has no power to make 'top-up payments' to cover any shortfall between the charges of the home and any income support. . . health authorities have, financially, an 'all or nothing' responsibility for patients . . .

The Authority were faced with perhaps three courses of action:

a. to provide an NHS in-patient bed in the hospital or other suitable NHS premises (if beds were available); or

b. to purchase a bed for their patient in a private hospital or home (if resources extended to this for this category of patient); or

c. to advise . . . that their resources did not extend to (a) or (b) and the alternatives were:
—that [the father] should be cared for at home, with *some* NHS services provided by the DHA or GP and such social services as could be provided by the Local Authority;
—that [the father] should apply for a place privately in a private nursing home to which the NHS could not contribute.'

Findings

29. When the first consultant saw the complainant's father in March 1988, he was unable to offer him a bed on a psychogeriatric ward, and he evidently considered that a consultant geriatrician might be able to help improve the father's mobility. Against that background he sought to refer the father to the second consultant, provided the complainant with details of private nursing homes and gave her the telephone number of a voluntary organisation. I consider that he did what he could, in the circumstances prevailing in March 1988, to assist the complainant, and I believe her expectation, that any shortfall in fees would be met by the DSS, was most probably the result of a misunderstanding, for which I am not disposed to criticise the first consultant.

30. The complainant's father's condition subsequently improved and had reached the stage where he might be considered suitable for transfer to local authority residential care around the time when the first consultant heard of the difficulty over the fees. The final decision that the father was not suitable for transfer to Part III accommodation was conveyed to the complainant in May 1989 and is outside my jurisdiction as it was made by a local authority panel. Before then, however, the complainant had written to the consultant saying that she had been off work for one month suffering from depression, and on 7 May she wrote

referring again to the deterioration in her mental health and added that she was pregnant. By that time therefore it had been clearly established (paragraph 14) that the father needed nursing as opposed to residential care and there were the additional social factors to be taken into account arising from the complainant's own health.

31. The evidence suggests that from November 1988, if not before, the first consultant considered it most unlikely that a bed could be offered to the father unless his condition deteriorated. Furthermore, the first consultant's letter to my officer (paragraph 16) indicated that he considered admission might, by then, not have been appropriate because there were other patients with a greater need of a bed. It is regrettable therefore that the true position was not explained to the complainant and that even as late as 10 July 1989 the DGM wrote that the father would certainly have been admitted if a bed had been available. I have been told why it was that the consultant did not consult with professional colleagues (paragraph 25), after the decision that the father was not suitable for Part III accommodation, to consider what—if anything—could be done to resolve the situation. The fact remains, however, that the complainant was left very much to her own devices and, even though the outcome may well have been the same, a multi-disciplinary discussion on a situation such as this would have helped all concerned to focus on her predicament and, possibly, to provide some constructive help.

32. I have found no evidence to suggest that those concerned were not sympathetic to the complainant's predicament. There is a conflict of evidence between the complainant and the PPSM regarding their conversation on 10 July and, while the PPSM undoubtedly upset her, I do not believe that that was intentional. Nevertheless it seems to me that he was a little injudicious in the way he explained the situation to her.

33. I turn now to the central issue of the DHA's responsibilities towards the complainant's father. Health Authorities have a duty to provide some level of care for persons such as the father, who are judged to need long-term nursing care. However where—as in this case—demand exceeds available resources there may be some whose clinical priority is such that their needs cannot be met under the NHS.

34. It fell to the first consultant, after consultation with other members of the care team, to determine the father's priority in relation to other patients. The first consultant felt unable to offer him any service even though his need of long-term nursing care had been established. That was a decision which in my opinion was taken in the exercise of clinical judgment. However, I am concerned that the DGM was not made aware of his and the complainant's situation until he received the Member's letter of 8 June. If he had been told of the matter earlier it is possible that a more concerted attempt would have been made to help the complainant.

35. In sum, I uphold the complainant's complaint to the extent that she was misled as to the prospects of a hospital bed being found for her father and that the DHA did not address the situation with sufficient determination after he had been deemed unsuitable for Part III accommodation. I also believe that the PPSM was somewhat injudicious in the way that he spoke to the complainant on 10 July. I recommend that the DHA make a suitable *ex gratia* payment to the complainant in recognition of the distress she was caused as a result of the shortcomings I have found in the way her case was handled.

Conclusion

36. I have set out my findings in paragraphs 29-35. I was sorry to learn that the complainant's father, who had been admitted to hospital in another Health Authority, later in 1989, died in January 1990. I have criticised certain aspects of the DHA's handling of the complainant's case and I am pleased to record that they have agreed to implement my recommendation in paragraph 35. The DHA have also asked me to convey through my report—as I do—their apologies to the complainant for the shortcomings which I have identified.

Case No W.206/89–90—Expectations of a private patient

Background and complaint

1. On 16 August 1988, the complainant was admitted, as a private patient, to the GP maternity unit (the unit) at a general hospital (the hospital), because the private ward, to which she had been admitted for two previous confinements, was closed. She gave birth to a son that day and was discharged on 19 August.

2. The complainant complained that the service and care she had received in the unit were of a much lower standard than she could reasonably have expected in the light of her previous admissions as a private patient.

Investigation

3. I obtained the comments of the health authority (the DHA), which administer the hospital, and examined the relevant correspondence. My officer took evidence from the complainant and from the members of the DHA staff concerned. At an early stage of my investigation the DHA's legal adviser expressed some doubt whether I had power to investigate this complaint. I had no such doubt, nor had my predecessors in similar circumstances, as is evident from such published cases as W.401/79–80 and W.248/80–81.

4. The following extracts from the handbook of 'MANAGEMENT OF PRIVATE PRACTICE IN HEALTH SERVICE HOSPITALS IN ENGLAND AND WALES' (the DOH handbook), issued by the Department of Health and Social Security in 1986, are relevant to this complaint:

> 'DESIGNATED OFFICERS
>
> 34. Private patient officers [PPOs] must be designated at hospitals where the treatment of private patients is authorised . . . The [PPO] is responsible for:
>
> 34.1 advising patients who have elected to be treated privately before admission . . .
>
> . . .
>
> LOCATION AND AUTHORISATION OF PAY BEDS
>
> 39. There is no requirement that pay beds should be particular beds (or beds at particular locations within a hospital) set aside solely for private patients. Private patients may be accommodated in any part of an authorised hospital, in single rooms or other accommodation most suited to their medical and nursing needs . . . It is likely though, that many hospitals will have accommodation recognised as that to which private patients are usually admitted . . .
>
> . . .
>
> STANDARDS OF ACCOMMODATION
>
> 44. The charges payable by private patients are an average of the cost for all patients of providing accommodation and services at hospitals in the relevant class. The charges include not only elements for the room and "hotel" services but also nursing and other staff costs, drugs, dressings and capital expenditure. This should be explained to patients in advance.
>
> 45. Patients should also be told that admission as a private patient does not guarantee any particular level of service by the hospital or permit a higher standard of hospital care than is available to any other patient, private or not. If particular beds are usually used by private patients and it is known which beds are likely to be occupied, it may be helpful to offer to show the room to the patient in advance. Health authorities should arrange to do this where there is any doubt that the accommodation will be satisfactory to private patients.
>
> . . .

UNDERTAKING TO PAY

. . .

52. Patients should be fully informed before they give an undertaking to pay, of:

52.1 the nature of the facilities being made available (eg single room or other accommodation) see paragraphs 44 to 45

. . .

55. These explanations should always be given. It is not sufficient to rely on the patient or representative reading the form of undertaking. Nor is it safe to assume that information has been given to the patient at an earlier stage.'

5. Also relevant are the following extracts from appendix A to the DHA's 'PRIVATE PATIENT POLICY' (the DHA policy) which was in force at the time of the complainant's admission:

'*Procedure for Admission, Discharge and Invoicing of Private Patients*

. . .

Admission

1. When a private patient. . . is to be admitted as an inpatient, the Consultant or his medical secretary will contact the Sister on Private Ward to arrange admission . . .

2. If required the medical secretary will confirm the reservation to the patient in writing. . . plus information for private patients (form PP5) or these details may be given direct to the patient by the Consultant when the initial consultation takes place.

3. On the day of admission the form of undertaking to pay the private patient fee [form PP3] will be completed by the patient and collected by the Sister. The agreement form will be collected daily by the General Office staff.

. . .'

6. The complainant told my officer that she had decided to have private care for her third confinement because she wanted to have a few days' rest after the birth before returning home. She had discussed her wishes with the consultant obstetrician and gynaecologist (the consultant) who was caring for her. He had been unable to say where she would be accommodated in the hospital, as the private ward had been closed, but had told her that one option was the unit. She had been very happy with her two previous confinements in the hospital's private ward. Assuming that she would be provided with care of a similar standard, affording her the rest she sought, she had not asked for further information. She had not been given or sent form PP5 (paragraph 5), which gave details of private patient charges, before her admission; nor had she been offered a pre-admission visit to the unit or any information about its organisation or facilities. She had not been told that she could expect no better service than that available to NHS patients (paragraph 4). Having previously visited a friend on the unit (in 1985), she had known that it was an active delivery unit (where mothers gave birth in their rooms rather than in a labour ward), but not that the unit policy required mothers to keep their babies with them at all times, or that there were no nursery facilities. After her admission and shortly before the birth of her son, a staff midwife (the SM) had asked her to sign the form PP3 (paragraph 5). She did not recall being given form PP5 at that stage, but, if she had, she would have been unable to absorb the information, being by then well advanced in labour and having been given pethidine.

7. Contrary to her expectations, the complainant had found that she was unable to rest and relax, particularly as she was required to keep her baby in the room at all times. Being exhausted after having been in labour all the previous night, she had asked for her baby to be taken from her room for the first night after the birth; however, she had been told that that was against the rules of the unit. On the second night, the woman in the adjacent room had been in labour and in distress from midnight until about 6.00 am; the noise of that had kept her awake. What

was more, twice that night she had had to find feeds for her baby because there was no member of staff available to do so. The new-born baby in the next room had cried throughout the following day and, as there was no nursery or other provision for babies removed from mothers, the complainant had again been unable to rest. By the third night she had become distraught and the sister on duty (the first sister) had taken her baby from the room, though she had shown the complainant a notice to the effect that that was a dangerous and prohibited practice and had said that she would probably be reprimanded for what she had done. The complainant said her rest had also been disturbed on 18 August, when a party of visitors from the WRVS had visited the unit and the head of midwifery services (the HMS) had brought two or three of them into her room where they remained for five or ten minutes.

8. The complainant had asked friends not to visit as she wanted to rest, and visiting had been restricted to close family. On 16 August, her husband and two daughters (aged eight and eleven), who were visiting her, had been asked not to leave the room as a delivery was imminent elsewhere on the unit. On 17 August, one of her visitors had been asked to leave because there were too many persons in her room; and on another occasion her husband's 12 year-old brother had been refused entry. The complainant appreciated that, in an active delivery unit, it was desirable to have some restrictions on people coming and going, but that had made her feel uneasy and was not compatible with private patient status. On the private ward she had been allowed unrestricted visiting.

9. The complainant told my officer that, by contrast, on the private ward it had been up to her to decide whether to have her baby in the room with her, and her baby had routinely been taken to the nursery at night. Although very run-down in appearance, the private ward had been quiet, allowing her to rest; staff had always been available to help and she had been allowed unrestricted visiting. If she had been fully apprised of the nature of the unit—which she regarded as unsuitable for private patients—she would not have stayed for longer than the usual 12 to 24 hours after the birth. The service and care she had received were not of a standard to justify private charges and, at a meeting with the district general manager of the DHA (the DGM), she had offered to pay the amenity bed rate only but to donate the balance of the DHA's charges to the special care baby unit at the hospital.

10. The consultant told my officer that he could not recall the complainant telling him that she wanted a few days rest after the birth, or discussing how long she would stay on the unit. As the private ward was closed, the unit—providing in his view the highest standard of accommodation in the hospital—was the only other suitable accommodation for private patients. However, in a GP unit it was not possible to predict the level of activity or noise at any given time, and that sometimes made the unit unsatisfactory for private patients. The potential disadvantages in that respect should be pointed out to private patients at an early stage. He had had some sympathy for the complainant in her complaint first because she had been in the unit at a busy time, two other women having been delivered there during her stay whereas only about 150 deliveries took place in a year; and second that the staff had not taken away her baby when she asked them to do so.

11. On being told by the complainant that she wished to have her baby as a private patient, he would have informed the clinical matron for maternity (the CM) by telephone. Neither he nor his secretary would have given the complainant the PP5 form referred to in the DHA's policy (paragraph 5), as it was not their practice to do so; nor would he have explained that, as a private patient, she could expect no better service than that available to NHS patients. He would not either have explained the facilities and organisation of the unit, as he did not consider that to be part of his role. The consultant thought he had received a copy of the DHA's policy but did not recall any discussion on its implementation. He could not remember receiving a copy of the DOH handbook.

12. The first sister, who was on duty in the unit on the nights of 17/18 and 18/19 August, confirmed that, when the complainant asked for her baby to be removed from her room, she had explained to her that, as there was no nursery and she was attending to another patient in established labour, she would be unable to look after him. She had apologised for the fact that the complainant had had to look for baby feeds on two occasions: that too had been because the woman in labour had required attention. The following night she had shown the complainant the notice which said that, for reasons of safety and hygiene, babies were not to be removed from patients' rooms. However, because the complainant was very distressed and her baby was crying, she had, nevertheless, taken the baby out of the room. She did not think that the unit was a suitable place for a mother who wanted rest and her baby to be looked after. The noise of patients in labour meant that quiet could not be guaranteed.

13. The second sister, who had worked on the private ward and was now in charge of the unit, told my officer that the private ward had been purpose built, having three single rooms and a nursery. Patients had not been delivered on the ward but had returned there for post natal care. The complainant would have been allowed unlimited visiting; her baby would have been fed by staff if that was what she wished and would have been removed from the room on request. The unit, on the other hand, had facilities designed to correspond to a home confinement, and mothers usually went home 24 hours after delivery. It was not suitable for private patients because it did not have a day room, a nursery, or sufficient staff to feed babies; and a three day stay on the unit was too long.

14. The second sister said it was unfortunate that the complainant had been on the unit at an unusually busy time. The policy was that babies should be kept with their mothers at all times, but she would have expected staff to use their judgment and to have responded to the complainant's requests to remove her baby. She had refused entry to the complainant's 12 year-old visitor (paragraph 8) in accordance with the regulations for the unit, which prohibited visiting by children other than those of the patient. She confirmed that she and the HMS had accompanied a group of WRVS women around the unit on 18 August, and that a small group had entered the complainant's room, but for no more than ten seconds. (The HMS could not remember entering the room but said she would not have allowed the party to stay there for five or ten minutes (paragraph 7).) As the complainant had received her ante-natal care privately, she would not have received the usual pre-admission notes which described the way in which the unit was run. I have seen that a memorandum, about the unit, given to NHS patients read 'Your baby will remain with you in your room throughout your stay on the Unit' and 'Your own children are encouraged to visit you . . . it is not possible to admit other children'.

15. The CM confirmed the second sister's evidence about the differences in policy between the private ward and the unit. The complainant would have had very different experiences in each.

16. The SM denied that the complainant had been given pethidine before signing form PP3 (paragraph 6). She said the drug had been administered later, after she had been seen by the consultant.

17. The unit general manager (the UGM) told my officer that, at the time of the complainant's admission, no PPO had been designated under the provisions of the DOH handbook (paragraph 4). Nevertheless, the hospital administrator (the HA), who was responsible for the general office, had acted in that capacity. Accounting procedures relating to private patients were administered by staff in the general office whom she expected to act in accordance with the private patient policy (paragraph 5). The consultant had been responsible for explaining the facilities to the complainant and she was satisfied that he had done so, although she did not know if he had told the complainant about the level of service she could expect. She did not know whether the complainant had been given, and had had explained to her, form PP5; there had been no management procedure for recording that such information had been given to a patient. She had assumed that, when the complainant was admitted, an administrator from the general office had attended

208974 D

the unit, countersigned the PP3 form and made any other necessary explanations. It was unacceptable that the complainant had been asked to sign the PP3 form when in the late stages of labour, and that the general office staff had had no involvement in her admission arrangements. In the light of this complaint, her advice had been that the private patient procedures should be revised. However, she thought that the complainant had no substantial grounds for complaint, except in relation to the refusal to remove her baby—and the DHA had already apologised for that. She thought the unit was suitable for private patient care.

18. The HA stated that the consultant had been issued with a copy of the DHA policy, which had been introduced at a medical staff meeting in 1986. Either the consultant or his secretary should have given form PP5 and all necessary explanations to the complainant, as set down in the DHA policy then in operation (paragraph 5). The consultant or the second sister were the most appropriate persons to have explained to the complainant the differences between the unit and the private ward; administrative staff would not have had that information. Hospital policy had been revised in 1989 and a PPO appointed. The PPO now undertook the information duties formerly assigned to consultants.

19. The DGM commented that it would have been difficult for the DHA to anticipate the complainant's expectations. Although the consultant had received a copy of the DOH handbook on 12 June 1986, he could not reasonably have been expected to explain the differences between the unit and the private ward in which the complainant had been a patient six years earlier. The DGM did not think that a visit to the unit before admission would have highlighted her particular concerns. He acknowledged that the complainant had been disappointed with her stay but, in his view, her only justifiable grievance was that staff had refused her requests to remove her baby, for which he had already apologised. However, in that explanations had not been given to the complainant as required by paragraphs 45, 52 and 55 of the handbook (paragraph 4), administrative procedures had been deficient. As a result of the complaint, the DHA policy had been revised. At a meeting with the complainant on 12 May 1989, he had apologised for the refusal to remove her baby from the room and had offered to consider a reduction in that part of the hospital charges which related to administration. That amounted to 27 per cent of the daily charge of £134·00. The complainant had been unwilling to accept his offer, arguing that she should pay only the amenity bed rate (£13.00 per day), but he had been unable to agree to that (although I note that he accepted from her a cheque made out on that basis and then pressed her for the balance due on the DHA's account).

Findings

20. The evidence is unequivocal that the purpose of, and practices in, the private ward and the unit were fundamentally different. I have also established that, at the time of the complainant's admission—and perhaps because they had few private maternity patients—the DHA had not fully implemented the requirements of the DOH handbook. No one appears to have had the task of explaining to private patients beforehand what facilities and services they would have available. The UGM has said it was the consultant's responsibility to make all necessary explanations (paragraph 17), yet he did not see it that way. That the service and care the complainant received in the unit was very different from that which she had found in the private ward is beyond dispute. I cannot conclude, from that, that the service was, as a consequence, of a much lower standard, which was the complaint as put to me. However, I have noted that the differences between what was provided in the ward and the unit were well known to staff. That should, in my view, have prompted action in compliance with the concluding sentence of section 45 of the DOH handbook (paragraph 4). I find that the DHA failed to provide the complainant, in advance of her admission, with the information to which she was entitled and which in all probability would have enabled her to decide whether the private maternity care offered would have allowed her to have the rest she wanted. NHS patients were given a leaflet explaining the facilities (paragraph 14), but the complainant did not have access even to that information. The DHA's suggested remedy (paragraph 19) does not, in my opinion, adequately reflect the failures

which I have found. The complainant has said that, had she been fully apprised of the nature of the unit, she would have stayed for only 24 hours—that being the normal length of stay on the unit (paragraph 13). Before I agreed to investigate the complainant's complaint she paid, through her Member of Parliament, the DHA's charges for three days' private accommodation. I recommend that the DHA offer to settle the matter by reimbursing the complainant with the charges for two of those days.

Conclusion

21. I have upheld the complainant's complaint. The DHA have agreed to implement my recommendation and have asked that I convey to the complainant, through this report, their apologies for the shortcomings I have identified.

Case No W.212/89–90—Handling of complaint by family practitioner committee

Background and complaint

1. The complainant's son, aged six, was seen, and prescribed a course of treatment, by a locum general practitioner (the locum GP) on 11 October 1988. However, her son's condition deteriorated and the complainant telephoned a deputising service (the deputising service) at 7.45 am the following morning to request an emergency visit. The receptionist told the complainant to wait until 9.00 am and then to telephone the surgery of her general practitioner (the GP) but, at the complainant's insistence, agreed to take a message for the GP. At 9.10 am another receptionist at the deputising service contacted the complainant to advise her that, as it was then after 9.00 am, she should telephone the GP to arrange a visit. The complainant contacted the surgery, and her GP's partner arranged for her son to be admitted to hospital. Later that day, 12 October, the complainant wrote to the FPC—now the family health services authority—to complain about the deputising service. The first response which she received was a letter from the deputy administrator (the DA) dated 6 July 1989, and a definitive answer to her complaint was not sent by the DA until 26 September.

2. The complainant complained to me that the FPC's handling of her complaint was inadequate in that:

(a) there had been an unacceptable delay in replying to her letter of complaint despite repeated attempts by the local CHC to get a response;

(b) the DA had not informed her whether the FPC had sought information from the GP about the incident which had given rise to her complaint; and

(c) she had been given no indication that the FPC had obtained an assurance that receptionists employed by the deputising service would not in future decide what constituted an emergency.

Jurisdiction and investigation

3. I explained to the complainant that the legislation which governs my work prevents me from investigating the actions of general practitioners in connection with services which they provide under contract with FPCs, and that my investigation would therefore be limited to the FPC's handling of her complaint to them under the informal procedure. I obtained the written comments of the FPC and examined relevant papers. My officer took evidence from the complainant, the FPC staff involved, staff at the CHC and the GP.

(a) *Delay in replying*

4. The complainant told my officer that she had expected an acknowledgment of her complaint to be sent within a few days and a full reply in four to six weeks. Neither had happened, so she had telephoned the FPC, she thought in December. A female member of staff had told her that the letter could not be found but, when she telephoned a few days later, she had been told that the DA, who was dealing with the complaint, was not available; then when she rang again he was on sick leave. No indication had been given of when she might expect a reply.

208974 D2

5. In view of the lack of progress she had contacted the CHC, still in December, and the assistant there (the CHC assistant) had taken details and said she would pass them to the CHC secretary. The CHC assistant had telephoned the FPC several times and had written to them on 16 March 1989. Later that month, or possibly in April, the CHC secretary had told the complainant that she was likely to see the DA on 4 May and would ask him about the complaint: in the event she had not seen him but had spoken to the general manager of the FPC (the GM), giving him a copy of the letter of 16 March. The CHC secretary had written to the GM on 6 June asking for a progress report but had not received a reply.

6. The complainant said that the DA's letter of 6 July had expressed apologies for the delay in responding to, and acknowledging, her complaint. He had explained the enquiries he had set in motion at the time, including an approach to the GP who 'was intending to make his own investigation', and that he had received no response to these. He had therefore written directly to the deputising service about the matter and would write to the complainant again when he had received their response. His further letter to her of 26 September had enclosed a copy of the deputising service's response, which acknowledged that their staff should not decide what was an emergency—and added that they had found it difficult to believe that they ever would. The complainant described the FPC's covering letter as 'too little and too late'.

7. The evidence given to my officer by the CHC assistant and the CHC secretary confirmed that their actions had been as described by the complainant. The CHC assistant added that someone in the FPC's administration had, in responding to successive telephone enquiries, told her in December 1988 that the complainant's letter could not be found, and then that it was to hand; and on 1 February 1989 that the matter would be brought to the DA's attention and, later that month, that the DA was on sick leave. The CHC secretary, for her part, said that in a telephone conversation, after her letter of 6 June to the GM (paragraph 5), about another matter she had mentioned to the DA the complaint and the probability that the matter would be referred to my Office. Within a few days the letter of 6 July had been sent to the complainant, with a copy to the CHC, and had seemed to have been prompted by mention of my Office. The lack of a response from the FPC had not surprised the CHC secretary, as she had previously experienced problems in getting replies from them.

8. The DA explained to my officer that general practitioners were contracted to provide a 24 hour service to patients. Some were allowed by the FPC to use approved commercial deputising services, usually to provide cover, depending on their own particular requirements, on weekdays from 7.00 pm to 7.00 am, at weekends and for one half day a week. Such an arrangement was a matter of contract between the general practitioner and the company concerned, the FPC's role being limited to monitoring the effectiveness of the arrangement. Most deputising services also offered an answering service usually to cover the period from 7.00 am to 7.00 pm and, although the FPC was not obliged to monitor that service, the DA said he had taken the view, on receiving the complaint, that it was appropriate to do so. Although the complaint should have been directed to the GP for attention in the first instance, he had decided to pursue the complaint himself in the context of the FPC's monitoring role. The family practitioner committees in whose area the deputising service operated had established a joint deputising sub-committee (the sub-committee) and had appointed as co-ordinator (the co-ordinator) the manager of the family practitioner committee for the locality in which the deputising service was based. Investigation of complaints within the FPC's monitoring role involved writing, through the co-ordinator, to the deputising service. He had written to the co-ordinator on 4 November 1988, enclosing a copy of the complainant's letter of 12 October to him, and he had also spoken to the GP about her complaint. He accepted that he should at the same time have acknowledged receipt of the complainant's letter.

9. The DA could not remember either that the CHC assistant and the complainant had telephoned, or whether the CHC assistant's letter of 16 March (paragraph 7) had been passed to him direct—although he admitted that it

probably had. He had not dealt with the copy of that letter, received by the GM in May (paragraph 5), or the CHC secretary's further letter of 6 June until his response of 6 July to the complainant. He had been conscious throughout June that he should be writing to her, but he had given other matters priority. As he had not received any response from the co-ordinator or the GP, he decided on 7 July to write to the deputising service direct, and they had replied on 22 August. He had then sent a final reply to the complainant on 26 September, which he accepted was 'too late' (paragraph 6). He had tried to convey what his enquiries had revealed, but some general issues had remained to be taken forward. He acknowledged that he had not conveyed that to the complainant. Complaints had not been closely monitored at that time, but management in his department had since been strengthened and an administration manager appointed, who either handled complaints herself or allocated them to another officer. Complaints were now generally acknowledged promptly, a timetable had been devised and the administration manager monitored progress. The DA was satisfied that complaints were now being dealt with promptly and efficiently.

10. The GM, to whom the DA was directly responsible for complaints work, told my officer that the regulations on handling of complaints received by family practitioner committees did not extend to the resolution of complaints such as that from the complainant. He agreed with the DA that the complaint should properly have been passed to the GP, to take up with the answering service, and the complainant informed accordingly. That the complainant's letter of complaint, the original of which he could not recall having seen, had not even been acknowledged was unforgivable. He had only become 'really conscious' of the complaint after its referral to my Office. He might not have seen the CHC assistant's letter of 16 March, as letters were usually passed straight to the person responsible for the subject matter; that letter, too, should have been acknowledged. He could not remember the CHC secretary speaking to him about the complaint, but that did not mean that she had not done so. He could not recall either having received the CHC secretary's letter of 6 June but thought he would have passed it to the DA, telling him to sort the matter out; however, there were no instructions on the letter—it was his usual practice to write such handling instructions on letters— so he might not personally have seen it.

11. The GM did not know why the delay experienced by the complainant had arisen but thought the absence of a 'bring forward' system was likely to have been a contributory factor—he was unhappy about reliance on reminders from patients. He regarded the handling of the complaint as abysmal and the delay as indefensible. He was reviewing complaints procedures in the light of the complaint, and he assured my officer that similar cases in future would be monitored against a timetable.

Findings (a)

12. The GP's surgery was covered by an answering service from 7.00 am to 9.00 am on 12 October 1988, and the underlying complaint was strictly one for the GP to deal with. Nonetheless the DA decided to investigate the complaint within the framework of the FPC's monitoring role, but he took no action on the lack of response from either the co-ordinator or the GP until his letters of July 1989 to the complainant and to the deputising service. I agree with the GM that it was indefensible for the complainant to have to wait nearly nine months for any response to her complaint, and then another two and a half months for a definitive reply. I criticise the DA for not acknowledging receipt of the complaint or following up the enquiries which he had, commendably, set in train early in November 1988; those staff at the FPC who did not apparently take positive steps in response to telephoned and written reminders from the complainant and the CHC; and the GM for failing to intervene to ensure that the enquiry was brought to a speedy resolution when the matter was drawn to his attention in May and June 1989. I have noted with approval that complaints procedures have since been improved and that a monitoring system is now in place. I uphold the complaint about unacceptable delay.

(b) Failure to say whether information had been sought from the GP

13. The complainant told my officer that the GP would have been aware of the incident, as she had discussed it with his partner when he attended her son on 12 October. The GP had asked her, when she visited the surgery on another matter at some unspecified time before his retirement on 1 January 1989, if she had been in touch with the FPC, and she had deduced from that that the FPC had not approached him about her complaint. In a letter to me, she wrote that it was not clear to her whether the FPC had discovered the GP's version of events.

14. The DA said that he had telephoned the GP a few days after receiving the complainant's letter of 12 October. The GP had expressed concern and had said that he intended to follow up the complaint with the deputising service, as the complainant's calls should have been relayed to either himself or his partner. (The DA's account was corroborated by his letter of 4 November 1988 to the co- ordinator—see paragraph 18.) The DA had not heard further from the GP but, because the GP and his partner had retired at the end of December 1988, he had not pursued the matter. He had informed the complainant, in his letter of 6 July 1989, about his approach to the GP and the lack of response from him or the deputising service.

15. In his account to my officer, the GP could not recall whether he had spoken to the DA about the complaint, although it might have been mentioned during discussions about other matters, including his retirement, at about that time. He could not remember either that the complainant had told him what had happened, but he had somehow been aware of the incident. The answering and deputising services, although separate, came under the same management. When he and his partner were not in the surgery, an answering machine was used to invite callers to telephone the answering service if the matter was urgent. The answering service would pass messages to the doctor on call or the deputising service, depending upon the instructions they had for that time of the day. Patients were given the number only of the answering service, which was different from that for the deputising service. He thought that the complainant's problems might have arisen from her telephoning the deputising service direct. Messages taken by the answering service after 7.00 am should have been passed to either himself or his partner, depending on who was on call; he, however, had been on holiday during October 1988 and his post had been covered by the locum GP.

Findings (b)

16. I am persuaded that, although the GP could not specifically recall the approach, the DA did contact the GP soon after receiving the complaint. He has confirmed that he did not follow up the approach to obtain the GP's account of events or comments upon them, but he did tell the complainant—albeit very belatedly—about the position. I do not therefore uphold this aspect of complaint.

(c) Lack of assurance about role of answering service receptionist

17. The complainant told my officer that she had not been happy with the DA's letter of 26 September and was concerned that the deputising service's receptionists had not been given guidance on what they should do in certain situations. In a letter to me she wrote that '. . . There is no indication as to how [the deputising service] intends to ensure that its staff will not decide what is an emergency in the future. . .'

18. The DA said in evidence that it was not for the telephone receptionist to decide what was, or was not, an emergency; the receptionist should have told the complainant that a deputising service was no longer available but that a message would be passed to the GP or his partner, depending upon who was on call. However, details of the complainant's call seemed not to have been passed on, and nothing had happened until the other receptionist telephoned the complainant at 9.10 am. The DA's letter of 4 November 1988 to the co-ordinator (paragraph 8) said, on the matter of the complaint:

> 'I am. . . enclosing for your information, a copy of a letter of complaint which concerns a more recent incident. Having spoken to [the GP] it appears the normal practice is for [the deputising service's] answering service to take calls between 7.00 am and 9.00 am and then convey messages to either

[the GP] or his partner. Although this matter seems to relate to [the deputising service's] answering service I thought you and the liaison officer should be made aware. I know [the GP] intends to take the issue up with [the deputising service].'

19. The DA stated that he had expected a reply from the co-ordinator and that, with hindsight, he accepted that he should have asked for one. In July 1989 he had realised that he needed further information, so he had written to the deputising service direct. I have seen that, in his letter which enclosed a copy of the complainant's original complaint to the FPC, he referred to his earlier approaches to the co-ordinator and the GP; as the lack of response precluded a proper reply to the complainant, he asked about the outcome of any investigations that might have taken place. The deputising service wrote in reply that they had no record of the matter but that:

> 'I would agree with [the complainant] that our staff should not decide what is an emergency or not and I find it difficult to believe they ever would.
>
> I have spoken to operators on duty at [the] time in respect of the call to telephone the surgery themselves. I believe this was done because our operators at that time of day have the greatest difficulty getting through to doctors' surgeries and they may have their hands full with such calls.'

The DA described the reply as 'wishy-washy,' and he had thought that the deputising service would keep records of calls, but that did not seem to have been the case. In his letter of 26 September to the complainant (paragraph 9), he had told her that, although the deputising service could not say what had happened, they had agreed that their staff should not decide what was an emergency; and that he was not sure whether the outcome of his enquiries would totally satisfy her, but no doubt she would let him know. As to the general issues to be taken forward, he explained that the sub-committee met approximately four times a year and that, although their role was to review the performance of the deputising service, aspects of the answering service might also be examined.

20. The DA went on to say that his intention had been that the issues arising from the complaint should be discussed at the annual review held in June 1990, and with that in mind he had written to the co-ordinator on 8 February 1990:

> '. . .
>
> I do think that [the sub-committee] might seek assurances from [the deputising service] that they do have access to [subscribing general practitioners] at all times from 7.00 am on weekdays, whether at home or surgery. If there is a problem with GPs accepting messages, in particular between 7.00 am and 9.00 am, I think we should be made aware.
>
> No formal complaint has been pursued in this specific case, although we did agree to pursue . . . instructions given to answering service operators during the period from 7.00 am on weekdays.'

He had not attended the annual review and did not know how the matter had been taken forward. He later told my officer that the liaison officer at the sub-committee had expressed satisfaction, in the light of discussions with staff and management at the deputising service, that receptionists there would not decide what constituted an emergency: their sole function from 7.00 am was to take details of calls and pass them to the appropriate GP. The deputising service's policy was that they had to have access to duty doctors, and the liaison officer had not perceived any problem with that. The DA agreed that a letter explaining the outcome of the further action taken would have been an appropriate way of rounding off the complaint.

Findings (c)

21. The DA was not content with the deputising service's letter of 22 August and decided to pursue through the sub-committee the issues raised by the complaint. However, he did not tell the complainant about that, nor did he follow up his request to the co-ordinator until prompted to do so by my officer: I criticise him for that. The issues were later taken up with the deputising service, and I have

noted that the liaison officer was satisfied that, as urged by the complainant, receptionists there would not in future decide what constituted an emergency but would pass on all calls received to the appropriate GPs. The DA has said that he should have sent a further letter to the complainant setting out the final outcome of her complaint. That is my view also, and I uphold the complaint that relevant matters were left unresolved as far as the complainant was concerned.

Conclusions

22. My findings are in paragraphs 12, 16 and 21. I have found some serious lapses in the handling of the complaint. The FPC, or Family Health Services Authority as it now is, have asked me to convey to the complainant through my report—as I do—their apologies for the shortcomings I have identified.

Case No W.258/89-90—Communications surrounding a decision not to resuscitate a patient

Background and complaint

1. On 24 March 1988, the complainant's 88 year old mother was admitted as an emergency, suffering from bronchopneumonia, to a hospital (the hospital), which is administered by a health authority (the DHA). On 29 March the complainant discovered that his mother's clinical records stated that she was 'not for the 222s' which meant that, in the event of her requiring cardio-pulmonary resuscitation (CPR), she would not receive it.

2. The complainant complained that:

(a) the decision that his mother should not be resuscitated had been made without the family being consulted or informed; and

(b) the DHA's handling of his complaint had been unsatisfactory, and had not resolved his original concerns.

Investigation

3. I examined the complainant's mother's clinical and nursing records and other relevant documents. One of my officers took evidence from the complainant and the DHA staff involved. I formed the opinion, during my investigation, that some of the decisions taken by the staff concerned had been reached in consequence of the exercise of their clinical judgment: such decisions are statutorily not open to comment or question by me.

(a) *The decision not to resuscitate*

4. The complainant told my officer that before his mother's admission to the hospital, she had been very active. He had informed the admitting doctor, whom he named (the first HO), of that because he had wanted him to know that his mother had a good quality of life. He had asked the nurses about his mother's condition each time he visited, but they had said he needed to speak to a doctor. He had eventually spoken to a woman doctor on 29 March. She had opened his mother's clinical records and he had been able clearly to see the '222' entry. He had asked why it had been made, and the doctor had asked him whether he understood what it meant. He had replied that he did: his mother should not be resuscitated if she had a cardiac arrest. The doctor had said that she did not know why the entry had been made, and that it had been written by the admitting doctor. She had asked him if he would like it removed, and he had confirmed that he would. He had been upset and amazed that the entry had been made without discussion with the relatives.

5. The first HO told my officer that he had been on call on 24 March and had examined the complainant's mother in the Accident and Emergency (A and E) department at about 7.00 pm, before her admission. She had been rather unwell but the question of resuscitation had not crossed his mind at that point. Later that evening, another on-call doctor (the second HO) had telephoned him to ask whether the complainant's mother was for resuscitation. He had replied that she was not, and the second HO had made the entry in the records, on his instructions. The '222' entry had been made in the complainant's mother's records so that other

staff who attended her were aware of the decision. On 29 March the decision had been reversed, and he had thought that reasonable since the complainant's mother was by then on the road to recovery. He had no recollection of speaking to the complainant at the time of his mother's admission, although the complainant might have been present and have spoken to him. Such a conversation would not in any event have influenced his decision which had been taken in light of the complainant's mother's clinical condition and her age.

6. The first HO said there had not at the time been any written policy about resuscitation. The unwritten policy had been that, where circumstances left no room for doubt, the examining doctor would make the decision. If the doctor was uncertain, he would either contact his senior or leave the decision to the consultant. The decision in the complainant's mother's case had been an obvious one to take because her death, had it occurred, would have been due to respiratory failure, with secondary heart failure; her chance of survival would have been less than one per cent. It would not, therefore, have been a matter merely of restarting her heart. Had there simply been a deterioration in her condition, she would have received all the treatment necessary to save her life up to the point of ventilation and defibrillation. Normal policy had been not to inform relatives about resuscitation decisions because they would not understand, and that would be the last thing that relatives of an ill patient would want to discuss. Decisions not to resuscitate a patient were not formally reviewed, because most patients recovered.

7. The second HO, who was working abroad at the time of my investigation, wrote to one of my officers:

> '. . . I do not recall [the complainant's mother] . . . another House Officer saw her in [the A and E department]. It was the usual practice for patients to go to the overnight stay ward from there, prior to selection to the appropriate medical ward the next day. I can only assume therefore, that it was there that my entry in the notes ' not for the 222's ' was made. Such an entry was usually made as a joint decision between doctors and nursing staff. The doctors were usually junior medical staff, that is House Officers and Senior House Officers. The nurses were of Staff Grade or above. Indeed it was often the nursing staff that requested a resuscitation status on a patient to be documented, as they were usually first on the scene of an arrest situation.
>
> I do not believe there was a defined resuscitation policy at [the hospital]. I was certainly never given specific instruction on this matter. Each case was considered on an individual basis, with important factors being the nature of the illness, its prognosis, concurrent illnesses etc. The age of the patient became an important factor in the very elderly, but there was no specific cut off point. However, it certainly became more relevant in those greater than 85 years of age.
>
> . . . most decisions regarding resuscitation were taken without consultation with relatives. . . Summary of conversations with relatives was almost always recorded in the medical notes. Without exception, I do not recall a patient being consulted to ascertain their own resuscitation wishes.
>
> . . . I think the dignity of the patient is extremely important when considering resuscitation status. I try whenever possible to discuss with relatives before making such decisions. '

8. The senior house officer (the SHO), who had admitted the complainant's mother to the ward, thought the second HO's ' 222 ' entry had probably been made during a ward round at 10 pm; the nurses would have asked him what to do if the complainant's mother had a cardiac arrest. The SHO had accompanied the consultant on his ward round the next day, and he had not changed the decision about the complainant's mother's non-resuscitation. There had been no official hospital policy on resuscitation, and no written directive. The practice had been to regard a decision about whether a patient was for resuscitation as clinical. The decision was made by two doctors, normally a house officer and a senior member

of the team. A decision might be made either on admission or later, but the question was not relevant for every patient admitted. Where a decision was taken by a house officer when the patient was admitted, it would be reviewed the following day by the consultant or registrar on the ward round.

9. A registrar (the registrar), who no longer worked at the hospital, told my officer that he had seen the complainant's mother on a ward round on the morning after her admission. She had shown evidence of heart failure and of bronchopneumonia, and had been unwell. He would have seen the '222' entry and had concurred with it, as had the consultant. Resuscitation had not been appropriate for the complainant's mother since, because of her diseased state, it would not have been effective, or have been beneficial for her. The quality of her life before admission had not therefore been a factor to be taken into account. The recovery rate for all patients who had a cardiac arrest was between three and five per cent. There had been no resuscitation policy at the hospital when he was working there. The decision whether to resuscitate or not was a clinical one for the junior doctors to take; their decisions were governed by the consultant, who was the final arbiter. Relatives were not usually informed.

10. The woman doctor to whom the complainant had spoken on 29 March was a final year pre-registration student acting as a locum house officer (the locum). She told my officer that, on her second day, the nurses had asked her to speak to the complainant, because he was wanting information about his mother's progress. She had told him that his mother was improving, and that there were plans for her discharge. Because the complainant's mother was not one of her own patients, she had referred to the clinical records to see what had been written. At that point the complainant had seen the '222' entry and had asked her why it was there. He knew what it meant and he wanted it removed. She had agreed to do so, and had explained why it had been made. She had also explained that the entry was unlikely, by that time, to be relevant because his mother's condition had been improving. The locum commented that she would have made the same decision as the first HO, at the time of admission. Even if the complainant's mother had been spritely before her illness, the chances were that, had she survived a cardiac arrest, she would not have been the same. The locum had been unaware of any official resuscitation policy at the hospital. The action which had been taken was what she would expect to find wherever she worked, in that the medical staff most closely involved had made the decision, with the consultant taking responsibility for the junior medical staff's action. She would try to take account of relatives' views, but they were not always present at the right time.

11. A consultant physician (the consultant) told my officer that the complainant's mother had been admitted under his care. The first and second HOs had made the correct diagnosis and had treated her appropriately. Because she had been so desperately ill on admission, the doctors' clinical opinion at that time had been that a full CPR was not advisable. He had not been aware of that decision at the time. He had seen the complainant's mother within 24 hours and had agreed the diagnosis. However, since her condition had improved by then, he had not reiterated the '222' instruction, and that had effectively cancelled it. After that, the complainant's mother had made good progress and had eventually been discharged home. Decisions about whether or not to resuscitate were debatable and difficult. Generally, he would see extremely ill patients, with his medical team, during his ward round. The team would decide whether to resuscitate or not, and that decision, once made, would be discussed with the nearest available relative. In arriving at the decision, he would ensure that his team had taken account of the severity and nature of the patient's illness, any expressed wish of the patient, and the attitude of the relatives. In the complainant's mother's case, the admitting doctor had made the correct decision, in the absence of clear guidelines about resuscitation. It had been within that doctor's remit, in the emergency situation, to make the decision by using his own clinical judgment. The complainant might not have been present at the time, to enable the matter to be discussed with him. A patient's quality of life before an acute illness was of secondary importance. In view of the complainant's mother's toxic state at the time of her admission, any heart resuscitation procedure could have resulted in damage to her health. That

had not been the case the following day when he had seen her, and from that time she had been 'for resuscitation'. Staff had clearly understood that his most recent entry in the clinical records reflected the current state of clinical management. The locum should have told the complainant that the instruction had not been reinstated; he thought that the locum had written 'he wants her for 222' (see paragraph 12(ii)) in order to reassure the complainant.

12. My examination of the complainant's mother's records revealed that:

(i) the clinical records showed three entries for 24 March, and one for 25 March. The first 24 March entry was the first HO's A and E department examination note, and the second was the SHO's ward admission note. The third was the second HO's entry which read 'NOT FOR THE 222s'. The 25 March entry was by the SHO and related to assessment of the complainant's mother's condition and need for treatment at the consultant's ward round: there was no reference to CPR:

(ii) the locum's entry in the clinical records, for 29 March, (written it seems to me in terms which I accept had to be brief but verged on ambiguity) read:

'Asked to see her son. Explained that she should make a good recovery—expect home [around] 1/52 [one week].He wants her for 222—Agreed + [and] D/W [discussed with] nursing staff. Seems well but breathless still. Eating and drinking well. Review on WR [ward round]'; and

(iii) the nursing records contained no relevant entry.

13. On 19 April 1990 the DHA sent to me a document entitled 'Cardio-pulmonary Resuscitation Guidelines'. Their covering letter stated that the new guidelines, having been approved by the various medical committees, were being implemented. That part of the document relevant to the complainant's concerns read:

'THE ETHICS OF RESUSCITATION

. . . Resuscitation attempts in the 'mortally ill' do not enhance the dignity and serenity that we hope for our relatives and ourselves when we die. . . . All too often resuscitation is begun in patients already destined for life as cardiac or respiratory cripples, or who are suffering the terminal misery of untreatable cancer.

The decision 'not to resuscitate' has to be taken by the Clinician in charge of the case. This has to depend on the following factors:—

1) The severity and type of illness of the patient

2) The possible prognosis

3) The patient's own wishes

4) The opinion of the relative who may be reporting the known wishes of the patient who cannot communicate.

5) The wishes of the relatives where possible

6) The attitude of Medical and Nursing Staff in the hospital environment.

It is worth pointing out that many relatives of elderly/sick patients do not wish for 'heroics' and often say so. Such wishes are respected. Resuscitation implies cardio-pulmonary resuscitation in the hospital environment. . . . Quite frequently [the emergency team] will not be aware of the circumstances of the individual patient. They simply put into action the resuscitation protocol which is well established. This can occasionally be distressing to the patient and to the onlookers. Such a resuscitation programme in the elderly sick is beset with complicating problems. The quality of life left after such a programme could be quite distressing and disappointing.

In order to avoid unnecessary distress the Clinician attempts in conjunction with his Junior Staff to make a conscious decision based on all the factors available to 'resuscitate' or 'not resuscitate' a particular patient. It also provides advance information to the on-call crash team who may respond. Wherever possible these matters are discussed with the relatives.

. . . It is imperative that a careful consideration be given to every patient. . . The decision to 'resuscitate' or 'Not to resuscitate' has to be reviewed every day in an acutely ill patient. In difficult circumstances a second opinion should be sought.

A recently appointed Junior House Officer, or Senior House Officer with limited experience should not be allowed to make these decisions. The matter has to be discussed with the Registrar on duty or the Consultant in charge of the case.

NON RESUSCITATION

Instructions to Junior Medical Staff

Each Consultant must provide advice appropriate to the Specialty—

1) Assessment of the type and severity of the illness

2) Sequence of action to be implemented

3) Documentation in the notes

Newly appointed House Physicians and Senior House Officers must inform the Registrar or the 'Consultant on duty' before writing in the notes 'Not for C.P.R.' or 'C.P.R. is inappropriate'.

Wherever possible 'Non Resuscitation Policy' must be discussed with the relatives. Senior of the Junior Staff, i.e., experienced Senior House Officer or Registrar, and possibly a Consultant, must see the relatives.

Relatives must be made aware that in serious terminal cases if 'not for C.P.R.' is not written in the notes, then C.P.R. protocol will be instituted automatically. Diverse opinions from relatives (if any) must be documented.

The statement 'C.P.R. is inappropriate' should be time limited to 24—48 hours.

Daily review should be undertaken.

Problems, if any, should be discussed at the Unit Audit Meeting and with the C.P.R. Officer.'

Findings (a)

14. The original decision that the complainant's mother was 'not for the 222s' was, in my opinion, one made by the first HO in the exercise of his clinical judgment; it was endorsed on the following day by the registrar and the consultant. Neither the first HO nor any other junior member of the consultant's team thought that relatives were normally involved in such decisions. By contrast, the consultant has said that such decisions, usually taken during his ward rounds, *were* discussed with the nearest available relative. I am very concerned at the manifest confusion, between the consultant and the junior doctors, as to whether the policy was—or was not—to consult relatives. The responsibility lay with the consultant for ensuring that a common policy, whether written or otherwise, was followed by his staff, and the confusion at the time is a matter which I criticise. In the complainant's mother's case, her son was present at the initial examination in the A and E department, but the first HO would not have consulted him because he did not believe that he was expected to do so. Even were that not so, he did not at that point consider the question of CPR, and was reminded of it only later by the second HO—by which time the complainant was unavailable.

15. My investigation has also revealed what I regard as an extraordinary lack of appreciation by the junior medical staff that the consultant, at his ward round the next day, in effect reversed the decision not to resuscitate the complainant's mother. The belief of the first HO and the SHO is that the non-resuscitation decision was reversed by the locum—a final year pre-registration student—on 29 March. Fortunately, that difference of understanding was not put to the test in the intervening period. I note with approval, therefore, that the DHA's written policy, as it now exists, calls for a non- resuscitation decision to be entered in the clinical records, to be reviewed daily and to be time limited. I uphold the complaint in the sense that the consultant's policy was not adequately communicated to his juniors (whom I do not regard as culpable).

(b) *Handling of complaint* 16. I set out below the relevant events and correspondence:

31 March 1988	The complainant wrote to the DHA's district general manager (the DGM) outlining the circumstances of his complaint and asking what the DHA's policy was about discussing non-resuscitation with relatives.
17 April	The complainant met the DGM and the registrar.
18 April	The DGM wrote to the complainant summarising their discussion and offering a further meeting with the consultant if the complainant remained dissatisfied. (The complainant pointed out to my officer that he had not received this letter at the time.)
21 April	The DGM wrote a letter to the complainant in identical terms to that of 18 April, except that it did not include the offer of a meeting with the consultant.
27 April	The complainant wrote to the regional medical officer (the RMO) outlining his complaint and the result of his meeting with the DGM, and stating why he remained dissatisfied.
11 June	The complainant met the RMO's staff to discuss his complaint.
11 July	The RMO told the complainant that he was arranging for his complaint to be reviewed at an independent professional review (IPR).
20 July	The complainant told the RMO of his understanding, from the RMO's staff, that he should meet the consultant before the IPR took place. The complainant sought confirmation that the RMO did not wish that meeting to go ahead.
29 July	The RMO informed the complainant that he had written to the consultant asking him to meet the complainant.
14 September	The complainant met the consultant and the unit general manager in post at that time (the first UGM).
14 September	The first UGM wrote to the complainant about the outcome of their meeting; he enclosed a copy of the DGM's letter of 18 April and offered further discussion if the complainant wanted it.
15 September	The complainant wrote to the DGM enclosing for his consideration a 'Patient's rights' document which included a suggested policy in respect of non-resuscitation of sick/elderly patients.
19 September	The DGM wrote to the complainant indicating that the complainant's meeting with the consultant and the first UGM had been extremely satisfactory. He thanked the complainant for his interest and help.
26 September	The complainant told the DGM that he was glad that he was considering the document. He also observed that he had not met the consultant earlier and drew attention to the difference between the DGM's letters of 18 and 21 April.
7 November	The consultant wrote to his defence organisation informing them that the matter had been resolved.
21 November	The complainant told the DGM that he would not be satisfied until he saw a written policy which satisfied his original comments.
23 November	The DGM informed the complainant that the development of a resuscitation policy would take a long time, but that he would contact the complainant again when he had some 'concrete information'.

5 December	The complainant asked the RMO that his complaint be reviewed at an IPR in accordance with the letter of 11 July.
16 August 1989	The RMO told the complainant that a CPR committee had been set up at the hospital to review existing policies and to issue a document in due course. He hoped the complainant accepted that as a satisfactory response to the problem.
6 October	The complainant wrote to me, explaining that he remained dissatisfied with the lack of consultation about the decision not to resuscitate his mother, and with the way in which the DHA had handled his complaint.

17. The complainant told my officer that, at the meeting on 17 April, he had challenged the registrar about the decision not to resuscitate his mother; he had also asked for independent evidence that the decision accorded with normal practice for someone of his mother's age suffering from the same condition. The registrar had looked shocked, and had not known what to say. The DGM's subsequent letter of 21 April had not contained the independent evidence he was seeking, but had merely repeated what had been said at the meeting: that was why he had written to the RMO. He felt that the DGM, and not the UGM, should have been present at the meeting on 14 September. The letter had said he was present as an 'independent assessor', but the complainant had doubted this because he was both UGM and, by profession, member of the consultant staff. His mother's consultant had explained in depth about resuscitation and had used terms which were beyond the complainant's comprehension. The consultant had also said that if the complainant had seen him at an early stage, the complaint would not have gone that far. The complainant said he had replied that he had not had the opportunity to meet the consultant before, at which point the consultant had referred to the DGM's letter dated 18 April containing the offer of a meeting—but the complainant had never seen that letter. The consultant and the first UGM had made him feel as though he was making a fuss about nothing, although they had asked him what he thought should be in a resuscitation policy. He had therefore sent the DGM a copy of a document which he had acquired in America, and which—he had thought—could be used as a standard in the United Kingdom. The DGM's letter of 19 September had implied that his complaint had been resolved. He had not accepted that and had written again. The secretary to the community health council (to whom he had sent copies of his letters) had told him, in November, that the consultant had written to his defence organisation informing them that the complaint had been resolved; that had prompted his further letter of 21 November. The DGM's reply had been vague and the complainant, feeling that he was getting nowhere, had written again to the RMO. His complaint had been totally mishandled by the DHA since he had never been told why he was not consulted about the decision not to resuscitate his mother. The DGM had also sent him the wrong letter, thereby precluding him from meeting the consultant at an early stage.

18. The registrar told my officer that he had attended the meeting with the complainant and the DGM on 17 April because the consultant was away. He had tried to explain to the complainant the complications involved in his mother's care, and that, in her case, resuscitation would not have been successful. The complainant had not seemed to believe his explanation. He had tried to keep to the point in hand, but the complainant had talked generally about ethical issues. Although the content of the DGM's subsequent letter had not been incorrect, it had not stressed the points he had made.

19. The consultant told my officer that he had become involved in the complaint at a late stage, and that he had been away when the DGM initially attempted to resolve the complaint with the assistance of the registrar. In May 1988 there had been some suggestion that the complaint had been resolved, but he had heard later that the complainant had written to the RMO. The RMO had then asked him to

meet the complainant, and he had done so on 14 September. The meeting had been amicable. The complainant had given him the impression that he was satisfied with the explanations. He had tried to explain the difference between basic and advanced resuscitation, and had probably assumed that the complainant knew something about the subject. He had also explained that he had not reiterated the 'Not for 222' instruction. The first UGM had acted impartially. The consultant had not been aware that the complainant had not previously received the offer of a meeting with him and had no idea why the offer had not been included in the DGM's letter of 21 April. The issue of resuscitation was something with which he had long been involved, and the complainant's complaint had coincided with his interest in arranging a resuscitation policy and in obtaining a resuscitation officer for the hospital. On 22 June 1989 he had written to the then unit general manager (the second UGM) in order to set up meetings about resuscitation. A committee had been required to evolve a resuscitation policy, and the policy had then needed approval. The evolution of the guidelines had been thorough and lengthy, but the process had been necessary for acceptance of the policy throughout the DHA.

20. The first UGM told my officer that, at the meeting on 14 September, the consultant had answered the complainant's points as far as possible and had agreed to look at medical policies on resuscitation. They had told the complainant why the decision not to resuscitate his mother had been taken by a junior doctor. The complainant had accepted, in principle, that it was not always straightforward to await the consultant's decision on such matters. The complainant had been told that the entry in his mother's clinical records had been made for the benefit of other staff. The meeting had been free and frank. The complainant had appeared satisfied that the consultant would pick up on the points made and that there was the potential for introduction of policies, if that was indicated as a result of the investigation. With regard to the letters sent to the complainant in April, he thought that the letter of 18 April, copied to the consultant, had been a draft and had not been sent to the complainant. Complaints such as that from the complainant were in his view better dealt with by senior medical staff as soon as possible, especially where they concerned sensitive medical issues. The handling of the complainant's complaint had involved too many people, and the complainant had activated various channels of complaint. He had thought that the complainant was satisfied with the letter summarising the meeting, since he had not written again even though he had been invited to respond if he remained dissatisfied. The first UGM said that he had tried to explain to the complainant that it would take some time to draw up an agreed policy, and that the complainant had seemed to accept that.

21. The second UGM told my officer that, when he took over from the first UGM, the DGM had asked him to look, with the consultant, at the formulation of a resuscitation policy. The process of putting a policy together had taken longer than he would have liked. The approved policy (paragraph 13) had eventually been circulated on 18 April 1990. He believed that the handling of the complainant's complaint had been dealt with by the DGM.

22. The DGM told my officer that his initial letter to the complainant had been based largely on what the consultant wanted him to say. The theme of his later letters had been about the lack of a formal resuscitation policy. His job had been to obtain the information necessary to answer the complainant's complaint, and then to reply in a form that was readily understandable. He had tried to ensure that the complainant saw those who could resolve his complaint. My officer pointed out to the DGM that the complainant's original concerns did not appear to have been answered. The DGM accepted that, if no-one had told the complainant why he had not been consulted about the decision not to resuscitate, then the handling of his complaint had been at fault. He had not informed the complainant of the development of the DHA's resuscitation policy because the complaint had been referred to me, and he had believed it would not be 'protocol' to continue his communications with him. (I should point out that my intervention need not have prevented the DGM keeping the complainant informed.)

Findings (b) 23. The complainant's original complaint addressed three issues: why the decision not to resuscitate had been taken; why the decision had been taken without reference to his mother's relatives; and what the DHA's policy was with regard to resuscitation. The consultant has said that the question of non-resuscitation was very difficult; it is a matter of regret therefore that the first meeting was arranged when he was not available. Had he been there, the matter might have been resolved then. The DGM's subsequent letter of 21 April (I do not believe that the letter dated 18 April was sent at that time) appears to have attempted to deal only with the complainant's first point. Nevertheless, it was the DGM's impression, and that of the consultant, that the complainant's complaint had been resolved at that stage. From then onwards, the DHA's handling was confused and unco-ordinated and subsequent events did not address the issues clearly. It was also open to the complainant, however, to put clearly to the DHA—as distinct from the RMO—the issues with which he remained dissatisfied after the early attempts to resolve them failed. Had he done so at the time, it might have helped. As it was the consultant and the first UGM met the complainant on 14 September, and both were under the impression that they had resolved the complaint. Although I do not know precisely what was said at either meeting, I believe that attempts were made to answer all three of the complainant's points—but I criticise the fact that they were never all clearly dealt with in writing. While I find that the DHA went to some lengths to help the complainant, I can see why he has remained dissatisfied with the written replies he received, and in that respect I uphold his complaint. I hope he will be gratified at the fact that his complaints contributed to the production of a resuscitation policy.

Conclusion 24. I have set out my findings at paragraphs 14—15 and 23. The DHA have asked me to convey through this report—as I do—their apologies to the complainant for the shortcomings I have identified. I have found surprising the novelty of establishing a written resuscitation policy in this DHA and I intend to bring this apparent gap in procedure to the notice of Parliament through my Annual Report.

Case No W.369/89–90—'Patient's friend' at a meeting with a consultant

Background and complaint 1. The complainant, who suffered from diverticulitis, was admitted to a hospital (the hospital) in October 1987. He was discharged after three weeks but was readmitted, on more than one occasion, undergoing an emergency operation during the last of those admissions. On 4 August 1988 the complainant complained to the hospital, through the local CHC, about his treatment and aspects of his stay at the hospital. He was not satisfied with their reply and sought a meeting with the consultant surgeon who had been responsible for his care (the consultant) saying that he wished to be accompanied at the meeting by a representative from the CHC. The consultant agreed to meet the complainant but not to the presence of a CHC representative.

2. The complainant complained to me that the consultant had been unreasonable in his refusal to agree that a representative of the CHC could attend a discussion about the original complaint to the hospital.

Investigation 3. I obtained the written comments of the health authority which administer the hospital (the DHA) and examined other relevant documents and correspondence. One of my officers took evidence from the complainant; from officers of the CHC; and from the DHA staff involved.

4. In his interview with my officer the complainant gave details of his admissions and treatment at the hospital. Wanting explanations about what had been wrong with him, he had approached the CHC as he had not felt sufficiently confident to ask the consultant questions without assistance. The secretary of the CHC (the CHC secretary) had written to the hospital but not all the complainant's questions

had been answered to his satisfaction; someone at the CHC had therefore suggested that the complainant might seek a meeting with the consultant. He had thought that a good idea, but as the consultant was an 'educated' man, he had wanted the CHC secretary present for support and to give him confidence. He had been dismayed by the consultant's refusal to see him in the presence of someone from the CHC. My officer told the complainant that the DHA had, in their response to me, indicated that the consultant had said that he would be prepared to meet him with a CHC representative after an initial meeting with the complainant alone. The complainant had not known that but in any event he would not have been happy with the arrangement, as he would have felt at a disadvantage on his own. He also believed that, unless the CHC secretary was there, he would have been interrogated by the consultant.

5. The assistant secretary at the CHC (the CHC assistant secretary) explained that the complainant had originally visited the CHC offices on 1 August 1988. She had drafted the CHC secretary's letter to the hospital, forwarding to the complainant a copy of their reply dated 19 December, with which he had not been satisfied. She had therefore contacted the assistant operational services manager (the AOSM), who had signed the hospital's first reply, and had suggested a meeting between the consultant, the complainant and a CHC representative; the AOSM had said she would be prepared to arrange that. The AOSM had eventually written on 10 May 1989, saying that the consultant had refused to meet the complainant in the presence of someone from the CHC. The CHC assistant secretary had passed that information to the complainant, who was disappointed as he had wanted a CHC representative present to boost his confidence. She explained that officers of the CHC acted as the complainant's friend at such meetings, not as an investigator. The hospital had offered an outpatient appointment with the consultant but the complainant had turned that down believing that the offer had been made as an alternative to answering his questions. There had been a later offer of an outpatient appointment to which a member of the family was invited, but the complainant had refused that too, insisting that he required the support of someone from the CHC. The complaint had by then reached an impasse, and she had not previously known a consultant refuse a meeting such as was being sought by the complainant.

6. The CHC secretary told my officer that a meeting with the appropriate consultant often helped in resolving a complaint. She had written to the consultant in question on 6 September explaining that the complainant had asked that she should accompany him simply because she had helped him put his original complaint to the hospital, and asking whether he would be prepared to review his previous decision. His secretary had telephoned later to say that he would not do so. The CHC secretary had not realised that the consultant was objecting only to CHC attendance at an initial meeting (see paragraph 11) but when she passed the information to the complainant he had remained adamant that he would not see the consultant without someone from the CHC. She considered that management, especially the assistant manager of the Acute Unit (the AM) and the AOSM, had handled the problem well; they had been sympathetic and helpful and had kept her informed.

7. The AOSM, who had been responsible for dealing with complaints at the time of the complainant's original approach, said that she had sought information from the staff involved before replying to the CHC. However, since that had not satisfied the complainant, she had agreed with the suggestion of a meeting (paragraph 5)—medical questions were best settled by discussion with the relevant consultant. She thought it was for the patient to decide whether a CHC representative should attend such a meeting. She had informed the consultant, on 13 February 1989, of the complainant's request and had tried to make the handling of the complaint as easy as possible for the consultant—to the extent that she had the complainant's manuscript statement typed, for clarity, and she had located the clinical notes. She had never met the consultant or spoken to him about the complaint; she had offered to meet him, but his secretary had doubted he would agree to that. She had eventually received a reply, dated 3 May 1989, from the consultant, and its contents had surprised her. The consultant had seemed to be irritated by the

208974 E

request from the complainant and the CHC (I have seen that the consultant wrote that if the stage was reached where a patient would not see a doctor 'without a legal representative or a member of some other organisation which acts on a semi-legal basis the whole basis of medical practice will be destroyed.') The AOSM thought the consultant had misunderstood the role of community health councils and wondered whether she had explained with sufficient clarity the purpose of the meeting. The DHA's complaints procedure (see paragraph 9) had referred to the CHC's role in providing support to people who wished to make complaints, and she had replied to the consultant on 10 May saying that, as the complainant had decided that he required such support, she felt his wishes should be respected. She had copied her letter of 10 May to the unit general manager (the UGM) for information and had informed the CHC secretary of the consultant's response, asking how the complainant wished to proceed. The CHC secretary had replied that the complainant did not wish to see the consultant alone and that he was puzzled by the consultant's attitude. The AOSM had tried to contact the consultant but without success and, on 23 May, had agreed with the AM that the UGM should write to him. She had passed her papers to the AM on 24 May and had had no further involvement with the complainant's complaint.

8. The AM told my officer that she had been aware of the difficulty in dealing with the complaint but had not become involved personally until the AOSM handed the matter over to her. She had not been convinced, after reading the papers, that a letter from the UGM would change the situation. With the UGM's agreement, she had met the consultant on 7 June and had had an amicable discussion about the complaint, including how it had been handled and the need to resolve it. She had discussed with the consultant the duty of management to ensure that patients' complaints were resolved satisfactorily, the role of the CHC and the advantages of a meeting, and she had suggested that it would be helpful to have the CHC secretary in attendance. The consultant, however, had felt under no obligation to see the complainant with a representative from the CHC but had said he would see him in his outpatients clinic, when a friend or relative could be present. The consultant had not actually said that he would consent to the CHC's presence at any further meeting, but the AM thought that that had been implied.

9. The AM explained that the hospital's acute unit had a complaints panel comprising her line manager, a nursing representative, a representative of the consultant staff (the consultant representative) and herself; the panel monitored complaints, looked for trends and decided on the action to be taken to prevent recurrences. The panel met quarterly and, although the complaint could have been discussed at such a meeting, there was scope for flexibility and she had written to the consultant representative on 20 June asking for his advice. He too had spoken to the consultant but no change in approach had ensued. Although the DHA's complaints procedure had not been published until March 1989, a draft version had been in operation since the previous year. However, the consultant would not have seen a copy at the time of investigation of the complaint. I have seen that part of the procedure read:

> 'The CHC is able to advise people living in the District on how and where to lodge complaints, to draw to the attention of the Health Authority general, as well as individual, matters of complaint, and to act as advisers to patients' families and close friends who find it difficult to express their grievances.'

The AM found it understandable that the complainant should want someone from the CHC present at a meeting with the consultant.

10. The consultant representative described his role as that of intermediary between management and his consultant colleagues. The AM had explained the difficulties which had arisen in the complainant's case, and he personally had not seen any reason why a CHC representative should not attend the meeting. However, having spoken personally to the consultant, he had concluded that he could not influence the situation and had so informed the AM. In general, consultants were uneasy about complaints from patients, and in his view they should meet their patients to discuss complaints; if it would help, they could ask a colleague also to be present.

11. The consultant, when interviewed by my officer, was accompanied by his solicitor and dictated an account of his treatment of the complainant to my officer. The consultant then told my officer that he had never understood why the complainant wanted to meet him to discuss the complaint. However, he had always been willing to meet the complainant, and it was usual for a patient who was concerned to be given an appointment at his next outpatient clinic. He had wanted to see the complainant either on his own, or accompanied by his wife or another relative, so that the matters of concern could be listed and discussed. If that failed to satisfy the complainant, he then would have seen him with someone from the CHC. He did not think it appropriate for a CHC representative to attend the first meeting, nor did he believe that there was a statutory requirement for that to happen. When a question in the context of his letter of 3 May 1989 (paragraph 7) was put by my officer to the consultant, the consultant's solicitor commented that the consultant had no contractual duty but only a duty to behave as a reasonable consultant. The consultant recalled that the CHC secretary had accompanied another patient at a meeting to discuss a complaint and he had found her to be very helpful; that, however, had been after he had first had a discussion with the patient. The consultant was not aware of a local complaints procedure and said that he could not recall discussing the case with any of the administrative staff (apart from the AM when she had arranged his interview with my officer) or with the consultant representative.

12. The UGM said that, although she had received copies of correspondence from the AOSM, she had become aware of the seriousness of the problem only when the AM had discussed it with her. Her initial view had been that the consultant had misunderstood what the original complaint was about, perceiving it as a challenge to his clinical judgment. The consultant might also not have understood the role of the CHC in relation to patients' complaints. The AM, who was in the UGM's view very good at communicating with consultants, had suggested a personal approach to the consultant (paragraph 8) and had told her subsequently about the consultant's views. She would have spoken herself to the consultant, but the AM and the consultant representative had advised her not to do so. She would have taken a different line had the consultant refused outright to see the complainant, and she felt that the consultant was uneasy about the predicament in which he had placed himself. The complainant's wish to have a CHC representative present at a meeting with the consultant was in her view reasonable. The CHC secretary was an effective officer who guided complainants but did not fuel complaints—the CHC secretary took the line of acting as patients' friend and helping them to articulate their concerns.

13. I consider that at this point it will be helpful to rehearse the ample guidance that has been issued on the involvement of a CHC in complaints. I have noted that Department of Health and Social Security circular HRC(74)4, which defined the role of community health councils, stated that they 'will be able, without prejudicing the merits of individual complaints or seeking out the facts, to give advice, on request, on how and where to lodge a complaint and to act as a 'patient's friend' when needed'. A later circular (HC(81)15) saw 'no objection to individual CHC members or officers providing. . . assistance [with making complaints] if they are asked and wish to do so'.

14. Guidance to health authorities on the investigation of complaints was contained in circular HC(88)37 and asked that staff should 'deal with these in a way which reassures the patient'. Attached to the circular was a procedure, negotiated at national level with the medical profession, for dealing with complaints about clinical judgment; this provided, at the stage where the complaint had passed from the local level to a review by two independent consultants, for complainants to be accompanied, if they wished, by a relative or personal friend—and the circular made clear that it was for the complainants to decide who that friend should be. In evidence to the House of Commons Select Committee on the Parliamentary Commissioner for Administration (which oversees my work as Health Service Commissioner) about the conduct of independent professional reviews, the Deputy Chief Medical Officer of the

208974 E2

Department of Health said that the Select Committee's view was accepted 'that it is for the patient to decide who their friend shall be, whilst allaying the fears of the medical profession by emphasising that 'such a person is there to help and support the patient, and not to act as an advocate or in any way which detracts from what is essentially a clinical consultation''. (HC 136, 1987–88 Q.164.)

Findings

15. The complainant has explained why he wanted the support of someone from the CHC at any meeting with the consultant and felt unable to accept the offer of a prior discussion accompanied only by a relative. The main purpose of the proposed meeting was to allay his concerns and obtain explanations and, although about clinical matters, should, I believe, have been viewed as part of the complainant's concern to resolve his complaint. The complainant clearly felt that he would be at a disadvantage on his own and needed support from someone with more experience in such situations, and I am in no doubt—nor were hospital staff from whom I have taken evidence—that his request was reasonable. Although the complainant's wish to discuss matters with the consultant had not reached the stage to which I refer in paragraph 14, it is clear to me that his request to be accompanied by a friend (in the person of the CHC secretary) was consistent with both the intentions of the procedure described in that paragraph and the DHA's own guidance (paragraph 9). Although the references, in paragraph 14, to independent reviews and the Select Committee relate to later stages in the clinical complaints procedure, the presence of a 'friend' at the initial discussion with a consultant cannot but serve to reassure the patient and quite possibly to preclude the complaint from proceeding to the next, more formal, stage. I hope that the consultant will now accept that the secretary of the CHC would be acting not as a representative of that body but purely, by invitation, as a 'friend' of the complainant. I recommend that the DHA seek the consultant's early agreement to the complainant's request and I trust that in the light of the evidence set out in this report, I shall be able to receive news that a discussion between the consultant, the complainant and the friend nominated by the complainant—in the person of the CHC secretary—has taken place without a prior meeting excluding that friend. I uphold the complaint.

Conclusion

16. My findings are set out in paragraph 15. I am pleased to record that the consultant has now agreed to meet the complainant in the presence of the CHC secretary acting as 'patients friend'. I have found no reason to criticise the actions of other members of the DHA's staff, who have displayed sympathy for the complainant's predicament, but the DHA have nevertheless asked me to express through this report—as I do—their apologies for the difficulties he encountered.

Case No W.411/89–90—Delays in handling a complaint under the independent professional review (IPR) procedure

Background and complaint

1. In July 1988, the complainant complained to a health authority (the DHA) about the clinical aspects of the treatment she had received the previous April. She was dissatisfied with the outcome of her complaint, and the DHA offered to refer the complaint to the Regional Medical Officer (the RMO) of the regional health authority (the RHA). Although she had a meeting on 4 October 1989 with a doctor acting on the RMO's behalf, it was not until 16 January 1990 that arrangements for an IPR—to be held on 31 January 1990—were notified to her. The RMO informed her of the outcome on 7 February 1990, but she learned later that the DHA were not informed until April.

2. The complainant complained that the RMO had been dilatory both in setting up the IPR, and in notifying the results to the DHA so that they could improve standards of service.

The clinical complaints procedure

3. Circular HC(81)5, issued in April 1981 by the Department of Health and Social Security (DHSS), as it then was, introduced a memorandum of guidance (the memorandum) on which health authorities were to base their arrangements for dealing with complaints about the exercise of clinical judgment by hospital medical and dental staff. There are three stages to the procedure, the first of which is not relevant to this complaint, being concerned with arrangements for trying to resolve the complaint locally. The second stage is invoked where the complainant remains dissatisfied and the matter is referred to the RMO, who discusses the complaint with the consultant concerned. The consultant may consider that a further talk with the complainant will resolve the matter, but if that fails, or if the consultant feels that such a meeting would serve no useful purpose, the RMO discusses with the consultant the value of offering to the complainant the third stage procedure. If in the light of those discussions (including, where necessary, discussions with the complainant) the RMO considers it appropriate, the third stage is set in motion. That requires the RMO to arrange for all aspects of the case to be considered by two independent consultants in active practice, nominated by the Joint Consultants Committee (JCC). The independent consultants are given the opportunity to read all the clinical records, and their view—after conducting the IPR—is reported to the RMO on a confidential basis. On completion of the IPR, the district general manager of the authority against which the original complaint was raised is required to write to the complainant explaining, where appropriate, any action the authority has taken as a result of the complaint, following the RMO's advice regarding what is said about any clinical matters.

4. The memorandum was drawn again to the attention of health authorities in June 1988 by DHSS Circular HC(88)37 (the circular), in which advice was given on the procedures to be followed as a consequence of the Hospital Complaints Procedure Act 1985. The circular provided that, where a complaint involving the exercise of clinical judgment could not be resolved locally, the matter should be drawn to the attention of the RMO '. . . without delay so that appropriate action can be taken to ensure that the complaint is dealt with promptly . . .'. A general requirement of the circular was that the complainant should be kept informed of progress, interim replies or holding letters being sent where appropriate.

Investigation

5. When in November 1989 I first received a complaint from the complainant about the long delay in arranging an IPR, I declined to investigate the matter at that stage because the IPR was still pending. The complainant renewed her complaint to me on 10 June 1990, and on 8 August she sent me her correspondence with the DHA and the RHA. As she was able to satisfy me that the RHA had been given the opportunity to investigate her additional complaint that the DHA had not been provided with the IPR findings, I agreed to an investigation. I obtained the comments of the RHA, and examined other relevant papers. One of my officers took evidence from the complainant; from the secretary to the local Community Health Council (the CHC secretary); and from the RHA staff involved.

6. The complainant originally complained to the DHA about the treatment she had received while under the care of a consultant obstetrician and gynaecologist (the first consultant), when she was a patient at a hospital (the hospital) in April 1988. The complainant put her complaint in writing to the hospital's unit general manager (the UGM) on 7 July 1988. The complainant and her husband met the consultant and the UGM on 10 August, and the UGM summarised the outcome in a letter to the complainant dated 18 August. The complainant remained dissatisfied and, after further correspondence between the CHC secretary and the UGM, she wrote on 11 October to the UGM confirming that she wished her complaint to be referred to the RMO. The UGM did not receive the complainant's letter until 21 November (see paragraph 8).

7. I now set out the main correspondence and key events:

(a)	1 December 1988	The UGM wrote to the RMO providing all the background papers to the complainant's complaint.

(b) 8 December	The personal assistant to the RMO (the PA) wrote to the UGM requesting the complainant's case notes.
(c) 16 December	The UGM replied that the case notes would be available after Christmas.
(d) 1 February 1989	The first consultant wrote to the RMO providing background information further to information already supplied on 23 November and saying: '. . . It is difficult to avoid the conclusion that the complaint is third party led with my colleague [the second consultant] and [the CHC secretary] implicated. [The second consultant] has not discussed the case with me . . .'
(e) 15 February	The UGM wrote to the PA enclosing the complainant's case notes. He apologised for the delay, saying that the consultants concerned had been using them.
(f) 25 April	The DHA's district adviser (nursing and quality assurance) (the DANQA) wrote to the PA enquiring about progress with the complaint forwarded on 1 December.
(g) 10 May	The PA wrote to the DANQA apologising for the delay. She explained that the RMO and the first consultant had had preliminary discussions and that the RMO had hoped to deal with the matter personally. However, pressure of work had led to delegation of the complainant's complaint to the newly appointed clinical complaints adviser (the CCA). Furthermore, the second consultant had advised that she was due to operate on the complainant, who would not therefore be fit to pursue her complaint for at least six weeks.
(h) 5 June	The CHC secretary wrote to the PA explaining that the complainant was very well after her surgery and anxious for a date to be fixed for a meeting with the CCA as soon as possible.
(i) 2 August	The DANQA wrote to the RMO asking about progress on a number of outstanding complaints, including the complainant's.
(j) 3 August	The complainant wrote to her Member of Parliament (the Member) complaining about the RHA and seeking her assistance to expedite the matter.
(k) 7 August	The CHC chairman wrote to the chairman of the RHA complaining about the RHA's handling of two complaints, including the complainant's, relating to the exercise of clinical judgment by medical staff.
(l) 11 August	The RMO wrote to the DANQA explaining that progress on the complainant's complaint had been delayed because of her operation but that the matter was now proceeding. Arrangements had been made to interview the first and second consultants early in September.
(m) 25 August	The RHA chairman wrote to the CHC chairman and to the Member explaining that the RMO had taken action to ensure that delays were avoided in future. The complainant's complaint had been delayed because the RHA had been advised that, as a consequence of the operation, she was unlikely to be fit to proceed for a couple of months.

(n) 6 September	The CCA met the first and second consultants.
(o) 2 October	In a letter to the CCA, the second consultant wrote: 'I was wondering whether your meeting with [the complainant] has been satisfactory and whether perhaps you had managed to persuade her to take a more benign view of her situation. Perhaps now that she is recovering . . . and feeling a lot better, she will not pursue her complaint.'
(p) 4 October	The CCA met the complainant and the CHC secretary.
(q) 5 October	The PA wrote to the JCC enclosing details of the complainant's complaint and requesting the names of two independent assessors to conduct the IPR.
(r) 17 November	The JCC supplied the PA with the names of the two assessors.
(s) 19 December	The PA sent the assessors details of the complaint and copies of the complainant's case notes, and asked for a mutually convenient date for them to meet the complainant.
(t) 16 January 1990	The PA wrote to the complainant, her general practitioner and the first consultant informing them that the independent assessors would like to meet them on 31 January.
(u) 31 January	The IPR was held at the RHA's headquarters.
(v) 7 February	The CCA wrote to the complainant informing her of the outcome of the IPR. His letter included the following extract from comments by the assessors: 'The fourteen month delay in holding the third stage review of this case is excessive. Arrangements should be made to speed up procedures. They tell me you accepted the above comments but still felt . . .'
(w) 8 February	The PA wrote to the DANQA stating that the IPR had been undertaken on 31 January, and that the result of the assessors' investigation had been conveyed to the complainant.
(x) 27 February	The JCC wrote to the RMO pointing out that one of the assessors had expressed concern that the RHA had taken 14 months to arrange the IPR and requesting that action be taken to reduce such delays.
(y) 12 March	The PA wrote to the JCC explaining that there had been some circumstances specific to the complainant's complaint which had introduced unavoidable delays. Other delays were the responsibility of the RHA, but those had now been overcome.
(z) 16 March	The DANQA wrote to the RMO pointing out that the general manager of the DHA had not received any information about the outcome of the IPR, and asking that the situation be remedied.
(aa) 3 April	The complainant wrote to the CCA stating that she was disturbed to learn that the findings of the IPR had not been conveyed to the DHA. The DHA were therefore not aware of remedial measures promised by the first consultant and were consequently not in a position to monitor progress.

(bb) 18 April — The CCA wrote:

(i) to the DANQA saying that there had been a review of the way in which the RMO communicated with districts after an IPR and, as a consequence, he was now enclosing a copy of his letter dated 7 February to the complainant;

(ii) to the first consultant enclosing a copy of his letter dated 7 February to the complainant and drawing attention to the conclusions reached; and

(iii) to the complainant confirming that the DHA and the first consultant had been informed of the outcome of the IPR.

(cc) 21 May — The DANQA wrote to the CHC secretary informing him of the action the DHA had taken as a result of recommendations made by the IPR assessors.

8. The complainant said, in evidence to my officer, that the CHC secretary had telephoned the UGM on 17 November 1988 and discovered that the UGM had not received her letter of 11 October. Nevertheless, the UGM had agreed to forward her complaint to the RMO on the basis of that telephone conversation, and she had subsequently sent him a copy of her letter. On 8 February 1989, the CHC secretary had telephoned the PA, who had said that the complainant's case notes had not yet been received but that she would chase them up. The CHC secretary had telephoned the PA again on 6 March and 11 April, and on the latter occasion the PA had said that she would make enquiries and let the CHC secretary know the outcome. The complainant had been concerned that the IPR would be set up at the same time as her operation and, when she was admitted in mid-May, the second consultant had told her that, had it not coincided with her admission, the RMO had wanted to have the IPR then. No one had contacted her about the IPR, but someone had obviously been in touch with the second consultant. The CHC secretary had found out that the RMO had delegated her complaint to the CCA because of pressure of work. The PA had told the CHC secretary, on 31 May, that the CCA had assumed that the complainant would not be fit to pursue her complaint for six weeks, and he had gone on leave. That had meant that no progress could be made until July.

9. On 7 July the CHC secretary had telephoned the PA and been told that the CCA would be seeing the first and second consultants at some time on his return from annual leave. The RHA chairman's letter of 25 August (paragraph 7(m)) had been the first positive indication of progress but, even so, the CCA had still not written to her. On 22 September she had been invited to meet the CCA on 4 October and, at the meeting, the CCA had said that he wanted to proceed from square one. They had therefore gone through the complaint in some detail, and the CCA had said that he would arrange the IPR as soon as possible. The PA had telephoned her on 12 January 1990, enquiring whether 31 January would be suitable. After the IPR, she had received a letter from the CCA (paragraph 7(v)) which was reasonably accurate, and she had been reassured to note that remedial action was to be taken. She and the CHC secretary had assumed, mistakenly, that a similar letter had been sent to the DHA. She wondered whether, if she had not written to the CCA (paragraph 7(aa)), any action at all would have been taken. The RHA's attitude had seemed to be that, if they delayed long enough, the complaint might go away. Complainants should not have to wait for an IPR or for any remedial action to be taken. Almost a year had elapsed between making her original complaint and her meeting with the CCA, and by then it had not been easy for her to recall instantly the events leading to her complaint. She and the CHC secretary, and not the RHA, had taken the initiative all along.

10. In his response to me on behalf of the RHA, the regional general manager wrote:

> 'Our letter to [the JCC] dated 12 March 1990 [paragraph 7(y)] explains the reason for some of the delay in processing this complaint. Although the final letter to [the DHA] was not sent until April 1990 the independent assessors had discussed their findings and recommendations with [the first consultant] when they met with him.'

11. The PA told my officer that the first consultant had approached the RMO about the complaint some time between 18 November and 1 December 1988—when it was officially referred by the UGM. It was because of that informal contact that the RMO had decided initially to deal with the complaint himself. However, he had been able to do little with the case until the complainant's case notes arrived, eventually, on 16 February 1989. By that time, his workload had become such that he had found it necessary, in March, to pass the complaint, and others, to the CCA who had recently been appointed to help him. The PA had been trying to arrange a meeting between the CCA and the first and second consultants when she discovered from the second consultant, early in May, that the complainant was due to undergo an operation and would require a six week recuperation period. She had not contacted the complainant about that, because she had not wanted to disturb her. A decision had therefore been taken, on the advice of the second consultant and in the complainant's best interests, to postpone the processing of her complaint.

12. The PA said that the CCA had been keen to process the complaint but had experienced difficulty in arranging a meeting with the first and second consultants. He had eventually met them on 6 September, and the complainant on 4 October; he had then decided that the complaint should proceed to the third stage. Her delay until 19 December in contacting the assessors, nominated by the JCC on 17 November, had been due to her heavy workload. After the IPR, she had written to the DHA on 8 February informing them that the IPR had taken place and that the CCA had responded direct to the complainant. The RMO's preference at that time had been to communicate direct with complainants, and not with the district health authority concerned. That procedure had since been brought into line with the memorandum (paragraph 3) so that the RMO now wrote to the authority, which then informed the complainant of the outcome of the IPR. The failure to notify the DHA of the outcome of the complainant's IPR had, for two months, prevented them from taking action on matters which were their responsibility. As to keeping complainants informed of progress in setting up an IPR, it had not been the practice of the RMO to do so.

13. The CCA confirmed that the complaint had been passed to him when he took up his duties in March 1989, and he said he had moved as fast as circumstances allowed. News of the complainant's further operation had caused a temporary halt to the proceedings in May. He had needed to see the clinical notes, the consultants involved and the complainant herself in order to decide whether the complaint should proceed to the third stage. Difficulty in arranging a meeting with the first and second consultants had caused delay between June and 11 August. The day after he had met the complainant, a letter had been sent to the JCC requesting the nomination of two assessors, and the IPR had eventually been arranged for 31 January 1990, just under four months after the decision to proceed to the third stage. The complainant's IPR had been arranged during the Christmas period, and it had proved difficult to get the independent assessors together, so he did not regard the time taken as unreasonable. In accordance with instructions given to him by the RMO when he took up his duties, he had written direct to the complainant, on 7 February, detailing the outcome. It had later become clear that the RHA should have reported the outcome to the DHA, and that the DHA should then have written to the complainant. Although the details of the complainant's IPR had not been sent to the DHA until a couple of months later, the first consultant had been informed quite clearly what the faults were. Nevertheless, he could see the complainant's point, and he assured my officer that that situation would not arise again because the RHA had changed its system (paragraph 12).

14. The RMO, who had taken up his post in April 1986, told my officer that he had underestimated the amount of work generated by the IPR procedure. Complaints had been received at a rate of about one per week during the first three months of 1989, and each case would normally take about nine months to complete. A specialist in community medicine (the SCM), to whom he had delegated all aspects of the IPR procedure, had retired at the end of December 1988, and he had taken over all her cases. He had intended that to be a short term

measure until he appointed the CCA, whom he had employed to deal exclusively with clinical complaints. Transfer of a case from one officer to another created difficulties, and the complainant's complaint, the last to be dealt with during what had been a difficult period in his office, had been received shortly before the SCM's departure. As the CCA had not started until March, he had dealt with the case initially—he had received a request from the DHA and spoken to the first consultant. When he saw the case notes, his initial thoughts had been that the complaint should proceed to the third stage. However, since he had felt unable to deal with the complaint quickly, he had decided to set it aside for the attention of the CCA; that had slowed down progress at that stage. The CCA had been new to the system and would have taken a few months to settle into the job. He had given the CCA written guidelines on how to deal with complaints, and the PA had been available for advice.

15. The RMO said that the RHA's practice of writing direct to the complainant with the results of the IPR had been influenced by the fact that transcribing errors could occur if the number of steps was not kept to the minimum. He had felt, moreover, that a reply from the authority against which a clinical complaint had been made would not carry conviction. He had discussed the matter with CHCs, and they had supported the practice then in operation. His aim had been to issue a letter giving the assessors' findings in words which the complainant would understand, and indicating any action to be taken as a result of the complaint. He had never sent the independent assessors' report to the complainant, since it was confidential to him or his representative. The intention had been to inform health authorities of the outcome by sending them a copy of his letter to the complainant, drawing their attention to any action required. The system had later been changed to conform with the procedures contained in the memorandum, and the RHA now provided district health authorities with a draft of what the RHA considered should be contained in the letter to the complainant, and asked that a copy be sent to the consultant concerned. That ensured that health authorities were automatically notified of the outcome of the IPR, and that the complainant and consultant were informed, in writing, almost simultaneously. The RHA had also introduced a system for keeping complainants informed of progress. Once the decision had been taken to proceed to the third stage, the aim was to complete that process within three to four months. He accepted that the RHA had been dilatory in arranging the complainant's IPR.

Findings

16. The complaint was referred to the RHA by the UGM on 1 December 1988, and the resulting IPR was held, some 14 months later, on 31 January 1990. The initial delay in obtaining the clinical notes was not of the RHA's making, but I have seen no evidence of concern on the part of the RMO that they were not received until mid February. The CCA did not meet the complainant until about eight months later, that delay being attributable to several factors. First, the RMO delegated the responsibility for the complaint to the CCA who was new to the task, but I cannot exonerate the RHA for the delay which arose from that. Second, the CCA (without consulting or informing the complainant) postponed any action for the six weeks or so which he assumed the complainant would need to recuperate from her further surgery. It seems to me that the CCA could have arranged to see the two consultants during that period, waiting only to interview the complainant until she was fit again: had that been done, much of the delay of five months could have been avoided. Third, the CCA experienced difficulty in arranging a preliminary meeting with the first and second consultants. I have not been told what the difficulties were, but three months (from 5 June until 6 September) to arrange such a meeting brings the complaints procedure into disrepute (paragraph 4). I strongly criticise the series of delays in progressing the second stage of the procedure, which ended with the decision in early October to set up the IPR. I can understand the complainant's concern at not having been approached by the RHA at any point throughout the second stage until she was invited to meet the CCA on 4 October. That was discourteous, and she must have become very frustrated at the lack of action. I note that the RHA have since introduced a procedure for keeping complainants informed of progress (paragraph 15) and I look to them to keep a close eye on the procedure, which is a requirement of the circular (paragraph 4).

17. The CCA has said, with some justification in my view, that the four months taken to complete the third stage was not unreasonable. After the IPR, he wrote direct to the complainant with the result, rather than to the DHA as required by the memorandum (paragraph 3). The principle behind the provisions of the memorandum is that the health authority against which the original complaint was made remains responsible for seeing it through to a conclusion. However, the practice followed by the RHA prevented that from happening in the complainant's case until some 10 weeks after she had been notified of the results of the IPR. I am driven to conclude that it was her action in approaching the RMO—who had already received, but taken no action upon, a letter from the DHA—which prompted him to give the results to the DHA. I believe that it was my intervention in other cases investigated by me that led to the conformity with the procedures of the memorandum (paragraph 15). I consider that the delay in setting up the IPR, the failure to follow the guidance contained in the memorandum, and the consequent delay in giving information to the DHA, constitute serious maladministration, and I uphold the complaint.

Conclusion

18. I have set out my findings in paragraphs 16 and 17. The RHA have asked me to convey to the complainant through my report—as I do—their apologies for the shortcomings in their handling of her complaint.

Case No W.417/89–90—Deficiencies in nursing care and poor communications

Background and complaint

1. On 14 March 1989, the complainant's mother was admitted to a ward at the first hospital under the care of a consultant orthopaedic surgeon (the first consultant). A knee replacement operation was carried out the next day. In the evening of 16 March, the complainant's mother experienced severe pain in her leg, and a locum senior house officer (the first SHO) loosened the plaster cast. On 1 April part of the wound burst, and on 7 April, when the results of a swab test were received, the complainant's mother was prescribed antibiotics; on 12 April she was taken to the operating theatre, where a haematoma (bleeding in the wound) was evacuated. On several occasions during her mother's stay, the complainant asked to see a doctor, but without success. On 5 May, her mother was transferred to the care of another consultant (the second consultant) at the second hospital for a skin graft to her leg. She returned to the first hospital on 25 May, when the complainant asked again to see a doctor. The next day the complainant wrote to the first and second consultants, and she met the first consultant on 6 June. The complainant's mother was discharged home on 16 June.

2. The complainant complained that:

(a) loosening of her mother's plaster cast on 16 March had been unnecessarily delayed;

(b) nursing care on the ward had been inadequate in that:

  (i) on 12 April, when her mother's leg had begun to bleed, the ward sister (the first sister) and a nurse had ignored her call for help until another patient attracted the sister's attention; and

  (ii) on her mother's return to the first hospital on 25 May, the nurses had not provided medication for her;

(c) communications had been deficient, and the staff insensitive, in that:

  (i) although her mother had believed that a doctor had advised that only some of the sutures in her knee should be removed, the nurses had removed them all;

  (ii) despite several requests, the first sister had not arranged for her to see a doctor about her mother's condition or, until prompted, said why she had not done so;

(iii) nursing and medical staff had given contradictory information to her mother and herself about the existence of an infection; and

(iv) the meeting on 6 June with the first consultant had been intimidating as four other hospital staff, who were not introduced to her, had been present without her prior knowledge.

Jurisdiction and investigation

3. Before I started my investigation, my officer told the complainant that I could not investigate any actions, taken in connection with the diagnosis of illness or the care or treatment of a patient, which in my opinion were a consequence solely of the exercise of clinical judgment. I obtained the comments of the Health Authority (the DHA), which administer the first hospital, and I examined all the relevant papers including clinical records at both hospitals. I was seriously disturbed, and my investigation was hampered, by the fact that almost all the DHA's nursing records except for some nursing care plans were missing by the time I started my investigation; they have still not come to light. My officer also took evidence from the complainant and her mother, and from the DHA staff concerned.

(a) *Delay in loosening plaster cast*

4. The complainant made notes of her experiences and those of her mother, and my report draws on those notes, which formed part of her correspondence with the DHA, as well as on her and her mother's oral evidence to my officer. She said that, when she left her mother at about 8.00 pm on 16 March, that part of her mother's leg visible above the cast had been swollen and discoloured. Her mother had apparently cried in pain from then until after 11.00 pm when the plaster cast was eventually split open. The complainant's mother said that the first SHO had told her that the key to the plaster room could not be found, and that the night sister had had to go to a neighbouring hospital (3·5 miles away) to fetch a plaster saw. She had recounted that to a nurse, who had replied that the key was always available in the ward office. In a letter to the hospital, the complainant expressed concern that there might have been a connection between the delay and the subsequent development of the haematoma.

5. In their reply to me, the DHA stated that the complainant's mother had been given strong painkillers but, as that had not been effective, the plaster cast had been split. They had been unable to establish why her mother had been told that the plaster room was locked; access to the room was available at all times, and staff had been reminded of that.

6. A staff nurse on a late duty (1.15–9.15 pm) on 16 March (the first SN) told my officer that, quite early on in the evening, the complainant's mother had had a swelling under her plaster cast, causing considerable pain. Painkillers had been given, and a doctor had been called both by herself and, she thought, by other nurses. (I have seen that there was one other staff nurse (the second SN) and a nursing auxiliary on duty that evening, and that Co-proxamol—a painkiller—was given during the 7.30 pm drug round.) She had arranged for the plaster removing equipment to be obtained from the plaster room in the accident and emergency (A and E) department for the doctor to use. She had not been aware of difficulties arising from the fact that the equipment was locked away, and she did not think that the doctor had arrived by the time she went off duty. The second SN, who had been in charge, would have mentioned the problem with the plaster to the night shift at handover.

7. The second SN told my officer that she could not recall the complainant's mother complaining of pain, or the handover to the night staff. Some plaster-cutting equipment was held on the ward, but larger items were kept in the A and E department and were easy to obtain.

8. The staff nurse in charge on night duty (9.00 pm–7.15 am) (the third SN) could not recall whether the complainant's mother's pain had been mentioned during the handover, which would have lasted 20 to 30 minutes. On finding that the complainant's mother was in severe pain, she had administered a strong painkiller intramuscularly (I have seen that Omnopon was given at 9.35 pm). She had contacted the first SHO and, as he had asked for plaster-cutting equipment to be obtained in advance of his arrival, she had then contacted the night sister

(the second sister), who arrived later with the equipment and, with the first SHO, attended the complainant's mother—she could not recall when they had arrived. The complainant's mother had in the meantime been complaining of pain and had asked for a further injection, but the third SN had been unable to give that so soon after the previous dose.

9. The second sister told my officer that, when she arrived on the ward at about 9.45 pm, the staff nurse had told her that the plaster cast needed to be released, and that the first SHO had come to the ward but had since been called away. She had telephoned the A and E department, and the senior nurse on night duty there (the SNND) had told her that the cupboard was locked and asked if she could get the plaster-cutting equipment from somewhere else. She had then contacted the operating theatres and, when the equipment arrived from there at about 10.00 pm, she had telephoned the first SHO. She had no idea who would have said that the equipment had been obtained from a neighbouring hospital. She thought that the cupboard in the A and E department, although open during the day, was locked at night for security reasons.

10. The SNND confirmed having received a telephone request for a plaster saw, which would normally be obtained from a cupboard in the plaster room; however, on that occasion the cupboard had been locked, and the key was not in the key cupboard. She had then suggested that the sister might try to obtain the equipment from the operating theatres. When she made a routine visit to the ward some time after 11.00 pm, the complainant's mother had been asleep and the plaster cast had been split. The plaster room cupboard had never been locked before, and she had raised the matter the following morning with the A and E department manager, who told her that it had been done because equipment had been lost. The night staff had not been told beforehand about that, and the cupboard had been left unlocked since that night; a combination lock had instead been fitted on the door of the room in which the cupboard was situated, and staff were being notified how they could gain access. She said there would have been no need to fetch a saw from the neighbouring hospital which, because of its functions, would not have had one.

11. The first SHO who had been on the first consultant's team remembered an isolated problem with obtaining a saw, and he believed that it had related to this complaint. He had been new in post at the time and had not known where the plaster-removing equipment was kept, but the nurse in charge would normally have obtained it for him. As far as he was aware, there was only one set of equipment, and he knew of no occasion when a saw had been obtained from a neighbouring hospital. There had not been a recurrent problem in obtaining plaster-removing equipment.

12. The first consultant told my officer that a lot of pain would be expected after a large operation, but plaster casts were taken off only if there was a major problem, such as inadequate circulation of blood in the foot. The senior house officer or registrar would decide whether or not to release the cast. There should not have been a delay as simple equipment for cutting plaster was readily available in a room close to the ward, and a duplicate set was kept in the operating theatres.

13. In a letter dated 10 October, the hospital's unit general manager (the UGM) told the complainant that 'although the plaster was not removed immediately, there does not appear to have been any significant delay that could have contributed to causing the haematoma . . .'. The UGM obtained comments from the first consultant and the first sister before sending her letter.

Findings(a)

14. As far as I have been able to establish, the first SN was aware of the complainant's mother's pain some time before 9.00 pm, and the plaster was not loosened until at least 10.00 pm. That is a long time to be left in severe pain, but I am persuaded that the nurses did what they could to relieve her discomfort. Contrary to the DHA's assertion, there was difficulty in obtaining plaster-removing equipment which had been locked away that night. Once that fact was discovered, equipment was obtained from elsewhere (though I find no evidence

that this was from the neighbouring hospital). The clinical opinion of those concerned (paragraph 13) is that the haematoma was not attributable to any delay in loosening the plaster cast, and I can make no comment on that. There was obvious confusion and poor internal communication which I criticise. Delay might well have been avoided had the staff concerned known beforehand about the new security arrangements—the SHO came before the equipment arrived but had to go away again (paragraph 9). I note with approval that the staff now know how to get to the equipment. I uphold this complaint.

(b) *Inadequate nursing care:* (i) *Call for help ignored (12 April)*

15. In her notes, the complainant recorded that, when her mother got out of bed, blood had run down her leg. The first consultant's secretary (the secretary) had assisted her mother back on to the bed and had told the first sister, who sent a nurse to help. The nurse had put a pad on the wound, and the secretary had washed the blood out of her mother's slipper. When her mother had then walked to the lavatory, the wound had bled again. Her mother had called out to the first sister who was talking to a nurse a few yards away. They had continued talking until another patient called more loudly. The nurse had held a paper pad to her mother's leg as she went back to bed.

16. The complainant's mother's recollection of the incident, when interviewed by my officer nearly a year afterwards, was that it had occurred when she was first allowed out of bed; as she was returning from the lavatory, her leg had bled and her slipper had filled with blood. The first sister and a nurse had ignored her call but, on being alerted by another patient, the first sister had said it was better for the blood to come out, and that she should go back to bed. The secretary, who was passing by, had helped her to bed and washed her slipper. The secretary had returned later and asked if anyone had yet been to see her.

17. The secretary, who had been working in what she described as a linen cupboard as a temporary office opposite the room where the complainant's mother was, told my officer that she had seen the complainant's mother by her bed with blood running down her leg, and another patient calling for a nurse. As no nurse was present, she had gone to help the complainant's mother, who was distressed; she had sat her down, elevated her leg, and wiped it with a towel. She had washed the slipper in the wash basin and, before returning to her office, had told the first sister what had happened. When she came out of her office about ten minutes later, no one had attended the complainant's mother; she had told her that she had spoken to one of the staff, and that someone would be along shortly.

18. The nursing care plan for 8 April read 'may sit out but not to mobilise yet'. The care plans between that date and 29 April were missing.

19. The recollection of the first sister (who has now left the hospital for other self-employment) was that, at the time of the incident, the complainant's mother had been able to move about. She had understood that the complainant's mother was on her way to the lavatory (the lavatory was at the end of the ward, near the nurses' station), when her knee had bled, and that when she called for help, no one had been present. The first sister said that someone had come to fetch her and, on going to the patient, she had found stale blood and fluid on the floor but no fresh blood; the stale blood behind the wound (the haematoma) had apparently gushed out when the complainant's mother got up. She had either cleaned the leg herself or asked one of the nurses to do so. She had reassured the complainant's mother, who was frightened, and a nurse had taken her back to bed. The layout of the ward made it difficult for the staff to see everywhere, and it was possible that no one had answered her call at first. However, if someone shouted or rang a bell, the nurses would answer as soon as possible.

20. Neither of the two staff nurses who were on duty with the first sister on 12 April recalled an incident such as that described by the complainant's mother. The first SN believed that the complainant's mother's leg had once bled when she was walking to the lavatory; she had called for help, and someone had fetched some pads. The ward was quite noisy, and the staff might not have heard the call. The

other staff nurse (the fourth SN) recalled an occasion when the complainant's mother's leg had lost some fluid rather than blood, but on that occasion the complainant's mother had been using a commode. Other nursing staff interviewed by my officer considered it unlikely that the first sister would have deliberately ignored a patient who was calling for help. The SNND told my officer that, as the complainant's mother had had a haematoma, the leg would probably have bled on movement. She could not imagine a nurse ignoring a patient where there was bleeding of any degree.

Findings (b)(i)

21. I have found difficulty in reconciling the varying accounts, but it seems to me quite probable that there were two incidents: the first when the complainant's mother got out of bed and was helped by the secretary, and the second when she attempted to walk to the lavatory. In the deplorable absence of nursing records, I can surmise only that on 8 April she was not expected to get out of bed, but by 12 April she was being encouraged to move around. Her principal complaint is that, on the second of the occasions to which I have referred, the first sister did not initially respond to her call or provide assistance. While the secretary's account lends some credence to that, the first sister avers that she recalls going to the complainant's mother and giving her help and reassurance. The complainant's mother's alarm and distress on finding her leg bleeding is understandable and I consider that she may well have had difficulty in attracting attention. The inconsistencies in the evidence which I have received are such that I make no finding on this aspect of the complaint.

(b)(ii)*Omission to give medication (25 May)*

22. The complainant wrote that, on returning from the second hospital, her mother had missed lunch and had been given a sandwich at about 2.00 pm, but not her lunchtime medication. When the sister came round later with the drugs trolley, she had told her mother that she did not have, from the second hospital, the details of her drugs or treatment. The complainant's mother said she had told the first sister what drugs she had been receiving.

23. According to the admission sheet, the complainant's mother was readmitted at 3.00 pm on 25 May. The drug chart indicated that five different drugs were prescribed for her that day, none of them being administered until 7.30 pm. Flucloxacillin (an antibiotic) was written up for administration at 7.30 am, 1.30 pm (the only drug scheduled for that time), 7.30 pm and 11.00 pm. Three of the other drugs were to be administered only once a day (at 7.30 am), and the remaining one was to be administered three times daily (at 7.30 am, 7.30 pm and 11.00 pm).

24. The first sister commented that, although the complainant's mother had not returned to the first hospital in time for the 1.30 pm drug round, she had received the drugs prescribed for 7.30 pm. The fact that one dose of the antibiotic had been missed had not mattered, as she had been receiving doses for a long time. The absence of details from the second hospital would have been only a minor problem, and information had been obtained later by telephone. (The clinical records contained a typewritten record of a discharge report given orally by the second hospital, and a discharge letter received subsequently by the first hospital.)

25. The SNND (paragraph 9) had become acting head of nursing services (the acting HNS) by the time of my investigation. In the latter capacity, she told my officer that, when a patient returned from another hospital, a nurse would carry out an assessment, and ask a doctor to see the patient and to re-prescribe the drugs. Drugs could not be administered until that had been done. (The clinical records indicated that a doctor saw the complainant's mother, and re-prescribed drugs, at 6.00 pm on 25 May.) If a patient was on long-term antibiotics in tablet form, the levels in the blood would take a long time to reduce, so to miss one dose did not make much difference (a point endorsed by a senior house officer (the second SHO) on the first consultant's team).

Findings (b)(ii)

26. While the complainant's mother apparently missed one dose of Flucloxacillin, that arose not from an oversight by staff but from the fact that she did not return to the first hospital until some time after the 1.30 pm drug round. I note in any case that, in the clinical judgment of those concerned, the omission of one dose would not be significant. Although the discharge summary did not reach the first hospital on 25 May, the necessary details were obtained by telephone, and at 6.00 pm a doctor prescribed drugs, which were given at the subsequent drug round. I do not uphold this complaint.

(c) *Deficient communications:* (i) *Removal of sutures*

27. The complainant's mother said that the second SHO had told her that the stitches (or sutures) only at the top half of her wound should be removed after the knee operation on 15 March. However, the first sister had said that there was no reference to that in the records, and that all the sutures should come out. A staff nurse had removed them, but the bottom of the wound had then gaped and strapping had been applied. The complainant's mother was concerned that that could happen to someone else if doctors did not give written instructions to the nurses. The complainant had been concerned, on her mother's return from the second hospital, lest the sutures arising from the skin graft should also be taken out too early, allowing the wound to burst—as she believed had happened after the knee operation. She made a note on 31 May that it had been left to the first consultant to decide how many sutures should be removed and that, later that day, the first sister had removed them all.

28. In their reply to me, the DHA stated that the wound had burst not because the sutures from the original operation had been removed, but because of the haematoma. They had found no evidence in the records to show that the nurses had not followed the doctor's instructions.

29. The first SN told my officer that she had removed the sutures after the knee operation and would not have taken them all out had she not been told to do so. She thought the first SHO had given instructions on that during a ward round. The wound had been quite well healed at that time, but the haematoma had caused it to gape; she had padded it fairly tightly, put steristrips on, and told the first sister. She thought that the complainant's mother had asked if the gaping was usual, and she had explained that it was caused by the haematoma. Her belief was that the first sister also had spoken to the complainant's mother about the haematoma.

30. The second SHO told my officer that she recalled some discussion about how many sutures should come out after the knee operation, and when they should be removed. In the event it had made no difference, as the wound would still have gaped, but the complainant's mother would have heard differing opinions, and that could have been confusing. The SHO remembered that the complainant's mother had asked what was happening, and that the staff had tried to reassure her.

31. The first sister said that nurses would inspect sutures as a matter of routine and, for a knee wound, would normally remove them on the twelfth day. She had kept a special book in which she would note down points arising from the doctors' rounds, afterwards transferring them to the patients' nursing records. Any advice from a doctor on the removal of sutures would have been noted. (The DHA told me that the ward round book for the period of the complainant's mother's stay was not available. The books contain rough notes and are only kept for a short period of time before being destroyed. The DHA did not volunteer information on what was a short period of time.) She had no recollection of the removal of the sutures after the knee operation. However, in a statement prepared for the DHA on 6 July 1989, she recorded that on 28 March the sutures had been removed and steristrips applied to the lower inch of the wound, which was gaping.

32. The first sister recalled that the discharge letter from the second hospital had suggested a date in May for removing the sutures to the complainant's mother's skin graft (that letter, and a note of telephoned advice by a doctor at the second hospital, proposed 31 May). The first consultant had instructed that alternate sutures be taken out, and that the wound should then be examined (an entry made by him in the clinical records on 31 May read ' Stitches out today apart from a few

at bottom'). She remembered taking out the sutures herself; that was usually a quick task, but in this case there had been many small sutures, which were embedded and difficult to remove. The wound had been healed by then and, in her opinion, the sutures should have come out earlier. Although the consultant had asked that only half of them be removed, she had considered that they should all come out, and she had removed them all.

33. The acting HNS told my officer that surgeons would often ask nurses to remove alternate sutures. However, if the wound was satisfactory, the nurse might remove the remainder, using her professional judgment in deciding whether to do so.

34. The first consultant told my officer that either he or a registrar would advise the nurse in charge of a ward how many sutures to remove, and when, but that would not necessarily be entered in the clinical records. If there was no problem, nurses would act on their own initiative and remove sutures after 12 days. Were the wound not completely healed, they would sometimes remove alternate sutures. If a wound was not going to heal, leaving the sutures in did not rectify matters: the sutures might cut into the skin, and it would be better to remove them. Doing that too early would not cause a wound not to heal. In this case, the haematoma had caused the wound to burst open, and to have left the sutures in after the knee operation would not have prevented that. As to the removal of sutures after the skin graft, he thought the wound had healed by 31 May, when the first sister removed the sutures. There was no major issue as to whether all or only some sutures should be removed, and that was often left to the sister's discretion.

Findings (c)(i)

35. The complainant and her mother have voiced concern about both occasions on which sutures were removed. According to the second SHO, there was some debate about the removal of sutures after the knee operation which, not surprisingly, caused the complainant's mother some anxiety, particularly as the wound gaped after the sutures were removed. I have been told that the haematoma was the cause of the problems and that sutures would not have been able to prevent that. Having removed the sutures according, as she believed, to instructions, the first SN took action to dress the wound. With regard to the subsequent skin graft sutures, the first consultant advised that some sutures should be left in, but the first sister decided, in the exercise of her professional judgment, to remove them all. In the first consultant's clinical opinion, whether all or only some of them were taken out would not be significant for the healing of the wound, and that was a matter often left to a sister's discretion. I do not uphold this complaint, but I hope that the complainant's mother will be reassured that, in the opinion of the professionals concerned, the removal of the sutures did not affect her progress.

(c)(ii) *Arrangements to see doctor*

36. The complainant told my officer that, on telephoning the ward on 24 March, she had learned that her mother had developed anaemia. She had asked (she could not recall whom) if she could speak to a doctor and had been told that a meeting could be arranged for 26 March. When she visited the ward later on 24 March, the first sister had explained that her mother had developed anaemia, some degree of kidney failure and, possibly, a bladder infection. The sister had said that there would be no point in her speaking to an orthopaedic consultant (such as the first consultant) about such problems, but had offered to arrange for her to see a 'medical consultant' (a physician) the following week. By 20 April her mother's medical problems had been resolved, so she had not pressed to see a doctor about them. However, still being concerned about her mother's knee, she had asked again to see a doctor about that. Again she did not recall which nurse she had asked, but she had once more been told that arrangements would be made. On 27 April, she had reminded the first sister of her earlier agreement to arrange for her to speak to a doctor. The sister had replied that, as the problems had been resolved, there was no longer any need to speak to a doctor. The complainant had explained that she was worried about the skin graft operation, which the first consultant had mentioned to her mother during his ward round the previous day, but the sister had given no particular answer to her requests to see a doctor.

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37. The complainant said that, at the second hospital, a doctor had explained to her what would happen to her mother and had invited her to ask to speak to him whenever necessary. The medical staff had frequently seen her mother, and the complainant had felt confident that she was being closely monitored. On her mother's return to the first hospital on 25 May, she had again asked the first sister if she could speak to a doctor but had been told that that would not be helpful until after her mother had been examined. The next day she had written to the first and second consultants (I have seen both letters, and the second consultant's reply). On visiting the ward on 30 May, she had made an appointment, through the secretary, to see the first consultant on 6 June.

38. The DHA told me that the first sister had suggested that the complainant should discuss her mother's anaemia with the medical team responsible for that aspect of her care. As a senior physician was not available until later in the week, there had been some delay; meanwhile the complainant's mother's anaemia had improved. After checking with the 'orthopaedic doctor', the sister had not felt it appropriate to arrange the meeting.

39. The first sister told my officer that the complainant's mother, who was well-liked, had been understandably upset at times, as her knee replacement had developed complications. She had not always appeared to take in what she was told. The complainant had asked many questions, often asking different members of staff the same question. She had also taken notes, although the sister could not say when that had started. Eventually the first sister had asked the nurses to refer the complainant either to herself or to the second SHO. Nurses would either arrange for relatives to see whichever doctor was available or, if they wished to see the consultant, record that in the nursing records and make arrangements through the secretary. If relatives complained or seemed unhappy, the nurses would suggest that they speak to a doctor. She had first met the complainant when the physicians were treating her mother for kidney problems, which had subsequently cleared up. On 26 March (Easter Sunday), neither the second SHO nor the house physician caring for the complainant's mother had been on duty (the second SHO confirmed that she had been away from 24 to 27 March, and from 29 March to 10 April). She had told the complainant that no one was available to explain things to her properly, but that she would arrange it in the week. However, the house physician, on being contacted, had said that she did not see any need to speak to her, as the problem had by then been resolved and she had spoken to her mother. The sister had conveyed that to the complainant, who seemed satisfied with the explanation.

40. The first sister recalled that the complainant had asked to speak to her on a later occasion, and had also asked to see a doctor when her mother had returned from the second hospital; she had replied that it would be better to wait until after the consultant had seen her mother. Information had not been withheld but, with hindsight, more effort should have been made so that the complainant could see a doctor each week; it would also have been helpful had the house physician agreed to speak to her. She believed however that the second SHO had spoken to the complainant.

41. Five staff nurses recalled that the complainant's mother had been anxious, particularly when she saw her knee wound. The first sister had had most dealings with the complainant, and none of them could recall her asking to see a doctor, or knew of any problem in making such arrangements. The first SN recalled that the first sister would spend a lot of time talking both to the complainant and to her mother. The secretary told my officer that the complainant's mother had been upset because of the complications which had developed, one of her main worries being about infection and the possibility that she might lose her leg. (In a letter of 16 June 1989 to the DHA, the complainant too, mentioned the fear that her mother might lose her leg.)

42. The acting HNS could not understand why the complainant had not seen a doctor. Junior doctors were on the ward every day. She would expect the nurses to tell a relative if a doctor was not available, and she considered that there had been an unnecessary delay before the complainant had seen a doctor.

43. Neither the first nor the second SHO recalled having seen the complainant, or having been asked to do so. Both said that they were willing to see relatives and were not aware of any problem with such arrangements. The first consultant told my officer that one of the senior house officers, who provided the day-to-day care on the ward, should be available to see relatives first. If the doctor on duty did not know the patient, it was better, unless the matter was of immediate concern, for relatives to wait until the relevant doctor came on duty. Relatives who were not satisfied could ask to see a more senior doctor and either he or the registrar would see them by appointment. For a relative to wait as long as the complainant to see a doctor was unusual. (In a letter of 11 July 1989 to the hospital manager, the first consultant expressed concern about the complaint that the complainant was 'refused access' to any doctor; he commented that the second SHO was very willing to see relatives, and he could not understand why the difficulty had arisen.)

Findings (c)(ii)

44. Despite several requests, the complainant did not see a doctor to discuss her mother's condition until 6 June. Her mother was known to be anxious, did not always seem to take in what she was told and even feared that she might lose her leg. The complainant's repeated enquiries might have caused staff difficulties but, given the complications and her mother's distress, I do not find her persistence surprising. In all the circumstances, arrangements should in my view have been made earlier for her to see a doctor. It is indeed better for relatives to see a doctor who knows about the patient, but that is not always possible, and I have noted the house physician's apparent reluctance to see the complainant. However, both SHOs would have been on duty for much of the time and have said that they were willing to see relatives. I agree with the first sister's acknowledgement that more effort should have been made to ensure that the request was met, and I find her at fault both for omitting to do so, and for not telling the complainant, until prompted, why no arrangements had been made. I recommend that the DHA remind nurses of the need to act upon a request from relatives to see a doctor, to inform them of any difficulties, and to record the request and any action taken. I uphold this complaint.

(c)(iii) *Contradictory information about infection*

45. The complainant's mother told my officer that nurses had told her that they were taking swabs of her knee wound, and she had understood the purpose of that to be to find out how far the infection had gone. The complainant's note recorded that, after receiving the results of a swab test, her mother was prescribed antibiotics on 7 April. Three days later, her mother was told that the wound was to be cleaned under general anaesthetic as the antibiotics were only holding the infection; her mother was apparently distressed by that news, and concerned about her progress. When her mother saw the second consultant on 3 May about the skin graft, he told her that, if the infection had reached the prosthesis, the operation might have to be repeated. In her evidence to my officer, the complainant recalled that staff had referred to 'infected tissue' and that, on arrival at the second hospital, her mother had been placed in isolation for three days. The suggestion that there had not, after all, been an infection, had first arisen at the meeting with the first consultant on 6 June. He had denied that there had ever been an infection explaining that the skin graft at the second hospital had been a success, and that her mother would regain independence and mobility. She had asked why infected tissue had been cut away on 12 April, and he had said that it had been not infected tissue, but tissue which would not heal; antibiotics had been prescribed to prevent an infection. As the second consultant had referred to an infection, and nurses had taken weekly swabs and had said that the infection was reducing, the complainant had been worried and confused by what the first consultant had told her.

46. In their response, the DHA said that the first consultant had explained that the wound was not infected, and that antibiotics had been given to prevent infection.

47. The first sister told my officer that, before the meeting with the first consultant, the staff had told the complainant and her mother that there was an infection. The nurses would have told her mother why they were taking swabs, but they would not have wanted to frighten her; any wound that was slow to heal

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routinely had swabs taken from it. The sister surmised that the complainant had misunderstood what the first consultant was saying, as the wound had been infected. She had not felt able to tell the first consultant that his explanation had not been clear to the complainant.

48. The second SN told my officer that she had accompanied the complainant's mother to the second consultant's outpatient clinic to discuss the possible skin graft. The second consultant had told the complainant's mother that, before admitting her, he had first to make sure that the wound was 'clear'; and that, if the infection had reached the prosthesis, it might have to be removed. The second SN had afterwards explained to the complainant what the second consultant had said; both the complainant and her mother had known that the wound was infected, and that the results of a further swab test were awaited. When the results were received on 4 May and were clear, the complainant's mother had been transferred to the second hospital.

49. The HNS told my officer that the complainant's mother had had a mild infection, and had been treated with antibiotics. The first consultant might have said that there was no infection, because he considered it to be of minimal significance. Nurses did not like giving information, considering that to be the doctor's responsibility, but if an experienced nurse had fully explained the situation, concern about the incompatibility of information received from nursing and medical staff might have been minimised.

50. The second SHO told my officer that there were degrees of infection, and that no clear distinction could be drawn between whether a wound was, or was not, infected. A minor infection might not have any significance, and doctors would not cause unnecessary worry by telling a patient about it. If a wound became infected, some doctors would tell their patients at an earlier stage than others. She had seen the complainant's mother nearly every day and remembered that, at one stage, there had been uncertainty about whether or not she had a 'full grown' infection: that had confused the complainant's mother. She and, she believed, the registrar had told her that there was some infection. She did not recall having discussed the matter with the first consultant.

51. The first SHO told my officer that it was a matter of judgment whether, at any point, an infection existed, and antibiotics were often used to prevent infection in orthopaedic surgery. The complainant's mother's wound had taken a long time to heal: that had been a problem, but infection had not.

52. The first consultant told my officer that senior house officers were encouraged to make entries in the clinical records once a week, and more often 'if something happened'; he would expect to see an entry within a week of an operation. Bacteria grew on any unhealed wound, but only if pathogenic (harmful) did they constitute an infection. In this case, the microbiology test results had not shown pathogenic organisms, and there had been no evidence that bacteria were contributing to the delay in the healing of the wound. Something had gone wrong with the wound, but the descriptions in the second SHO's letter and in the clinical records (see paragraph 53) were inaccurate, as there had been no major wound infection. The wound had broken down as a result of the haematoma, and there had been a danger that bacteria would develop; antibiotic therapy would prevent infection from entering the wound and causing a potentially irreversible infection process within the joint. Breakdown of wounds after knee replacements was a recognised and serious complication because, if satisfactory wound healing could not be achieved, the prosthesis had to be removed, resulting in arthrodesis (stiffening of the knee). He would have tried to explain to the complainant the cause of the problem but did not think that she had accepted what he said. He thought that most people seemed to understand quite clearly what he meant when he explained things to them.

53. The nursing care plan for 8 and 29 April listed 'infected wound site' as one of the complainant's mother's problems. The clinical records contained no entry for six days (15 to 20 March inclusive) after the knee replacement operation. After

the evacuation of the haematoma on 12 April, there was no entry for two weeks (13 to 25 April inclusive). On 7 April, it was recorded that the wound was 'infected with a discharge' and, after receipt of the swab results, an antibiotic—Amoxycillin—was prescribed to be administered four times daily. Further swab tests were taken on 12, 17 and 24 April, and 2 and 29 May. In a letter dated 26 April to the second consultant, the second SHO stated that the wound had 'unfortunately got infected'; an entry made in the clinical records, on the complainant's mother's return from the second hospital, on 25 May read 'Skin graft to [left] leg for skin loss following septic tissue after knee replacement'.

Findings(c) (iii)

54. My task is to establish not whether there was an infection—that is a matter of clinical judgment but also, it appears, of differing professional opinion—but whether contradictory information was given to the complainant and her mother. I have found that there were diverging perceptions among the staff. The nurses believed the wound to be infected, as did some of the doctors. I am not surprised, therefore, by the complainant's inability to accept the first consultant's assurance that there had been no infection. I accept that such matters are more complicated than they might appear to a layman, but I am left in no doubt that the position was not explained with sufficient clarity to the complainant and her mother. I recommend that the DHA remind nursing and medical staff of the importance of endeavouring to resolve any difference, whether expressed orally or apparent from the records, about the presence and significance of infection. I cannot help remarking on the paucity of entries in the clinical records—the consultant appears to have assumed rather readily that they would have been made more frequently. I recommend that the DHA should keep under review practice in making regular entries in the records. I uphold this complaint.

(c) (iv) *Meeting of 6 June*

55. The complainant told my officer that, by 6 June, she had felt under stress. The meeting had been held in a small consulting room, and a temporary secretary, two doctors (whom she thought might be students) and a sister (whom she had not seen before) had been present when she arrived. She had not been told that others would be there, and she had not been introduced to them. That had undermined her confidence and she had asked if she might take notes. While she could see the reason for the secretary, she did not see a need for anyone else to have been present.

56. The first consultant told my officer that he did not recall much of the meeting but considered that anyone in those circumstances would be tense and anxious. (In her letter to the consultant, requesting the meeting, the complainant had expressed her 'worry, concern and fear' about her mother's condition.) He did not remember who had been present; there was likely to have been a secretary and, possibly, medical or nursing students who attended to learn. He would not have introduced them, but it would have been clear who they were, as nurses wore uniform and medical students wore white coats; they all would have had name badges.

57. The secretary told my officer that relatives usually saw the first consultant during his outpatient clinic, and she arranged for them to arrive during the coffee break when only the first consultant and herself would be present. On 6 June she had been absent, and a locum had taken her place. When the consultant saw patients at his clinic, up to three nursing or medical students, the sister or staff nurse running the clinic, and the secretary would usually be present. He would talk to and teach the students, and dictate to the secretary. The consultant did not introduce those present, and some patients had complained to her about that. She agreed that to find four strangers at the meeting would have been difficult for the complainant.

58. The UGM told my officer that the DHA did not have a policy about consent to the presence, at a consultant's discussions with patients or relatives, of other staff or students. She did not consider it appropriate for the DHA to issue written instructions to consultants on such a matter; that was something on which consultants would use their discretion and professional judgment.

59. In circular HC(77)18, issued in May 1977, the Department of Health and Social Security—as it then was—issued revised guidance on 'a patient's right to decline to take part in teaching procedures'. The circular stated that 'on the first occasion that a student is present during [an] examination. . . , his status and the reason for his attendance should be explained to the patient whose co-operation should be sought'. The circular does not deal with interviews of the kind the complainant had but the philosophy underlying it is, in my view, just as relevant to such an interview.

Findings (c)(iv)

60. The first consultant has acknowledged that the complainant would have been anxious, but he did not see any need to introduce those present whose identity, he believed, would be evident. I do not share his blinkered view. Common courtesy makes it in my view incumbent upon someone in the consultant's position to explain not only why others are there, but who they are and to ascertain that there is no objection to their presence. I recommend that the DHA remind consultants of their responsibility to obtain consent to the presence of medical students—and, as a matter of courtesy, to explain why others are there unless the reason is transparently obvious. I uphold this complaint.

61. I did not undertake, as part of my investigation, to investigate the manner in which the DHA dealt with the complainant's complaint. I have already referred to the loss of almost all the nursing records (paragraph 3), which I regard as careless if not suspicious; the records appear to have been available when the sister made her statement in July 1989 but the UGM has told me that she was unable to find them when she met the complainant later that month. What is more, the clinical records were inadequate (paragraph 54). A particularly large number of staff had left the employment of the DHA. That must make it difficult for the DHA to maintain continuity of care or knowledge of procedures. It certainly compounded the difficulties faced by my officer. Finally most of the staff interviewed by my officer said that the DHA had not asked them for statements at the time of the original complaint, and some did not apparently hear about the complaint until my officer approached them. That inspires little confidence in the thoroughness of the DHA's investigation of complaints and I strongly recommend them to have a painstaking review of their methods.

Conclusion

62. I have set out my findings at paragraphs 14, 21, 26, 35, 44, 54 and 60. The DHA have agreed to implement my recommendations at paragraphs 44, 54, 60 and 61 and have asked that this report should convey their apologies to the complainant and her mother for the shortcomings I have identified.

Case No W.478/89–90—Provision of long-term care

Background and complaint

1. In April 1988 the complainant's mother was admitted to the neuro-surgical unit (the unit) at a hospital (the hospital), which is administered by a health authority (the DHA), with severe head injuries sustained in a road accident. The complainant's mother was discharged from the unit in October 1989 to a private nursing home (the nursing home). There she remains at a cost, when I accepted her complaint for investigation, of over £200.00 per week.

2. The complainant complained:

(a) that the DHA's actions, and arrangements for the care and rehabilitation of his mother, did not comply with the guidance in Department of Health circular HC(89)5 entitled 'Discharge of Patients from Hospital' (the circular)—and in particular, that undue pressure had been exerted on him and the family to move their mother to the nursing home;

(b) that it was the DHA's responsibility to provide for her needs; and

(c) about the dilatory way in which the DHA had dealt with the representations about his mother's care.

Investigation 3. I obtained the comments of the DHA and examined the relevant correspondence and other records. One of my officers took evidence from the complainant, the secretary of the local community health council (the CHC secretary) and the DHA staff involved.

(a) *Actions contrary to the circular* 4. The circular, which was issued, in February 1989, to regional and district health authorities for action, read:

> '. . .
>
> 3. The patient, and if appropriate, the family or carer(s) must be at the centre of the planning process. It will help to reduce any anxiety which patients may feel if they fully understand and agree with the arrangements planned . . .
>
> . . .
>
> 12. The attached booklet 'Discharge of Patients from Hospital' [the booklet] is intended to help Health Authorities in reviewing their procedures . . .
>
> . . .'

The booklet stated:

> '. . .
>
> A2. The [discharge] procedures should provide for:
>
> . . .
>
> ii. liaison with social services and housing departments about alternative arrangements, if it appears likely the patient will not be able to return to his/her current place of residence . . . Such arrangements must . . . be acceptable to the patient and, where appropriate, the patient's relatives or carers . . . Where a person moves from hospital to a private nursing home, it should be made quite clear to him/her in writing before the transfer whether or not the health authority will pay the fees, under a contractual arrangement. No NHS patient should be placed in a private nursing or residential care home against his/her wishes if it means that he/she or a relative will be personally responsible for the home's charges.
>
> . . .'

5. The complainant told my officer that pressure to discharge his mother had begun in October 1988 when the consultant neuro-surgeon responsible for her care (the consultant) had told the family that they had to consider the prospect of her discharge, because the time was approaching when the unit would not be appropriate for her care. Later that month a social worker based at the unit (the SW), who was very supportive, had given the complainant a list of nursing homes which might admit his mother and had recommended four or five for him to consider. The family had visited a number of homes, rejecting as unsuitable one of those recommended by the SW and consultant. They had met the consultant on several other occasions, but the complainant could not recall when the meetings had taken place or much of what had been discussed. At one meeting the consultant had encouraged him to apply to the Court of Protection (the Court) for receivership of his mother's affairs, as she was incapable of managing them herself, so that if she was discharged to a private establishment, the funds could be obtained. He had also said that, if the family did not apply for power of attorney, the DHA would do so. The consultant had also raised the issue of discharge when the complainant met him during visits to see his mother. The family had resisted the consultant's proposals fearing that they might have resulted in the need to sell the family home to pay the fees, and there had been a small possibility that their mother might, at some stage, return home. The DHA should in their view have provided continuing care rather than seek to pass the responsibility elsewhere (see paragraphs 17–24). Later, after taking legal advice, the complainant had made application to the Court for receivership. In later evidence to my officer, the complainant said that the Court had appointed him as Receiver and had authorised reimbursement to the DHA: he imagined that that would now be implemented.

6. The complainant said that the SW had also given him some idea of the charges made by the nursing establishments and had left him with the clear impression that the family would have to pay. She had suggested that the Department of Social Security might help with the fees but he had discovered that his mother's capital disqualified her from receiving such assistance. In May 1989, the SW had suggested that the DHA might make an advance to cover the nursing home costs, with reimbursement later from his mother's estate. The family had claimed against the person whose vehicle had knocked his mother down but expected the claim would take years to settle.

7. In June or July 1989 the family had accepted transfer of their mother to the nursing home; they had had no choice but to take a place somewhere, and that was the most suitable they had seen. He had not rejected the proposal that the DHA should pay his mother's fees and recover the cost from her estate after he had been granted receivership, but he had expressed some uneasiness to the SW as there might be insufficient capital to cover the costs. The SW had replied that that was outside her control. He had never formally agreed to the arrangements in writing or been invited to do so, and the family had not been at the centre of the discharge arrangements (paragraph 4)—as they were supposed to be—since they had not willingly agreed to them. He did not accept, either, a statement by the consultant that his mother could have returned to the unit if the arrangements turned out to be unsatisfactory (see paragraph 9). Their understanding had been that she could not return unless her condition deteriorated.

8. The CHC secretary said she had learned from the complainant, and not from first hand knowledge, about the pressure to move his mother to a nursing home (she wrote to the unit general manager at the hospital (the UGM) about that on 19 June 1989 (see paragraph 25(iii))). The complainant had sounded appalled when telling her of the consultant's suggestion about seeking receivership, although she had not discussed that with him. She commented that consultants were often unaware that their manner could be regarded as pressure.

9. In a statement about the complaint, the consultant wrote:

> '. . .
>
> During [the complainant's mother's] recovery period she had extensive . . . assessments [which] indicated that although she had made a good recovery she was likely to remain completely dependent and after discussion with members of the family it became clear that she was unlikely to be able to return to her home, at least in the foreseeable future.
>
> In September 1988 first discussions began between the Social Work Department and the family regarding a more suitable long term placement for the complainant's mother. A number of alternatives were explored . . . the complainant's mother's family visited the various homes and after a visit in May 1989 selected [the nursing home] as the most suitable. The complainant's mother was accordingly placed on their Waiting List for a place. The complainant's mother went for a trial admission for two weeks from July 24th–August 7th 1989 and she and her family reported her liking it. She was then readmitted to [the unit] until a place finally became available on 4th October 1989. As is recorded in the hospital notes, [the DHA] gave an undertaking re financial support and that the complainant's mother would be able to return to [the unit] if the arrangements turned out to be unsuccessful . . .'

10. The consultant told my officer that for more than a year the complainant's mother, who had passed the acute phase of her injury, had remained in the unit which was now inappropriate for her care. Her family had been at the centre of the planning for her discharge: he and the SW had had formal and informal meetings with them over many months and had secured their acceptance of the nursing home. He denied telling the family that the DHA would apply to the Court if they did not do so (paragraph 5). As their mother's consultant, he had kept them informed of her progress and discussed what would be an appropriate placement for her in the future. The cost of nursing home care had been a matter for the SW. She had

kept him informed of developments and he had supported her recommendation that the cost of a place at the nursing home should initially be met by the DHA, so that it could be secured quickly for the complainant's mother. He had not put pressure on the SW but had merely asked her to do all she could to help persuade the family to accept a more appropriate placement than the unit. The hospital had undertaken to re-admit the complainant's mother if her stay at the nursing home was unsuccessful (but a letter which he showed to my officer in that connection related only to the complainant's mother's trial admission at the nursing home).

11. The sister in charge of the complainant's mother's ward (the sister) told my officer that there had been visitors from the family every day and she had got to know them well. The consultant, who was concerned about the heavy demands made upon the unit, had pressed the SW to persuade the family to find a residential home acceptable to them and she had become the channel of information to the consultant from the family and to the social worker from the consultant. She had sought the family's views on the nursing homes which they had visited, and had conveyed their opinions to the consultant. She had encouraged the family to value the positive aspects of the homes they visited, until eventually they had identified one which seemed to be the most suitable. However the nurses had not put any pressure on the family.

12. The UGM told my officer that he became aware of the complainant's mother's case in August 1989, when the consultant had told him that he had obtained a place at the nursing home for the complainant's mother, who was several months past the acute phase of her treatment. As the nursing home needed to be certain that their fees would be met, the consultant had urged the DHA to pay them initially, on the basis that they would be reimbursed from the complainant's mother's estate; he had understood that the complainant's mother's family were seeking receivership and that that would soon be settled. The UGM, although unsure of the DHA's powers to make such payments, had agreed to the proposal and had written to the SW accordingly (see paragraph 25(viii)). She had replied that the complainant's mother's solicitor hoped that the Court hearing would be within the next six weeks and that the DHA should proceed with the proposed arrangements.

13. The UGM expressed himself satisfied that the family had been genuinely consulted and at the centre of the arrangements for the complainant's mother's discharge. The DHA would have been failing in their duty had they not encouraged the placement of the complainant's mother in a more appropriate setting, but their action had not in his view amounted to undue pressure. Only on seeing the complainant's letter of 23 October (see paragraph 25(xii)) had he become aware that there was unhappiness with the arrangements that had been made. As for the suggestion that the DHA might seek receivership in respect of the complainant's mother's estate, he doubted that the consultant would have known whether they could do that.

14. My officer was unable to trace and interview the social worker, who had gone abroad, but the area social services manager (the ASSM) told my officer that his department had only an advisory role in a case such as that of the complainant's mother. They assisted the DHA and the patient, or the patient's carers, but they did not determine placement or assume responsibility for the person's care.

Findings (a)

15. I deal first with the assertion that pressure was exerted on the family to move the complainant's mother from the Unit. The consultant has denied that he did so, although he and—through him—the SW clearly did their best to persuade the family to accept that the unit was not clinically appropriate for the complainant's mother. The evidence shows that the SW, whom the complainant described as supportive and sympathetic, played a key part. That makes it the more unfortunate that I was unable to obtain evidence from her. While that prevents me ascertaining her view of events, the other evidence I have gathered does not lead to the conclusion that undue duress was placed upon the family. I see nothing to criticise in the concern of staff, prompted

both by what they saw as the complainant's mother's best interests and by the needs of other patients requiring the specialised care provided for acute cases on the unit, to encourage and facilitate the complainant's mother's transfer to a more suitable environment.

16. The complainant has complained that the DHA's actions were at odds with guidance in the circular (paragraph 4). The guidance stresses the need for the arrangements for any alternative care after discharge to be discussed with the patient and, where appropriate, the family or carers. There is no doubt that the question of discharge was regularly discussed—indeed the complainant has alluded to that as evidence of pressure—but it does not seem to me that the SW or staff of the DHA had reason to believe that transfer to the nursing home was a course to which the family was opposed. The consultant has said that he did not see his role as extending to *discussion* of nursing home charges: in accepting that, I do not believe that, as consultant responsible for the complainant's mother's care, he could wholly dissociate himself from the financial implications of alternative provision, and I have seen that he commended to the UGM the proposal that the DHA should make an advance to cover the costs. In agreeing to that suggestion, the UGM had no reason to believe, having regard to the SW's reply, that the family were objecting to the principle that they should pick up the costs when the Court appointed a receiver. I criticise the DHA, however, for their failure to obtain agreement in writing to what was planned. Had they followed the guidance (paragraph 4), the family's concerns would much sooner have been brought out and could well have been resolved without recourse to me. I recommend that the DHA review their procedures to bring them into line with the guidance, and I uphold this complaint only in that written agreement was not obtained.

(b) *The DHA's responsibility*

17. The complainant maintained that the DHA should have continued to care for his mother; and that they had not done so because of a lack of funds. Persons recovering from head injuries represented a particular problem for the DHA because of the length of treatment, and because the level of staffing required seemed to be beyond their resources. His mother had made good progress in the nursing home, but there were fewer facilities than at the unit.

18. The CHC secretary expressed the view that the DHA had a continuing responsibility, under section 3(1) of the National Health Service Act 1977 (the Act), for head-injured patients such as the complainant's mother. She said that their main concern appeared to have been to free a bed in the unit, which was an inappropriate place for the complainant's mother. The DHA appeared to her to find difficulty in accepting their responsibility for such patients, in respect of whom they had no clear policy. In the complainant's mother's case, no one had been willing to address the policy aspect until CHC enquiries reached the district medical officer (the DMO) (see paragraph 25 (xiii)). The DHA had, now, begun to devise a policy strategy and was appointing a case co-ordinator for each patient.

19. The Act, which governs the provision of health services, states in section 3(1) that:

> 'It is the Secretary of State's duty to provide throughout England and Wales, to such extent as he considers necessary to meet all reasonable requirements—
>
> (a) hospital accommodation;
>
> (b) other accommodation for the purpose of any service provided under this Act;
>
> (c) medical, dental, nursing and ambulance services;
>
> . . .
>
> (e) such facilities for . . . the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service;
>
> . . .'

In letters to me sent in response to enquiries I made in the course of another investigation I recently conducted, the chief executive of the NHS Management Executive (the chief executive) wrote about the provision of care by health authorities:

> '. . . If in a doctor's professional judgement a patient needs NHS care, then there is a duty upon the Health Service to provide it without charge . . . this can be done by providing community nursing care to the patient's own home, by providing in-patient care or by a contractual arrangement with an independent sector home (ie paid for in full by the health authority). The level of service provided overall is a matter for individual health authorities in the light of local circumstances and priorities.'

and:

> '. . .
>
> a. there is no general duty on a health authority to provide in-patient medical or nursing care to every person who needs it. Legal precedents have established that the Secretary of State's duty under section 3 of the Act is qualified by an understanding that he should do so 'within the resources available' . . . Thus
>
> b. in any particular case the provision of such care may be deferred so that cases may be dealt with, in order of clinical priority, within the resources available; and
>
> c. consideration of clinical priority may mean that a particular patient may never be provided with in-patient nursing care . . .
>
> . . .'

20. The consultant told my officer that the complainant's mother would probably need sustained nursing care for the rest of her life. She was likely to remain completely dependent and unable to return home, at least in the foreseeable future. Head injured patients who had passed the acute phase no longer needed the services of the unit, but needed nursing care, mental stimulation and physiotherapy. He considered it was the DHA's responsibility to provide for such patients, but said they were not doing so because of financial constraints. The unit, which was a regional resource providing a service for eight health authorities, was inappropriate for patients who had passed the acute phase, and, some years earlier, the eight authorities had agreed to withdraw such patients from the unit and care for them themselves. Only the DHA had not implemented the agreement. He had raised the problem with the district general manager (the DGM) in 1989 (I have seen the correspondence), but the DGM had merely referred to the fact that the DMO was preparing a strategy (paragraph 18). Nevertheless, the unit did not discharge patients after the acute stage if there were good reasons for them to remain in the unit. In the complainant's mother's case, he was satisfied that appropriate care could be provided by the nursing home.

21. The DMO told my officer that patients with head injuries, many more of whom now survived, presented problems for many health authorities. Continuing in-patient care for patients who had passed the acute phase, and no longer needed that degree of medical attention, was inappropriate for the patient, and a wasteful use of hospital resources. The DHA had finite resources and had to have regard to their responsibility for all patients and to consider what category of care was most appropriate for the particular needs of a patient who was recovering from head injuries. The DMO maintained that not all such patients were, under the provisions of the Act, the responsibility of the DHA. She was endeavouring to put together a strategy which drew upon various sources, including the report of a regional working party on expanded rehabilitational facilities and a research study into brain-injury. The work was still at an early stage.

22. The DGM said that he understood the complainant's mother's needs to be primarily for social care with clinical support. As such, disputes about which agency was responsible were bound to arise. The Act did not in his view impose a responsibility upon health authorities for all head-injured people who no longer required in-patient medical care. Although the DHA had taken the lead in determining policy for such patients, no open-ended commitment could be made.

A patient who had ceased to need in-patient medical treatment should not be in hospital, and the prevailing thrust of policy, which favoured returning patients to the community, could not be ignored. He confirmed the consultant's evidence about the agreement among the eight health authorities but pointed out that what was an appropriate placement for patients was not always clear. Clinicians at the hospital were much involved in management and were aware of the resource implications of clinical recommendations. Nevertheless, not resources but clinical opinion about a patient's requirements had to be the determining factor.

Findings (b)

23. The complainant has claimed that the DHA had a duty to continue providing for the complainant's mother's needs. The consultant has said, on the basis of his clinical judgment which I cannot question, that, while she no longer needed the facilities of the unit, she still required nursing care, mental stimulation and physiotherapy. He considered that it was the responsibility of the DHA to provide that care, although he acknowledged that it could also have been provided by the nursing home. The DMO has contended that patients like the complainant's mother are, because of their particular needs, not necessarily the responsibility of the DHA, and that the DHA have to have regard to the costs involved and to their responsibility for the totality of patients. I have considered already (paragraphs 15–16) whether the placement was made with the family's agreement, and I am concerned here only with whether the care provided at the nursing home should properly have been provided or funded by the DHA.

24. The Act requires facilities for the after-care of patients to be provided by the Secretary of State to such extent as he considers appropriate and necessary to meet all reasonable requirements, and I have noted that the chief executive considers that NHS care should be provided without charge if in a doctor's professional judgement it is required. The complainant's mother had been an in-patient at the unit—initially in intensive care—continuously since her accident in April 1988. By 1989, her condition had improved to the extent that she no longer required the specialist facilities of the unit. Nevertheless, she remains severely incapacitated; in the consultant's view, she is likely to need sustained nursing care for the rest of her life, although he does not exclude the possibility that, at some time in the future, she might be able to receive it at home. It seems to me to be incontrovertible, therefore, in the light of the level of continuing care the complainant's mother will require and the chief executive's advice, that the DHA had a duty to continue to provide the care the complainant's mother required at no cost to her or her family. How the DHA fulfil that duty is, as the chief executive has said, a matter for the DHA, and I have noted in that respect that, unlike other users of the unit, the DHA do not themselves have an appropriate facility in which to care for such patients. They were instrumental in identifying, and then arranging, the complainant's mother's transfer to the nursing home as a suitable establishment in which the appropriate care could alternatively be given. In that respect I see nothing to criticise in their actions. However, given the responsibilities that the Act places on the DHA, and which the chief executive has explained, I consider that it is incumbent upon the DHA to meet the cost of the provision of that care. Accordingly, I recommend that the DHA should reimburse the complainant, as receiver of the complainant's mother's estate, in respect of the costs that have already been incurred by the estate, and that they should meet any further nursing home costs that arise, for so long as the complainant's mother is deemed, in relation to the provision of care or treatment which it is the function of the NHS to provide, to require such residential care.

(c) *Dilatory handling of representations*

25. I set out the relevant correspondence:

(i) 11 June 1989 — After speaking to her on the telephone, the complainant wrote to the CHC secretary, saying that the consultant had said the complainant's mother could not stay in the unit, and that she was on the waiting list at the nursing home. He asked her to determine how things stood with the DHA.

(ii)	16 June	The CHC secretary replied that the DHA were clearly responsible for providing the nursing care the complainant's mother needed; that she had asked the UGM how he proposed to adhere to the policy in the circular; and that the UGM would write to the complainant.
(iii)	19 June dated (incorrectly) as 9 June	The CHC secretary copied the complainant's letter (at (i) above) to the UGM, and expressed concern at the lack of provision for patients such as the complainant's mother, which she said was the DHA's responsibility and had 'wide implications', and at the pressure put on the family to discharge her.
(iv)	2 August	The CHC secretary informed the UGM that neither she nor the complainant had received a reply to her letter of 19 June (iii). She said the family were anxious for the financial position to be resolved.
(v)	4 August	The patient services manager (the PSM) wrote to the complainant apologising that his letter of 11 June had not been acknowledged and assuring him that his points were being investigated.
(vi)	4 August	The PSM requested the operational manager (the OM) whose responsibilities included the neurosurgical department to ask the consultant to investigate the issues the complainant had raised and to draft a reply on behalf of the UGM.
(vii)	8 August	Following a telephone call from the CHC secretary to the UGM's secretary, the PSM asked the OM to hasten the consultant's reply.
(viii)	10 August	The UGM wrote to the SW confirming that the DHA would finance the complainant's mother's place in the nursing home on the ground that there would be subsequent reimbursement from her estate. He copied his letter to the CHC secretary.
(ix)	4 September	The CHC secretary thanked the UGM for the copy of his letter of 10 August (viii) and asked if the complainant had been sent a reply to his letter of 11 June (i).
(x)	25 September	The UGM apologised to the complainant for not keeping him fully informed of the arrangements made for his mother. He trusted that the complainant was satisfied with the DHA's handling of his mother's needs and future care.
(xi)	25 September	The UGM copied his letter (x) to the CHC secretary and told her that the policy on patients such as the complainant's mother was being considered by the DMO.
(xii)	23 October	The complainant wrote to the UGM that the DHA, by failing to provide a specialist unit for the care and rehabilitation of the head-injured and by discharging such patients to private nursing homes, had not fulfilled their responsibilities; had applied unacceptable pressure on the family; and should assist with the complainant's mother's future treatment needs.
(xiii)	27 October	The CHC secretary wrote to the DMO that she was dissatisfied with the lack of response to the policy issues raised by the complainant. She asked for clarification of the DHA's policy.

(xiv) 7 November — The DMO proposed to the CHC secretary a discussion on the problems and potential solutions concerning head-injury patients needing long term care.

(xv) 24 November — The CHC secretary accepted the offer of a meeting; asked whether the DHA had replied to the complainant's letter of 23 October (xii); and pressed for a policy statement on who was responsible for the complainant's mother's nursing care.

(xvi) 1 December — The UGM replied to the complainant's letter of 23 October.

26. The complainant told my officer that he had got in touch with the CHC secretary because of his concern about plans to discharge his mother from the unit. Her reply (paragraph 25(ii)) had encouraged him but he had then heard nothing more for several weeks, so he had telephoned her to say that the DHA had not in fact written to him. Although, prompted by the CHC secretary, the PSM had sent an acknowledgment on 4 August (paragraph 25(v)), there had then been a further delay until the UGM's letter of 25 September, which did not address the points he had raised more than three months earlier. The UGM's reply to his further letter of 23 October had also left him dissatisfied, so the CHC secretary had then written to the DMO. That had resulted in a meeting on 27 November which he had not attended, and of which he did not know the outcome. After approaching me, he had received the UGM's letter of 1 December which, he said, had offered too little too late.

27. The CHC secretary confirmed that she had encouraged the complainant to write to her about his mother's future care and treatment. She had regarded his letter of 11 June (paragraph 25(i)) as a complaint and had been confident in telling him that the DHA would reply to him (paragraph 25(ii)). She had written to the UGM on 19 June, but early in August, after speaking first to an officer who dealt with complaints (the CO) and then to staff in the UGM's office, she had learned that he had not received her letter: she had sent copies to him. She had written again to the UGM (paragraph 25(ix)) after seeing his letter to the SW (paragraph 25(viii)). His response had been inadequate, so she had written to the DMO to obtain both a response on the DHA's policy towards long-term care for head-injury patients, and a fuller reply about the complainant's mother's case. The UGM had subsequently agreed that the DHA could have done better in replying to the complainant's, and her, enquiries. In order to try to avoid such problems occurring in the future, he now held monthly meetings with her.

28. The UGM told my officer that the CHC secretary's letter of 19 June 1989 had reached his office (by internal mail) on that day. Receipt of the letter had been recorded, but not its disposal (see paragraph 33). He had been on leave during June, and the director of hospital services (the DHS) had seen the correspondence and had written 'To [the CO] for file' on the CHC secretary's letter (I have seen that that was so). That indicated to him that the DHS had wanted the CO to raise, and action, a complaints file (but see paragraph 30). The UGM had not been aware of the correspondence until 4 August when he received the CHC secretary's letter of 2 August (paragraph 25(iv)), which he had referred to the PSM. He had thought that, by copying to the CHC secretary his letter to the SW (paragraph 25(viii)), he had dealt with her query. He had not interpreted the complainant's letter of 11 June (paragraph 25(i)) as a complaint but rather as an enquiry, since his actions had secured for the complainant's mother a place in the nursing home. He had therefore been puzzled to receive the CHC secretary's letter of 4 September (paragraph 25(ix)). With the benefit of hindsight he wished that he had telephoned the CHC secretary then to establish why she had written again rather than sending the brief reply to the complainant on 25 September (paragraph 25(x)).

29. The UGM said that, by contrast, the complainant's letter of 23 October (paragraph 25(xii)) had clearly been a complaint. He had been extremely busy at the time and had marked it merely for dictation in due turn, rather than for action as a formal complaint, and that, he accepted, had been discourteous. A few days later he had done the same thing with a copy of the CHC secretary's letter of 27 October to the DMO; it was only when he was asked by the DMO, who had received the CHC secretary's letter of 24 November (paragraph 25(xv)), if he had replied to the complainant, that he had realised his error. He had written to the complainant on 1 December. He had now arranged to meet the CHC secretary monthly.

30. The DHS, who had been responsible for administering the hospital complaints procedure, had difficulty in recalling the complainant's correspondence but said that 'To [the CO] for file' (paragraph 28) did not mean that the CO was to raise a file. If that had been his intention, he would have made it quite clear. He recalled sending the complainant's letter to the OM but thought that had been after the UGM had dealt with it and after a discussion when he had urged the UGM to recognise that the CHC secretary was raising a policy issue. However, he had not regarded the complainant's letter as a formal complaint about his mother's care. The DHS said he might have told the CO on 21 August not to treat the representation about the complainant's mother as a formal complaint (see paragraph 32), although he could not be sure.

31. The PSM said that she would reply to a range of complaints, but that the DHS dealt with those which were more involved. Complaints were sent either to her, in which case she passed them to the OM for action, or direct to the OM, who consulted her when necessary. She had not seen the CHC secretary's letter of 19 June 1989 until a copy was enclosed with the letter of 2 August (paragraph 25(iv)), which had been passed to her from the UGM's office. The correspondence had been copied to the CO for an investigation by the consultant (paragraph 25(vi)). (An undated manuscript note on a document I have seen says that the consultant had agreed to provide a draft reply. He told my officer that he could not recall any involvement in that correspondence.)

32. When interviewed by my officer, the CO was unsure who was responsible for administering the hospital's complaints procedures. However, she said later that the DHS was the designated officer for complaints—an appointment required under the Directions arising from the Hospital Complaints Procedure Act 1985. She had not seen any correspondence about the complainant's mother until August 1989 and did not know what had happened to it before then. She acknowledged that she had noted, on the copy of the PSM's letter of 4 August to the complainant (paragraph 25(v)), 'Chased 21.8.89': that indicated that she had tried to hasten progress. On that day she had also made a further note '21/8 Not Complaint General', although she could not recall who had told her that; possibly the DHS had done so as the PSM was on leave at the time, but it had meant that the matter was not to be treated as a formal complaint. The CO pointed out that, as far as she was concerned as the complaints officer, the issues raised by the complainant had not been recorded or treated as a formal complaint until the UGM's letter of 25 September to the complainant.

33. The UGM's secretary said that, on receiving the letter and attachments from the CHC secretary in June 1989, she would have placed it in a folder for the attention of the UGM or, in his absence, the DHS. Had it been returned to her for forwarding, she would have marked it out in the register; that had not been done (the register showed the letter booked in but not out), and she did not recall it being returned to her.

Findings (c)

34. Although the DHS had no recollection of it, it seems likely that the CHC secretary's letter of 19 June, which enclosed the complainant's letter of 11 June, was referred to him in the UGM's absence. What happened next is unclear. The correspondence was not treated as a complaint and no recorded action was taken. However, the PSM's note to the OM (paragraph 25(vi)) shows that at that stage

the correspondence was recognised as a complaint and she sought a draft response from the consultant. However, on 21 August somebody told the CO not to treat the correspondence as a formal complaint. I have seen no evidence of a draft response from the consultant, who cannot recall any involvement at that stage. The UGM believed that his letter to the SW of 10 August (paragraph 25(viii)) had resolved the complainant's concerns, but he should have realised his misunderstanding from the CHC secretary's letter of 4 September. He did not appreciate that the letter related to a complaint, but he did recognise the complainant's letter of 23 October as a complaint. Even so, on his own admission, he failed to treat it as such; it was over a month later, after the DMO approached him, that he saw the need to reply definitively to the complainant's complaint.

35. I do not regard the complainant's initial letter as making clear that a specific complaint was being lodged, and the CHC's pursuit then of the wider policy matters served to cloud the issues. I have been unable to establish exactly what was done with the various letters which the DHA received from the complainant and the CHC secretary. What my investigation has revealed is a casual and muddled approach which led to the DHA's failure to respond promptly and definitively to the complainant. I recommend:

(i) that the DHA, in the interests of their own administrative efficiency and improved handling of complaints, should review their procedures for dealing with complaints;

(ii) that the duties and responsibilities of the hospital's designated officer for complaints should be clearly defined and understood by all staff; and

(iii) that notes about action taken, or to be put in hand, should be unambiguous, attributed to the person concerned, and dated.

I uphold this complaint.

Conclusion

36. I have set out my findings in paragraphs 15–16, 23–24 and 34–35. The DHA have undertaken to implement my recommendations at paragraphs 16 and 35. In respect of my recommendation at paragraph 24, they have informed me that they are prepared to discuss with the complainant's mother's family a contribution to the costs incurred during her stay in the nursing home to take account of the care she is receiving which should properly be provided by the National Health Service. They have also asked me to convey through this report—as I do—their apologies to the complainant for the shortcomings I have identified. I regard these steps as a satisfactory outcome to my investigation.

Case No W.599/89–90—Provision within the NHS of long-term care

Background and complaint

1. In April 1989 the complainant felt unable to continue caring for her husband, who suffers from [a chronic debilitating condition], and wrote to his general practitioner (the GP) asking to which hospital he could be admitted. She was told, after some delay, that the matter had been referred to a hospital (the first hospital), but that no beds were available for the chronic sick, the policy being that they should be nursed at home. The complainant continued to press for her husband to be admitted to a NHS hospital but, in the meantime, arranged his admission to a private nursing home (the nursing home). In January 1990, the complainant's husband was offered a bed in another hospital (the second hospital). Both hospitals are administered by a health authority (the DHA).

2. The complainant complained that, between April 1989 and January 1990, the DHA had not provided the continuing long-term care her husband required; and she sought redress.

Investigation 3. I obtained the comments of the DHA and examined the relevant documentation including the complainant's husband's clinical and nursing records. My officer took evidence from the complainant, the secretary of the Community Health Council (the CHC secretary), the chairman of the DHA (the DHA chairman) and the DHA staff involved.

Legislation 4. The provision of health services in England and Wales is governed by the National Health Service Act 1977 (the Act), which states in Section 3(1) that:

> 'It is the Secretary of State's duty to provide . . ., to such extent as he considers necessary to meet all reasonable requirements—
>
> (a) hospital accommodation;
>
> (b) other accommodation for the purpose of any service provided under this Act;
>
> (c) medical, dental, nursing and ambulance services;
>
> . . .
>
> (e) such facilities for . . . the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service;
>
> . . .'

In letters to me sent in response to enquiries I made in the course of another investigation I recently conducted, the chief executive of the NHS Management Executive (the chief executive) wrote, in connection with the provision of care by health authorities:

> '. . . If in a doctor's professional judgement a patient needs NHS care, then there is a duty upon the Health Service to provide it without charge . . . this can be done by providing community nursing care to the patient's own home, by providing in-patient care or by a contractual arrangement with an independent sector home (ie paid for in full by the health authority). The level of service provided overall is a matter for individual health authorities in the light of local circumstances and priorities.'

and:

> '. . .
>
> a. there is no general duty on a health authority to provide in-patient medical or nursing care to every person who needs it. Legal precedents have established that the Secretary of State's duty under Section 3 of the Act is qualified by an understanding that he should do so 'within the resources available' . . . Thus
>
> b. in any particular case the provision of such care may be deferred so that cases may be dealt with, in order of clinical priority, within the resources available; and
>
> c. consideration of clinical priority may mean that a particular patient may never be provided with in-patient nursing care. *Further*
>
> d. where a person is receiving private care, in a nursing or residential home, the Health Authority has no power to make 'top-up payments' to cover any shortfall between the charges of the home and any income support . . . health authorities have, financially, an 'all or nothing' responsibility for patients . . .'

Failure to provide long-term care 5. In evidence to my officer, the complainant said that she had written to the GP in April 1989, seeking her husband's admission to hospital, because caring for him at home was having an adverse effect on her health. Three weeks later, in May, she had been told by the staff of the GP's surgery that her request for a long-stay bed had been referred orally to the first hospital. She had made further telephone calls to the first hospital and the surgery but recalled only that the GP had said that there were no long-stay beds for the chronic sick because DHA policy was for them to be nursed at home. Despair had driven her to seek a place for her husband outside

208974 G

the NHS, and he had been admitted to the nursing home on 11 June. An initial offer by the Department of Social Security (the DSS) to pay a sum which would cover a high proportion of the charges had deflected her from pressing the DHA to provide a long-stay bed; however, that offer had subsequently been corrected to a much lower figure; on 17 July, having become concerned about whether she would be able to continue paying the nursing home fees, she had written to the GP asking again if the complainant's husband could be accommodated in hospital. She had also enlisted the help of her Member of Parliament (the Member), who wrote to the DHA on 30 August asking 'whether [the complainant's husband] could be cared for in hospital, on a long term basis under the National Health Service'. In September, she had made a similar request, by telephone, to the deputy general manager, community health services (the DCHS), whose reply of 29 September had not satisfied her. She had therefore asked him, on 1 October, to confirm that the complainant's husband was not eligible for a hospital bed because he needed 'nursing care' rather than 'assessment', and that it was not DHA policy to provide beds for the chronic sick. The complainant said that an influential friend had also written to the DHA chairman (that letter, dated 2 November, sought the complainant's husband's admission to a 'suitable bed').

6. Further correspondence ensued, involving the complainant, the DHA, the influential friend and the DHA chairman. Then, on 9 January 1990, the DHA chairman informed the complainant that a newly appointed consultant geriatrician (the second consultant) would review the options available. The complainant told my officer that, after visiting her husband on 12 January, the second consultant had accepted that he could not be nursed at home and, a week later, had offered him a bed at the second hospital. She had replied saying that she did not consider the offer genuine because the second hospital was some distance from her home, overcrowded and under censure by the Hospital Advisory Service (the HAS).

7. The CHC secretary said that health authorities were looking increasingly to local authority social services departments to help with providing for those who did not need continuing medical care but who could not cope themselves or be looked after at home. The DHA had not achieved the right balance or made clear their policy about the provision of continuing nursing care. In the complainant's husband's case, they had appeared to be trying to reduce, or even abandon, their responsibilities. Someone in the complainant's husband's situation should have a genuine choice between NHS or private care: no one should be forced to go into a private nursing home.

8. The GP told my officer that, as a consequence of the complainant's letter of April 1989 (paragraph 5), the complainant's husband had been admitted to the first hospital on 1 May (he was discharged on 16 May) for assessment of his needs and for respite care. The GP could not recall speaking at that time to the consultant geriatrician then responsible for the complainant's husband (the first consultant) but he had probably done so; the complainant's husband would have been seen on the ward by the first consultant. He had discussed the complainant's later request, in July, with a nurse manager responsible for the ward at the first hospital to which the complainant's husband had previously been admitted (the nurse manager), and he had thought that she would reply to it (but see paragraph 15). On 4 or 5 September, the first consultant had confirmed that he could not recommend hospital admission, so later that month the GP, believing that the DHA had a responsibility to provide for the complainant's husband, had suggested to the DCHS that the DHA should pay the nursing home charges; however, the DCHS had said that that was not DHA policy. He had been consulted about the draft of the DCHS's letter to the complainant of 29 September (paragraph 5). He could not recall any further discussion with the first consultant, but later the second consultant had invited him to accompany him on a visit to see the complainant's husband at the nursing home in January 1990; he had been unable to do so but had learned subsequently that the second consultant had offered the complainant's husband a place at the second hospital.

9. The first consultant told my officer that balancing the requirements of the elderly for acute, rehabilitation or long-stay care presented a constant dilemma. In his view, patients who could not be cared for at home, yet did not require frequent medical intervention, should be placed in nursing homes and not in hospital. The DHA did not have sufficient resources to provide nursing homes, but there was no shortage of private nursing home places locally. Since 1977 the DHA had been developing the provision of respite care, under which patients were admitted to hospital for two (and sometimes three or four) weeks in every eight. That policy was clinically sound for the patients, and it gave rest to the carers. It had enabled the DHA to make much greater use of a relatively static number of beds.

10. The first consultant said that, on two earlier occasions in 1989, the complainant's husband had been admitted for respite care to a ward in which GPs retained medical responsibility for their patients. However, on 1 May the GP had, as was his right, admitted the complainant's husband to the 'consultant's' ward, such an arrangement normally being made to ensure that the patient was seen by a consultant—although not necessarily with a view to longer term hospital admission. The first consultant had carried out a full examination of the complainant's husband on 2 May, but he could not recall any discussion with the complainant or the GP, at the time of the complainant's husband's admission, or whether he had known of any request for the complainant's husband to be admitted to a NHS hospital. Indeed, his entry in the complainant's husband's clinical records for 9 May (which read 'wife struggling. . . wife wanted him to go [to the nursing home]. . .') indicated that he had known only that the complainant wanted her husband to go to the nursing home. He had not seen the complainant's husband again, or heard any more about him, until September, when the DCHS had consulted him about the complainant's request for hospital admission. Having spoken to the GP, he had not been able to endorse the request and had approved the DCHS's letter of 29 September to the complainant (see paragraph 17). He had not needed to see the complainant's husband, whose condition and outlook, as had been clear from the DCHS's comments, had not changed. The complainant's husband had not been a prospect for rehabilitation, and there could have been no improvement, medically, in his condition; he had needed constant nursing care but had not been a priority for hospital admission, requiring only respite care.

11. The second consultant, who had taken up appointment with the DHA in November 1989, told my officer that he had become aware of the complainant's husband's case in January 1990 when the DCHS asked him to review the position after further representations from the complainant. He had examined the complainant's husband at the nursing home on 12 January 1990 and had found that further medical intervention was inappropriate; that 24 hour nursing care was required, which could not be provided at home, either by the complainant alone or with occasional help; and that two persons were needed to assist the complainant's husband with virtually any task. After considering the situation, and discussing it with the GP and the DCHS, he had offered the complainant's husband a place at the second hospital. The DHA had, in the light of HAS criticisms of overcrowding, placed an embargo on admissions to the second hospital, but he had been specifically authorised to offer a place to the complainant's husband if he wished to do so, in the hope of transfer later to the first hospital. His offer had been perfectly genuine (paragraph 6). He had considerable sympathy for the complainant and her complaint, and he would have offered a place at the second hospital some months earlier had he examined the complainant's husband then.

12. The nurse manager told my officer that in April 1989 the GP had asked her about admitting the complainant's husband to a long-stay bed, but she had told him that none was available in the locality. Instead, the complainant's husband had been admitted to the ward for assessment for regular respite care. (An entry made in the nursing record at the time of the complainant's husband's admission read '[the complainant's husband] has been admitted. . . for assessment for I.C.B. [intermittent care bed] and also for respite for his wife. . .'.) She could not recall the complainant asking then for the complainant's husband to be admitted to a long-stay bed; rather, she had spoken of her husband going to the nursing

208974 G2

home, and that had been the intention behind his discharge on 16 May. She had told the complainant that the GP and the primary community care team would try and improve home support services provided between admissions respite care, but the complainant had dismissed those services as very poor, maintaining that what was required was residential care. The complainant had telephoned her at least once after the complainant's husband's discharge to ask if there was any possibility of admission to a long-stay bed. She had also discussed, with the GP, the complainant's letter of 17 July 1989 (paragraph 8); she had understood that the GP would answer it, and had taken no action herself.

13. The nurse who had been specifically allocated to care for the complainant's husband (the primary nurse (the PN)) had completed the nursing record on admission on 1 May (paragraph 12), and she could not recall the complainant or the complainant's husband asking for a long-stay bed. However, the complainant had expressed concern about her capacity to continue caring for the complainant's husband at home. The complainant's husband had been discharged on 16 May because his two-week assessment had come to an end.

14. The DCHS said he had first known of the complainant's husband's case when the complainant had telephoned him on about 24 August 1989. He had taken the call in the absence of the unit general manager for community health care services (the UGM) and had made a note of it for the district general manager (the DGM). After consulting the GP and the first consultant, he had replied to the complainant, on 29 September, that '[the complainant's husband] was not considered a priority for admission to a hospital bed' and that his needs were 'primarily for nursing care and attention rather than for medical assessment'. He told my officer that it was DHA policy not to contribute, in whole or in part, towards private nursing home fees.

15. The complainant's response of 1 October (paragraph 5) had caused him to ask the first consultant to review the priority of the case but, by the time he had learnt the outcome, the influential friend had written to the DHA chairman on the complainant's behalf. The DCHS had had to delay his response to the complainant until the DHA chairman had replied, but on 5 December he had copied to the complainant the DHA chairman's letter. Neither the complainant nor the influential friend had been satisfied and both had written again, as a result of which the DGM, the DHA chairman and he had met to decide what to do. They had concluded that the DHA could neither offer a long-stay bed near the complainant and her husband's home nor contribute towards the fees of the nursing home; nevertheless, in view of the representations they had received they had agreed that a second opinion should be sought from the recently appointed second consultant who had taken over responsibility for the catchment area.

16. The DCHS explained that the reason why the first consultant had not offered a long-stay bed from outside the complainant and her husband's locality was partly because he had known of the complainant's wish to visit her husband daily, but primarily because he had not considered the complainant's husband a priority for hospital admission. The DCHS had told the second consultant that, if he wished to offer a long-stay bed from outside the immediate locality, the DHA would not oppose that. The second consultant had told him, subsequently, that the complainant's husband required round-the-clock nursing care but that the only long-stay accommodation available was at the second hospital, some 12 miles from the complainant's home. The DCHS had agreed that the offer should be made, despite the distance and the HAS recommendation that the number of patients at the second hospital should be reduced (paragraph 11).

17. The UGM said that the DHA's policy of developing community services held the potential for leading to an undue decline in residential provision for the elderly. Because of that, the DHA had asked for a report, by April 1991, on whether that was in fact happening. Provision of long-stay beds in each of the district's six localities was not a top priority because available resources did not allow it; nor did they allow for the DHA to contribute towards the fees of all patients in private nursing homes—and the DHA were not prepared to take the invidious step of

paying for some but not others. At the discussion with the DGM and the DCHS (paragraph 15), the possibility of pressing the first consultant to offer the complainant's husband a long-stay bed, had been considered but not pursued. Relatives' views were an integral part of the process of deciding whether to allocate a long-stay bed for someone who was difficult to care for at home, and the complainant, with the support of others, had developed such a forceful view during the autumn of 1989 that ultimately it had became a decisive factor. Nevertheless, the offer of a bed at the second hospital had been genuine; opinions between one consultant and another varied considerably, and the different perceptions of the first and the second consultants had not been particularly unusual.

18. The DGM told my officer that the DHA's policy was to provide the best possible care at or near a patient's home, but in hospital if necessary. The decision on what care to offer in a particular case was the responsibility of the clinical team concerned, and it was for the consultant concerned to decide priorities. The DHA might try to influence a consultant in a particular case—and that could be held to have occurred in the complainant's husband's case—but that was unusual, and they could not direct a consultant in the exercise of clinical judgment. The DHA did not have sufficient resources to meet every need, but the distribution of acute, rehabilitation and long-stay beds was about right. They could not afford to provide for long-term nursing care for all who needed it, and to pay for beds in private nursing homes would be beyond their resources. After seeing the Member's letter of 30 August (paragraph 5) the DGM had agreed with the UGM and the DCHS the course of action to be taken by the DCHS. On receiving the influential friend's letter of 7 December 1989, the DHA chairman had urged that the second consultant be asked to consider offering the complainant's husband a long-stay bed. Both consultants had acted in accordance with DHA policy, and the fact that, when he became involved, the second consultant had offered a long-stay bed did not indicate that that should have been done earlier.

19. The DHA chairman confirmed that in December 1989 he had been anxious about the complainant's husband's situation. He, and all the senior officials involved, had wanted the second consultant to review the case in view of the complainant's ever-increasing concern—a factor which the DHA had been bound to take into account.

Findings and Conclusions

20. The complainant first sought long-stay NHS care for her husband when she wrote to the GP in April 1989 (paragraph 5). He discussed the request with the nurse manager who, it seems, told him that no such beds were then available. In May the complainant's husband was admitted to the first hospital for assessment for intermittent care and to provide respite for the complainant (paragraph 12), and during that period he was examined by the first consultant (paragraph 10). In July, when the complainant became concerned about the nursing home charges, she wrote again to the GP about a NHS hospital bed (paragraph 5). Again he discussed the situation with the nurse manager and not with the first consultant (paragraph 8). In August the complainant spoke directly to the first hospital and that led to the DCHS, after discussion with the GP and first consultant, advising her on 29 September that the complainant's husband was not a priority for hospital admission (paragraph 14). I have summarised this evidence to show that the first consultant, who had the responsibility for allocating long-stay beds in this case, was not involved, either directly or indirectly, with the complainant's request until September 1989. However, the evidence persuades me that his decision, taken at that time, would not have been any different had he been asked to consider long-stay admission earlier in the year.

21. In September the first consultant's conclusion, based on his knowledge of the complainant's husband on examining him on 2 May and on what he was told, was that the complainant's husband needed constant nursing care but was not a priority for hospital admission (paragraph 10). That decision was in my opinion taken by him in consequence of the exercise of clinical judgment, and I cannot question it. The complainant, with the support of the Member and the influential

friend, continued to press for her husband's admission to hospital. The DHA thereupon arranged a second opinion by the second consultant. The outcome was an offer—which I believe to have been genuine—of a long-stay place at the second hospital. That decision too, being founded on clinical judgment, I cannot question.

22. The complainant's complaint is that, between April 1989 and January 1990, the DHA did not provide the continuing long term care her husband required. My investigation has shown that, although the complainant's requests in April and July 1989 for a NHS long stay bed had quite properly been made to the GP, they were not then referred to the first consultant, and it was only after the complainant had made direct contact with DHA staff that that happened. However, the first consultant's assessment then, and earlier, was that the complainant's husband did not need frequent medical intervention and—therefore—24-hour hospital care. Health authorities have a duty to provide some level of care for persons such as the complainant's husband, who are judged to need long-term nursing care, and in this case, the DHA had developed, and was keeping under review, policies which it believed made best use of limited resources. However, where—as in this case—demand exceeds available resources there may be some whose clinical priority is such that their needs cannot be met under the NHS. I find that the decision by the DHA about the allocation of resources for the care of the chronic sick was a discretionary matter, and I cannot question such a decision unless I find evidence of maladministration in the way the decision was made: I have found no such evidence. In sum, since the decision on the complainant's husband's priority for admission was a clinical matter and the level of provision for long-stay care resulted from a properly taken discretionary decision by the DHA, I do not find the complainant's complaint to me about the failure to provide her husband with continuing long-term care, between April 1989 and January 1990, made out. It follows that I do not make any recommendation as to reimbursement of the charges either for any care the complainant arranged for her husband during this period; or, since I did not investigate her complaint about the DHA's actions from January 1990 onwards because they had by then offered a bed at the second hospital, in relation to his subsequent care.

Case No W.652/89–90—Delay in arrival of ambulance

Background and complaint

1. At 10.18 am on 2 May 1989, a general practitioner (the first GP) telephoned the Ambulance Service (AS) to request an ambulance to take the complainant's wife from her home to a hospital in another area (the first hospital) for admission by 3.00 pm that day—but 'the sooner the better'. At 12.09 pm the complainant, whose wife's condition was deteriorating, telephoned the AS and was assured that, although it was not known when the ambulance could be expected, she would be taken to the first hospital by 3.00 pm as arranged. The complainant asked to speak to the control manager (the CM), who agreed to see if the complainant's wife could be moved earlier than planned. Her condition continued to worsen and, at 2.45 pm, another general practitioner (the second GP) telephoned the AS; on being told that an ambulance would not now arrive for the complainant's wife until 3.30 to 3.45 pm, he asked for an improvement on that time. The AS asked him to contact them again if her condition deteriorated further. At 2.48 pm, the CM advised the complainant that he was unable to bring the ambulance arrival time forward. The second GP telephoned the AS at 4.05 pm to say that the complainant's wife should now be admitted to a local hospital, and an ambulance arrived at 4.30 pm for that purpose.

2. The complainant complained that the AS did not provide transport, as arranged, to admit his wife to the first hospital by 3.00 pm.

Jurisdiction and investigation

3. I obtained the comments of the Health Authority (the DHA), which administer the AS, and I examined relevant papers including the ambulance records for 2 May 1989 and transcripts of telephone conversations with the AS relating to the admission request. My officer took evidence from the complainant; from the AS staff concerned; and from the first GP, whose actions do not fall within my jurisdiction.

4. Circular HC(78)45, issued in December 1978 by the Department of Health and Social Security (the DHSS), as it then was, provided guidance to health authorities on the operational control and use of ambulance services. In a section on ordering ambulance transport, which drew a distinction between emergency calls and non-emergency requests, the circular stated that:

> 'Authorities should ensure that the procedure for ordering transport is as simple and time-saving as possible and that doctors and all others concerned are informed of current arrangements'.

In a section headed 'INFORMING THE PATIENT', it read:

> 'It is important that patients should fully understand the arrangements regarding ambulance transport and be notified of any change. . . When a request for transport cannot be met or undue delay seems likely, the ambulance service should make every effort to inform the patient and the hospital department involved.'

5. The complainant told my officer that, for over a year, the first hospital had been giving his wife cancer treatment with an experimental drug, which he had understood was being used for only 35 to 40 patients. He had usually taken his wife there by car—an average journey time of one and a half to two hours. On 2 May his wife had appeared very ill, and the first GP had arrived to see her at about 9.00 am. The first hospital had confirmed that a bed was available for her, so the first GP had telephoned the AS from the complainant's home to book an ambulance. The first GP had asked for the complainant's wife to be collected as soon as possible, but the AS had persuaded him to agree to an admission time of up to 3.00 pm. He believed that the first GP had then gone off duty. As his wife's condition was deteriorating very quickly, the complainant had telephoned the AS just after midday to find out when the ambulance might be expected. Having asked to speak to the person in charge, he had been put through to the CM and had asked if his wife could be admitted before 3.00 pm. Later that afternoon, he had telephoned the second GP to tell him that his wife's condition had worsened. He believed the second GP had then telephoned the AS from the surgery. After a further call from the complainant, the second GP had arrived to see the complainant's wife. He had told the complainant that it was too late for his wife to be taken to the first hospital and had arranged for her admission to a local hospital (the second hospital). The ambulance crew had told the complainant, when they arrived at his house, that they had started duty at 4.00 pm; at 4.55 pm the ambulance with the complainant's wife had arrived at the second hospital, where she died shortly afterwards.

6. The complainant said that some days later the deputy chief ambulance officer had telephoned about what had happened on 2 May. He had then received a letter dated 26 May (see paragraph 9), from the chief ambulance officer (the CAO), setting out the sequence of events that day. The complainant did not accept the CAO's explanation as, in his view, it did not answer the point that an ambulance had not arrived to take his wife to the first hospital by 3.00 pm as agreed that morning. He wished to know exactly what had gone wrong that day and what had been done to prevent the same thing happening again.

7. The AS were able to provide me with transcripts of the telephone calls on 2 May between the complainant, the first and second GPs and the AS. The sequence of calls was as follows:

(a) 10.18 am The first GP asked the AS for an ambulance to admit the complainant's wife to the first hospital that day. Asked for an admission time, he said 'As soon as an ambulance is available.' He accepted a time of up to 3.00 pm but added 'The sooner the better.' He specified a two-man ambulance and stretcher as the complainant's wife was 'wobbly on her feet'. He made no further reference to her condition.

(b) 12.09 pm The complainant telephoned the AS and, after some difficulty in getting through, spoke to someone in the control room (I have not been able to establish who that was) and

explained that his wife's case was rather urgent. He was assured that an ambulance would 'certainly be there in time to get her [to the first hospital] by 3 o'clock'. His call was transferred to the CM to whom he explained that his wife had been ill all weekend and was 'almost in an unconscious state'. He added that she was on an experimental drug and asked if she could be admitted before 3.00 pm. The CM agreed to see what could be done.

(c) 2.45 pm The second GP telephoned the AS to ask what progress had been made and was told that an ambulance should be collecting the complainant's wife 'between 3.30 and 3.45'. The second GP explained that her condition had 'deteriorated considerably' and asked if something could be done sooner. The officer in the control room explained they had been very busy and intended to use a vehicle coming into the area shortly. The second GP was asked to call again if the complainant's wife's condition deteriorated further.

(d) 2.48 pm The CM telephoned the complainant to let him know that he had not been able to bring the ambulance time forward. The complainant said that he had consulted the second GP because of his wife's poor breathing. The CM asked if he wished to make it an emergency call to a local hospital, but the complainant declined that, saying that his wife was being treated with an experimental drug at the first hospital, which had agreed to admit her.

(e) 4.05 pm The second GP rang the AS switchboard and had to wait while the operator sought a free line, explaining that the AS had been busy. The second GP was cut off, having said that he really wanted 999. He called back again through the switchboard and was put through to the control room. He explained that the complainant's wife was no longer fit enough to go to the first hospital and should be taken to the second hospital.

(f) 4.25 pm The complainant telephoned the CM to say that the ambulance had not yet arrived. He complained that his wife's case was an emergency and yet they were still waiting for an ambulance booked at 10.00 am.The CM said it had not been an emergency call.

8. The first GP told my officer that the complainant's wife had been under treatment at the first hospital with new anti-cancer agents. When he saw her on 2 May, she had required admission to hospital. He would normally be asked by the AS how soon he wanted the patient admitted, and he had wanted the complainant's wife to be in hospital 'as soon as possible'. Her case had been 'semi-urgent'; it had not been a 999 call, but it had not been non-urgent either. At that stage, he had been satisfied with the 3.00 pm time agreed with the AS. He had not received any information about how the AS categorised calls but was aware of telephone numbers available for doctors' use; he occasionally received circulars about the AS through the Family Health Services Authority (FHSA)—formerly the Family Practitioner Committee. His understanding was that an urgent call would be 999; alternatively, patients could be admitted within two hours, and he believed such calls also were classified as urgent. Finally, there were non-urgent calls which had to be booked in advance. He had not experienced any other problem with the AS, which in general provided a prompt, efficient service.

9. The DHA told me that apologies for the incident had been offered to the complainant, who had been invited to a meeting with senior AS officers. Disciplinary action had been initiated against two officers involved in the incident. (Personnel matters, including discipline, are statutorily outside my jurisdiction, but I have seen that the officers concerned were counselled as to aspects of their performance regarded as unsatisfactory and were told that, if there was no

improvement, disciplinary action could be taken.) In his letter of 26 May to the complainant, the CAO set out the sequence of events on 2 May as investigated by the AS. He concluded:

> 'The Medical Practitioners . . . at no time . . . upgraded the priority of your wife's admission to hospital, therefore the Officers involved continued to monitor the situation, dealing with patients in priority order within the resources available.
>
> . . . [the CM] offered you the opportunity to make the request an emergency. . . . Had you been able to accept this offer, your wife could have been admitted to [the second hospital] at approximately 1520 hours. . .'

10. The control officer (the CO) told my officer that he had been in post since December 1988; before that he had been a leading ambulanceman. He explained that the control room was staffed by one control superintendent, one control officer and three control room assistants (CRAs). The control superintendent, sitting alongside a CRA, dealt with emergency and urgent calls. On the other side of the control room the control officer, with a second CRA, handled non-urgent calls. A third CRA, if available, would sit between the two sides and help as necessary. (Other officers gave similar evidence about the organisation of the control room.) On his first day, the CO had been given training on the computer system, and on the second day, monitored by a control superintendent, he had operated the routine outpatient services. He had received no further training and, although written procedures governing the operation of control were kept in the control room, he had had no time or opportunity to familiarise himself with them.

11. On 2 May, the CO had been acting as superintendent. He had previously 'acted up' on a few night shifts, which were generally quiet, and once on a weekday early shift: those shifts were known to be busy and demanding but 2 May, which had followed a Bank Holiday, had been particularly busy (other staff confirmed that in separate evidence to my officer). He had been told by one of the control room assistants (the first CRA), who was dealing with non-urgent cases, that the first GP had made a booking with an admission time five hours ahead. A call with an admission time within two hours was classified as urgent; anything greater than that would be treated as a non-urgent booking. The CO had not known that the first GP had asked for the patient to be moved 'the sooner the better'. Between one and one and a half hours should be allowed for a journey to the area where the first hospital was, and he had planned to use a crew working from 11.00 am to 7.00 pm because other crews finished duty at 3.00 pm. On 2 May two premature babies had needed to be transferred to the second hospital from another local hospital (the third hospital) by 2.00 pm, and he had planned that the crew coming on duty at 11.00 am would transfer the babies and then collect the complainant's wife. The time available to get her to the first hospital by 3.00 pm had been exceptionally tight but, as far as he had been aware, her transfer had not been urgent. Had he sent the crew first to the complainant's wife, it would not have been possible to meet the babies' admission time.

12. The CO said that, when the ambulance crew were given the babies' transfer request (written evidence from the AS indicated that that was at 12.16 pm), they had been told they might then be needed to go to a hospital out of the area. The crew had not told him that a stretcher had been taken off the ambulance to accommodate an incubator, and the second hospital had not said that the incubator would have to be returned. One of the CRAs had told him—he could not recall when—that the crew had reported a 15–20 minute delay with the babies at the third hospital, but that would not have caused him to alter his plans (in fact they were delayed there for one and a half hours). In an urgent case he would re-negotiate the admission time with the GP but, with a non-urgent case, he would contact the GP only if there was an exceptional delay. He would not have contacted the complainant's wife's GP as he had known only of a 20-minute delay; he was not aware of any call from the crew about a further delay, although a call might have been 'lost' while control staff were responding to emergency calls. It was not possible simultaneously to monitor crews and control room staff; with his lack of experience at the time, and the high demand that day, he could have lost track of a particular crew.

13. The CO had not known of the complainant's call at 12.09 pm. The CM had, at some time, relieved him for about ten minutes, but he did not recall the CM mentioning the call, nor did he know if the CM had visited the control room at other times during that day. The first CRA had informed him, shortly before he went off duty at 3.00 pm, that a doctor was on the line and that the complainant's wife was not very well (I believe that was the second GP's call at 2.45 pm). He had told her to say that he should not worry, as the ambulance was either in, or coming into, the area and would not be long. The CO was not aware of the complainant's subsequent conversation with the CM at 2.48 pm. If he had known at the time that the complainant's wife was unconscious, he would have activated an emergency vehicle immediately.

14. The first CRA told my officer that, on joining the AS, she had worked in the planning room, taking advance bookings for patient transport. She had then moved to the control room and had picked up the job as she went along. For the first few calls she had been monitored by another CRA, although she believed that would normally be the responsibility of the superintendent. (Another CRA (the second CRA), who had worked for the AS since October 1988, gave similar evidence about her induction to the job.) The first CRA said she had attended a training course about six months after joining but, as the control room was short staffed, she had been called back. On 2 May she had been working on the non-urgent cases. She had recorded the first GP's request for an ambulance for the complainant's wife and, although she did not remember the call in detail, would have told the superintendent (in this case the CO) that she had taken an out-of-county call. When passing information to the superintendent, she would normally say what the patient's condition was and the time given by the doctor for admission. She did not know who had spoken to the complainant at 12.09 pm and did not recall any involvement of the CM. Later she had taken a call from a different general practitioner asking how long the ambulance for the complainant's wife would be; she would have asked the superintendent what the position was but did not recall his reply.

15. The second CRA told my officer that, on 2 May, she had been working with the CO on emergency and urgent calls; the complainant's wife's case had appeared as a non-urgent admission on the computer screen. Not until just before she went off duty at around 3.00 pm, had she been aware of any call about the booking, when the CM had told one of the control room staff that he had taken a call from either the complainant or a general practitioner—she did not know which—and had offered to make the admission an emergency. The CM had said that the offer had been declined as the complainant's wife had to go to a particular hospital. The CM had not been talking directly to her, or, she believed, to the CO but, in the control room, she would often be aware of several things at once. She did not recall the CM saying anything about the complainant's wife's condition.

16. The CM told my officer that he had been in post since December 1988 and had been responsible for the computer system as well as management of the control room; he had had little training for his job. CRAs came from outside the service and did mainly clerical work. COs were usually from the service and, having a complete understanding of ambulance work, were trained by sitting next to an experienced officer: there was no set training period. As control manager, he would look into the control room from time to time to see how busy the staff were; he would see if the staff were under pressure and would check on how they were coping. On the computer side, the system had been expanding and, following a management review he had, since July 1990, been appointed acting systems manager; as such, he no longer had responsibility for the management of the control room.

17. The CM recalled that, on 2 May, he had had to work on a computer breakdown. He had spoken to the complainant at 12.09 pm and had come close to upgrading the request to emergency status, but that would have meant taking the complainant's wife to the nearest casualty department (but see paragraph 20).

He had then gone to the control room; the CO had explained that there was only one ambulance then in the west of the area for emergency cover, so he had agreed that there was nothing more that could be done immediately. As the service had a statutory obligation to respond to emergencies, the CM had to maintain emergency ambulance cover. Emergency requests, and urgent calls (which he defined as those requiring admission within two hours) with an admission time before 3.00 pm, on 2 May had outweighed the urgency of the complainant's wife's case, which he had understood to be 'non urgent' (but see paragraph 21(a)) and the babies' transfer had had higher priority. (However, when my officer pointed out that the records showed that the babies' transfer had been booked on 27 April, he realised that the journey had not, after all, been urgent.) Had he known the gravity of her condition, he would have tried to move her quickly—possibly before the babies. He had not heard the complainant say that his wife was almost unconscious; during the afternoon he had gone to the control room several times in the hope that the workload might have eased. The CO had been under a lot of pressure that day and had had to make a decision based on the available information in a complex and rapidly changing situation. When the CM telephoned the complainant at 2.48 pm to let him know the position, he had not realised how much time had passed since the complainant's call. He had then gone to the control room, where he found that the second GP's call had just been received.

18. The CAO told my officer that emergency calls came through to the AS on dedicated telephone lines and were dealt with immediately. Doctors had three designated lines, installed in February 1988, direct to the AS control. Urgent calls were those where the doctor specified the time for getting the patient to hospital. Doctors did not always know what they wanted, so the staff would help by asking if admission was required within, say, two hours—the 'two hour rule'. However, a case requiring admission within five hours could still be categorised as urgent: that was at the doctor's discretion. Average urgent admission time was 45 minutes to one hour, and national standards laid down that 95 per cent of urgent cases should arrive no more than five minutes later than the agreed admission time. If a problem developed in meeting that time, control staff should contact the doctor to suggest either an extension or that the call be upgraded to an emergency. There was a continuing need to keep general practitioners informed about ambulance services, and that was done through the FHSA.

19. On appointment, control officers received tuition from the CM and would work alongside an experienced officer. Where appropriate, and depending on the availability of a course, the AS sent new recruits on a control officer course. (The DHA's district general manager told me subsequently that such courses, held at recognised Ambulance Training Centres, took place infrequently.) In the CAO's view, classroom tuition could not provide the same training as practical experience. Control officers faced a complex task and, whereas until January 1991 the control superintendent worked alongside other control room staff allocating work to ambulance crews, the superintendent now acted in a monitoring capacity and was able to overview the situation in the control room. Under the previous system, a control officer would assume that an allocated job was being undertaken unless notified otherwise by the crew. A delay of 15 minutes could be accepted, but when there was significant delay, the officer should look for another vehicle and contact the patient's relative or general practitioner. In his view, the situation that had arisen on 2 May had been one where an overview would have helped. At that time there had been two computer screen formats for booking same day calls: one for emergencies and another for both urgent and routine calls. With hindsight there could have been confusion between the urgent and routine cases, but, in March 1990, a three screen system had been introduced which would avoid that possibility. (The current control manager told my officer that, as the same computer screen had been used for urgent and routine calls, control room staff had not been able to differentiate between the two types of call, except by reference to the admission time.) Furthermore, routine calls were now dealt with in a separate room from the emergency and urgent work.

20. The CAO believed that, although ambulances had left the area on 2 May, others had been available at the time of the first GP's request. The 11.00 am to 7.00 pm crew had not had any calls until they went to the third hospital to collect the babies. It might have seemed logical to transfer the babies and then collect the complainant's wife, but the plan had been defeated by the need for the crew to return to the third hospital with equipment and staff. Moreover, the intended plan had not allowed much time to get the complainant's wife to the first hospital by 3.00 pm. The CAO considered that, when the complainant told the CM at 12.09 pm that his wife was unconscious, an emergency should have been activated by the AS; the crew could then have decided, in consultation with control and the general practitioner, whether she went to the first hospital (out of the area) or to the nearest accident and emergency department. The AS could have done better on the day and had since taken steps to try to prevent a recurrence of a similar problem. The AS had provided a monitoring position in the control room; and an instruction had now been issued to crews which made it a requirement, where a call was received just before they finished a tour of duty, to respond if failure to do so would be harmful for the patient or would mean that the planned admission time was not achieved.

21. The records I examined showed that:

(a) the first GP's request for ambulance transport was booked by the first CRA 'urgent for 15.00' and was included in the AS computer print out for urgent cases completed on 2 May;

(b) the request for the transfer on 2 May of the babies from the third hospital to the second hospital had been made on 27 April. That booking also was made by the first CRA and shows that an incubator would be used, and a nurse escort supplied. The journey did not appear in the computer print out of urgent cases for 2 May;

(c) five of the twelve emergency ambulances in use between 12 noon and 2.00 pm on 2 May were on journeys out of the county (paragraph 20);

(d) the 11.00 am to 7.00 pm ambulance crew made a 'speech request' at 12.57 pm;

(e) in addition to the first GP's call, between 10.00 am and 3.00 pm on 2 May, 27 urgent calls were received and allocated to ambulance crews. Eight were allocated to crews within 30 minutes, and a further four allocated within one hour;

(f) in a written statement made at the time of the AS's investigation, the CM said that, during the telephone call at 12.09 pm (paragraph 17), the complainant had explained the nature of his wife's illness;

(g) in the Code of Practice of nationally agreed control room procedures, calls to the ambulance service were divided into three categories; emergency; urgent; and non emergency. Urgent cases were defined as 'those which are not emergencies but which come next in order of priority. A definite time limit must always be agreed. This time limit must specify the latest time at which the patient should arrive at the treatment centre. The time is the latest acceptable by the caller from the time the call was received.' A later paragraph on procedures said that 'when receiving any request for ambulance transport, the degree of priority must be clearly established by control staff. If there is any subsequent misunderstanding it is unacceptable for the member of control staff to plead that they were not informed of the priority'; and

(h) the CAO issued on 10 July 1989 a service order which confirmed that the time limit agreed for an urgent case was the latest time at which the patient should arrive at the treatment centre. If a caller indicated that the patient's condition had deteriorated or become life threatening, the duty control officer should upgrade the priority, if necessary consulting a senior officer.

Findings 22. I am seriously concerned about what my investigation has revealed of the events of 2 May:

(i) the initial request was treated as non-urgent, even though it was recorded as urgent (paragraph 21(a)) and fell within the CAO's definition of an urgent case (paragraph 18);

(ii) the arrangements made for the complainant's wife's journey were, on the facts revealed by the evidence, destined for failure: the babies' journey was not urgent and necessitated a return to the third hospital (paragraph 21(b))—and other vehicles seemed to have been available to collect the complainant's wife (paragraph 20);

(iii) the CAO has said (paragraph 20) that the complainant's wife's condition had, by the time of her husband's call at 12.09 pm (paragraph 7(b)), become such that emergency measures should have been activated in consultation with the general practitioner. In that call, the CM—who perceived himself as being faced with a difficult choice between upgrading the request to emergency and respecting the complainant's wish for his wife to be taken to the first hospital—undertook only to go back to the complainant as soon as he had further news;

(iv) the CM in fact telephoned the complainant again nearly three hours later with an offer which the latter understandably felt was inappropriate for his wife's needs. The situation had not been discussed with either the CO, who was unaware of the degree of urgency involved, or a senior officer who could have taken an overall view of things; and

(v) neither the complainant nor the general practitioner was kept informed of problems being encountered in fulfilling the promised journey (paragraph 4).

It seems to me that there are two principal explanations for what went wrong. First, there were misunderstandings between the control room staff and the first GP as to what constituted an urgent call and, more worryingly, there was no shared understanding by the AS staff as to how the journey should be categorised. Second, the staff on duty in the control room were faced, on a busy day, with a situation for which they were inadequately prepared. The CAO and the CM, who himself admitted to insufficient training, have said that COs and CRAs depended, for the acquisition of knowledge, largely on practical experience working under supervision—regardless of the merits of that argument, the evidence is that the staff were unable to respond effectively. I note with approval the action taken by CAO to clarify the definition of urgent calls (paragraph 21(h)), to remove operational tasks from the control superintendent and to show urgent and routine calls on different screens (paragraph 19). I recommend that he issues clearer guidance, through the FHSA, to general practitioners about what information is needed to ensure that a call is accorded due attention. I recommend also that the DHA review arrangements for the training of control room staff with the aim of ensuring that they are all systematically trained and equipped to deal with abnormal demands and pressures of work.

23. Finally, while the CAO has acknowledged to me that errors were made, his letter of 26 May to the complainant (paragraph 9) did not, in my opinion, convey that. Given the distress which the complainant and his wife must have experienced while waiting for an ambulance, and the sad outcome of the day, I consider the CAO's response to have been inadequate and to have lacked any sense of apology for the failure to provide the agreed service. I uphold the complaint.

Conclusion 24. I have reported my findings in paragraphs 22-23. The DHA have agreed to implement my recommendations in paragraph 22 and have asked that this report should convey their apologies to the complainant for the shortcomings I have identified.

Case No W.668/89–90 and W.39/90–91—Failures in provision of ambulance transport

Background and complaint

1. On 21 June 1989, an emergency ambulance operated by an ambulance service (AS), which is administered by a regional health authority (the RHA), went to the home of the complainant's mother who had suffered a fall. She was conveyed to the ambulance in a carrying chair and then taken to a local hospital (the first hospital), which is administered by a health authority (the DHA). She was later moved to another hospital (the second hospital), also administered by the DHA. On 23 June, the complainant's mother was transferred by ambulance to a neuro-surgical unit (the third hospital), where she later died.

2. The complainant's father originally made this complaint to me. After his death she asked me to continue my investigation complaining:

(a) that her mother should have been conveyed from the house by stretcher, and not by carrying chair;

(b) that the transfer from the second hospital to the third hospital had been considerably delayed because the wrong type of ambulance had been provided; and

(c) that the AS's responses to complaints made by her late father had been tardy and had included inaccuracies.

Investigation

3. From the papers sent to me by the complainant's father it seemed that DHA staff might have played some part in the actions complained about. To enable me to establish whether that was so, the summary of complaint for investigation was directed to both the RHA and the DHA. I obtained their comments and examined the complainant's mother's medical records and the relevant correspondence. My officer took evidence from the complainant; from her father (before his death); from his two other daughters (the first and second daughters); and from the AS and DHA staff involved.

(a) *Use of a carrying chair*

4. The complainant's father told my officer that at about 9.15 pm on 21 June 1989 he had found his wife collapsed on the kitchen floor; she had earlier complained of feeling ill. It appeared that, as she fell, she had hit her head on the refrigerator door, as there was blood on it. He had telephoned the first daughter, who was a student nurse, for help. She had come with the second daughter and told him to call for an ambulance. The ambulance crew (the first and second ambulancemen) had, on arrival, come into the house without any equipment and, standing in the doorway to the kitchen, had looked at the complainant's mother, talking to each other; neither ambulanceman had examined her.

5. The second ambulanceman had returned to the vehicle for a carrying chair, and he and his colleague had dumped the complainant's mother into the chair before taking her to the ambulance, where they had transferred her to a stretcher. Contrary to what was said in the AS letter of 26 July (see paragraph 27(ii)), there had been room for a stretcher to be taken into the house; in the past he himself had been taken out of the house to an ambulance by stretcher. If a stretcher had been used for his wife, she would have had to be lifted only once and time would have been saved. (In my officer's view, and she has had some experience in such matters, the layout of the house made it possible to use a stretcher if required.) As to the suggestion that a chair had been used so that it was not necessary for both ambulancemen to leave the complainant's mother's side (see paragraph 8), for all the attention they had shown his wife, the ambulancemen could just as well have left her.

6. The first and second daughters confirmed their father's account. Thinking that their mother's breathing had stopped, the first daughter had, at one stage, asked the first ambulanceman if she was still breathing. He had placed the complainant's mother on her back and had half-heartedly attempted cardiac massage until the second ambulanceman arrived with the carrying chair. The second daughter

commented that her mother's head had still been bleeding when the ambulanceman arrived. While being transferred to the ambulance, the complainant's mother had been semi-conscious; her head had been unsupported and had rolled about as she was moved.

7. A statement, made jointly by the first and second ambulancemen for the AS on 20 July 1989, read:

> '. . . it looked to us as though the patient had suffered a possible Cardio Vascular Accident. We also noticed a smearing of blood on the kitchen floor, on checking the patient, we found a laceration to the rear of the patient's head. I asked my colleague for the chair and blanket. We conveyed the patient to the ambulance and placed her onto the stretcher . . .
>
> In conclusion, the patient was code 2 [unconscious] throughout the emergency, and in our opinion, the patient's laceration to the rear of the head took second place to care and management of the unconscious patient, this was the reason we did not dress the wound, which was no longer bleeding, thus saving valuable time.'

8. The first ambulanceman told my officer that he was a qualified ambulance person (QAP), trained to work on an emergency ambulance. Although each crew member had specific duties, they worked as a team and shared responsibility for decision-making about the care given to a patient. He recalled that the complainant's mother had been lying on the kitchen floor, to the right of the front door, and that she had had a cut on her head. A woman (I believe it was the first daughter) had been present but, as she was very upset, he had been unable to obtain information from her. He had taken the complainant's mother's pulse, which was firm, from the carotid artery and had observed that the cut on her head was not bleeding profusely. Suspecting that she had suffered a cerebrovascular accident (CVA), he had asked his colleague to bring a carrying chair and blanket from the ambulance. He had chosen a chair, rather than a stretcher, because laying a patient down increased blood pressure to the head, which was not advisable in a CVA case. It would have needed both of them to fetch a stretcher, thereby leaving the complainant's mother unattended, and would have taken longer—some three to four minutes, in contrast to a few seconds to collect the chair. The choice of equipment was a matter of judgment for the crew, and he was satisfied that he had made the correct decision. He had not examined the complainant's mother further, nor had he needed to give her cardio-pulmonary resuscitation—his actions had, he presumed, been misinterpreted (paragraph 6).

9. The second ambulanceman said that, when he and his colleague arrived at the house, the first daughter had been standing, distressed, by the door, and the first ambulanceman had gone straight into the house. He had followed, after collecting the Pneupac (equipment for administering oxygen) and opening the back doors of the ambulance. He had not seen the first ambulanceman examine the complainant's mother, but that might have been done before he joined him in the house. The complainant's mother had been semi-conscious, and the family had indicated that she had collapsed, rather than fallen. He and his colleague had seen the blood and had traced the source, but the wound had stopped bleeding. Considering the patient's semi-conscious state to be the priority, they had treated the incident as a CVA.

10. The chief training officer for the AS (the CTO) explained that all ambulancemen were trained on the basis of the 'green book', which gave instructions about the accepted methods of dealing with all types of casualties and situations. After arriving at an incident a QAP should immediately assess the patient for consciousness, respiration and coherence. Patients in cardiac respiratory failure required immediate resuscitation; if they were unconscious, or unable to give information, a full examination should be conducted in accordance with the procedure of which QAPs were aware. In the complainant's mother's case, the first and second ambulancemen had acted correctly in treating her state of consciousness as the priority condition. In his view, because of her head injury, she should have been taken to the ambulance on a stretcher; and he confirmed, on seeing the sketch plan of the house, that a trolley stretcher could have been used in the circumstances without adverse consequences to the head.

11. The chief ambulance officer of the AS (the CAO) expressed concern to my officer that the first ambulanceman appeared not to have conducted a full physical examination of the complainant's mother. Nevertheless, he was an experienced ambulanceman and had correctly diagnosed a CVA; he had done well to do so on the basis of the information available. He had been correct in disregarding the head injury, so long as it was not bleeding profusely, and giving the level of consciousness greater priority. The means by which the complainant's mother was transferred to the ambulance had been for the ambulancemen to decide in the light of the circumstances, including the condition and location of the patient, the ease of access, and the need for rapid action. The 'green book' (paragraph 10) called for carrying chairs to be used only to transport conscious patients, but that was no more than guidance and chairs could be used for patients who were not conscious if the ambulancemen considered that more appropriate in the particular circumstances. Similarly, it was not obligatory, in every situation, for ambulancemen to transport by stretcher patients who had incurred a head injury (paragraph 10). In the complainant's mother's case, use of a carrying chair had been appropriate. He confirmed that it would have taken two men to bring in the stretcher, and that a patient with a suspected CVA should not be left.

12. The consultant physician responsible for the complainant's mother's care at the second hospital (the consultant) told my officer that she had needed to be moved carefully but, given the short time taken to carry her to the ambulance, it would have made little difference whether a chair or a stretcher was used.

Findings (a)

13. The family are concerned that the use of a carrying chair aggravated the complainant's mother's condition, and that the first and second ambulancemen gave her insufficient care and attention. I have established from their own evidence that, contrary to what they had been trained to do, the ambulancemen did not carry out a full physical examination. The CAO has expressed concern about that—and it merits my criticism. I recommend that the AS remind their ambulance staff of the need to examine patients thoroughly. Nevertheless, the first and second ambulancemen correctly diagnosed a CVA and, having done so, gave that the highest priority in their subsequent actions. The CAO has explained why they were right to do so. I accept his reasoning and am not inclined to criticise their actions in that respect.

14. The decision to use a carrying chair rather than a stretcher I regard as a matter for the professional judgment of the ambulancemen, having regard to the training and guidance they had received. The CTO has said, however, that the complainant's mother should have been transported by stretcher, because of her head injury, and I have seen that the 'green book' required that only conscious patients should be transported by chair. As the complainant's mother had a head injury and was, I believe, unconscious, the ambulancemen acted contrary to the guidance under which they were required to operate. The CAO has indicated that the ambulancemen were not obliged to adhere rigidly to the requirements of the 'green book'; and in the complainant's mother's case, he was satisfied that an appropriate method of transport had been used. I do not find it satisfactory that there should be such ambiguity about what is correct procedure. It means that I can make no finding on the complaint. I recommend, therefore, that the AS should ensure that the guidance issued to ambulancemen should accurately reflect what is expected of them.

(b) *Ambulance transport on 23 June*

15. The complainant told my officer that in the evening of 22 June she had been told, by the ward sister at the second hospital, that her mother was to be transferred the next day to the third hospital and that any member of the family wishing to accompany her should be at the ward by 8.30 am. She had taken her father to the second hospital for that time and had then gone on to the third hospital to await her parents' arrival. She had telephoned the second hospital at least eight times that morning to find out what was happening, but on each occasion nurses had told her that her parents had not left but that the ambulance was coming to collect them.

16. The complainant's father told my officer that a nurse, whom he could not identify, had told him, in the morning of 23 June, that the ambulance would collect his wife between 10.00 am and 11.00 am. He had understood from the nurses that a vehicle had arrived at 11.00 am, but it was for sitting patients and unsuitable for the complainant's mother, as she had to be taken on a stretcher. At about half-hourly intervals thereafter, nurses had told him that an ambulance was on its way. At 1.45 pm an ambulance had come, but it, too, had been unsuitable, as it did not carry oxygen. Eventually a suitable vehicle had arrived and the complainant's mother was transferred. He had been given no explanations for the delay in providing a suitable vehicle.

17. In a statement prepared for the DHA and dated 4 September 1989, a staff nurse at the second hospital (the SN) wrote:

> '. . . I booked an ambulance by telephone for the transfer of [the complainant's mother] from [the second hospital] to [the third hospital]. As the lady was unconscious, in the booking of the transport I stipulated that this lady would need a stretcher with oxygen and she was to have a nurse escort.
>
> On Friday 25 [sic] June mid morning an ambulance came to the ward but it was inappropriate as it was only a sitter one. At approx. 1.15 pm the lady and her husband were still awaiting transport. I therefore then contacted [the Assistant Hospital Manager (the AHM)] who in turn rang the ambulance liaison. At approximately 1.45 pm the appropriate transport arrived to the ward and the lady was transferred along with her husband and a nurse as escort.'

18. The SN told my officer that non-emergency transport was ordered, between 9.00 am and 5.00 pm on Mondays to Fridays, through the ambulance liaison office at the first hospital; and at other times, directly with ambulance control (the AC). It was the responsibility of the nurse ordering the transport to decide what was required, and ward practice was to record that the request had been made by writing in the ward diary, on the day of the journey, the patient's name, the type of vehicle requested and any special requirements. In arranging the complainant's mother's transport, she had asked for a stretcher vehicle with escort and oxygen although she had not put oxygen down in the ward diary. (The entry in the ward diary, which I have seen, read '10–11 am [the complainant's mother] for transfer to [third hospital]—transport arranged—nurse escort.') In a letter to my officer, she wrote:

> '. . . once the ambulance liaison had been informed of the requirement of oxygen on transfer it was not necessary to put it in the diary . . .'

and, in a postscript:

> '. . . all ambulances of the type booked for [the patient] carry oxygen anyway.'

The SN could not recall specifically asking the complainant's father to come to the ward at 8.30 am, but relatives were asked to come at that time because the AS could not give a definite time for non-urgent work such as transfers.

19. The AHM told my officer that, while he was having lunch in the canteen on 23 June, the SN had contacted him to say that the wrong transport had been sent for the complainant's mother, as it had no oxygen on board. The complainant's father had been waiting since 8.30 am, so he had contacted the AC. Shortly afterwards, the SN had told him that an appropriate vehicle had arrived. Subsequently, when he was investigating the complainant's father's complaint, the SN had told him that, in ordering the ambulance, she had asked for oxygen. However, the transport request form (see paragraph 21) had not shown that. He and the ambulance liaison officer (the ALO) had discussed what had happened and had agreed that hospital staff, including those in the ambulance liaison office, would be reminded of the importance of passing on all relevant information to the AS when ordering transport (see paragraph 23). As to his reference, in a letter

(see paragraph 27 (iv)), to a one man sitting ambulance, that information had only been hearsay; he accepted that the first vehicle to come had had a two man crew, which was unsuitable because it did not carry oxygen.

20. The transport clerk (the TC), who was employed by the DHA to work in the ambulance liaison office at the first hospital, told my officer that she was responsible for co-ordinating requests for ambulance transport within the DHA and passing them to the AC. Requests were either urgent or general; if less than 48 hours notice was given, details of the journey required were recorded on the case movement and planning sheet (the CM & P sheet) for the day of travel and were relayed to the AC by telephone. The CM & P sheet entry for the complainant's mother on 23 June (which I have seen) was in her handwriting and, as it was not marked urgent, would have been received the previous day. She did not remember the request, but the entry indicated that transport had been requested to take the complainant's mother from the second hospital to the third hospital as a stretcher case, with escort, preferably between 10.00 and 11.00 am on 23 June. No request for oxygen had been made as she had not referred to it either on the CM & P sheet or when telephoning the request to the AC.

21. A control assistant at the AC (the CA) confirmed that she had completed the complainant's mother's transport request form, although she had no recollection of doing so. (The request was timed at '1238' on 22 June, and the information on it corresponded with that which the TC said she had given (paragraph 20); however, a pencilled addition, in a different handwriting, read 'Pt on O2' (see paragraph 22).) The CA told my officer that she would have recorded any request for oxygen in the special instruction box on the form. She would have completed the form at the time of receiving the request and then passed it to the planning department for action.

22. Referring to his work sheet for that day, the control officer responsible for the allocation of ambulances on 23 June (the CO) told my officer that the records showed that the complainant's mother's journey had been assigned to a vehicle manned by a two man crew who had no specialised training; there was no record, in the work sheet, of the single-manned sitting ambulance referred to in the SN's statement (paragraph 17). The journey had been scheduled for 11.40 am, but the crew's previous journey had taken longer than planned so they had been stood down for a break. At about 12.30 pm the crew had advised him that they were unqualified to carry out the journey, as the patient needed oxygen. At that stage he had added the words 'Pt on O2' to the ambulance request form and reassigned the journey to a vehicle manned by a qualified crew. However, that crew had informed him that they were behind schedule, so he had reassigned the job to a third vehicle whose crew came on duty at 2.00 pm. (The records kept by the crews substantiated that account and recorded that the complainant's mother was collected at 2.30 pm.)

23. The complainant's father's complaint was investigated, on behalf of the AS, by a senior ambulance officer (the SAO). He was, for legitimate reasons, not available for interview during my investigation, but his report for the AS confirmed the evidence given to me. It ended:

> '. . . no indication of oxygen therapy [was made] . . .
>
> I have advised [the ALO] to instruct once again the wards to provide the information and the transport clerks to obtain it. I will also have the request minuted at the next [ambulance/hospital] liaison meeting.'

24. The assistant chief ambulance officer (the ACAO) told my officer that failures to give information were unusual—hospitals usually gave too much—and he was confident that, had oxygen been requested, it would have been recorded. He considered that the CO had acted correctly when reallocating the complainant's mother's journey. The CAO, too, thought that the CA would have recorded the need for oxygen if it had been asked for; not all vehicles carried oxygen, and all control assistants were aware of the importance of including such information, in order to assist the journey planners.

Findings(b)

25. The SN asked for an ambulance to come, if possible, between 10.00 and 11.00 am. A vehicle was scheduled for 11.40 am, but its previous journey took longer than expected. I have ascertained, from the AS records made at the time (which I believe to be an accurate account of events, despite the differing evidence given by the complainant's father and the SN), that it did not arrive to collect the complainant's mother until 12.30 pm. That was unfortunate, particularly as the complainant's father had been waiting since 8.30 am, but I recognise that unpredicted delays in providing an ambulance can occur from time to time. I do not, in the circumstances of this case, criticise the AS as they had not agreed a time of collection. However, the complainant's father was not put fully in the picture about the reasons for the ambulance delay that morning. More important, because the family were not aware of the ambulance arrangements until the morning of 23 June, the complainant left her father at 8.30 am at the second hospital and went to the third hospital where she waited, with mounting anxiety, for her parents to arrive. There was a lack of full and effective communication between the hospital and the AS which caused avoidable distress. I recommend that the DHA and the RHA, together, examine their administrative procedures with the aim of better ensuring that patients and relatives are properly informed about non-urgent ambulance transfer arrangements and are warned whenever delays seem likely to occur.

26. The complainant's mother's journey was further delayed because the ambulance which arrived at 12.30 pm was found to be unsuitable, as the crew were not qualified to administer oxygen. The journey was rescheduled but, again for operational reasons, was not carried out until 2.30 pm. There was, therefore, a two-hour delay because of the breakdown in communication about the need for oxygen. The SN has maintained despite her own documentary evidence (paragraph 18) that she requested oxygen, but the TC has denied that. I blame the SN for the fact that the need for oxygen was not made clear. An unsuitable ambulance was supplied. I note with approval that hospital staff have been reminded of the importance of conveying all relevant information when ordering ambulance transport, and I recommend that the review which, I understand from the DHA, is in progress on how transport requests are recorded at ward level be concluded as soon as possible with the issue of clear instructions to the staff concerned. I hope that some consideration will be given to not calling relatives in prematurely in cases where it is known what the earliest time will be for an ambulance to call. I uphold the complaint against the DHA.

(c) *Response to the complaint*

27. I now set out the correspondence relevant to this aspect of the complaint:

(i) 4 July 1989 — The secretary of the local community health council (the CHC secretary) complained to the AS, on the complainant's father's behalf, about various matters including those which have been the subject of my investigation.

(ii) 26 July — In their reply to the complainant's father the AS said that the crew had used a chair because it was difficult to manoeuvre a stretcher in the house; the wound to the complainant's mother's head had been noticed immediately but her state of consciousness had taken greater priority; and the wrong ambulance had been sent on 23 June because the hospital had omitted to mention that oxygen was needed.

(iii) 31 August — Referring to (ii), the complainant's father's Member of Parliament (the Member) asked the DHA to comment on, among other things, the AS's observation that the hospital had not mentioned the need for oxygen.

(iv) 1 September — The AHM told the complainant's father's local councillor that the SN had correctly ordered a two-man stretcher ambulance, but that initially a one-man sitting car had been sent at about 11.00 am.

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(v)	18 September	The Member wrote to the AS inviting their response to the information disclosed in (iv) above.
(vi)	26 September	The CAO gave a response to the Member in relation to the matters in (i) not subject to my investigation.
(vii)	2 November	The CHC secretary advised the CAO that the complainant's father was dissatisfied with the AS's investigation and wished to meet a senior officer.
(viii)	2 November	The CHC secretary asked the DHA to clarify whether the AS had been asked to provide oxygen.
(ix)	24 November	The AHM told the CHC secretary that the SN had requested oxygen.
(x)	8 December	The CHC secretary reminded the CAO about his letter of 2 November (vii).
(xi)	22 December	The CAO apologised to the CHC secretary; no trace could be found of (vii) but a meeting would be arranged in the near future.
(xii)	5 February 1990	After meetings between the ALO and the complainant's father on 5 and 16 January, the chief administrator of the AS (the chief administrator) confirmed to the complainant's father that 'the crew did enter your premises with chair carrying equipment'; that they 'initially identified a laceration to your late wife's head but deemed her level of consciousness more important'; that to bring a stretcher into the house then 'would have meant both ambulancemen having to return to the vehicle, therefore, leaving your late wife unattended'; and, with regard to the patient's transfer to the third hospital, that 'It was only when our first crew arrived at your home (sic), that the Service was aware that [the complainant's mother] required oxygen therapy'.
(xiii)	8 February	The complainant's father told the CAO he was dissatisfied with (xii) and that the matter was being referred to me.
(xiv)	6 March	The CAO replied to (xiii) saying that the ambulancemen could not have seen the laceration on the complainant's mother's head until she was moved; that not every complainant was visited; and that a visit had not been necessary in this case as it had also been referred to the AS by the member and the CHC.

28. The complainant's father told my officer that he had been dissatisfied with the AS's handling of his complaints, mainly because it had taken six months for their representative to visit the scene of the incident. Until then all explanations about whether or not a stretcher should have been used had been made without anyone seeing the premises. By the time of the ALO's visit and investigation, the events had no longer been fresh in people's memories. That a visit had not taken place earlier because of the involvement of the Member and the CHC (paragraph 27(xiv)) had never been explained to him, and he did not accept it. There had been errors in the AS's replies, including the clear inference in the letter of 5 February (paragraph 27(xii)) that on 23 June the complainant's mother had been collected from home, when she had in fact been in hospital. They had given differing accounts as to why a stretcher had not been used, and about when the crew first saw the cut on the complainant's mother's head (paragraph 27(ii) and (xii)); and their letter of 5 February (paragraph 27(xii)) had stated that the crew entered the house carrying a chair, which was not true. Having seen the records of the request for his wife's journey on 23 June, he had accepted that no mention had been made of the need for oxygen; the ALO had agreed that a breakdown in communication

might have occurred between the hospital and the AS staff. Had that been reflected in the CAO's letter of 5 February (paragraph 27(xii)), the complainant's father would have been satisfied that that part of his complaint, too, had been answered.

29. The chief administrator told my officer that he had overseen the investigation into the complainant's father's complaint. Complainants were often visited but, because the complainant's mother had died, he had instructed that that would not be appropriate in the complainant's father's case. With hindsight, that had been an error of judgment. He had drafted the CAO's reply of 26 July (paragraph 27(ii)) on the basis of the reports submitted by the SAO and the divisional officer—operations, and a statement from the emergency crew. Loss of the CHC secretary's letter of 2 November (paragraph 27(vii)) had occurred because, at the time, manning problems had caused the AS to rely on temporary staff to record incoming correspondence. He had asked the ALO to visit the complainant's father to explain matters, including the complainant's mother's transfer from the second to the third hospital, and he had then written as full a reply as possible to the complainant's father. Reference to the crew taking the carrying chair into the house when they arrived had been a misinterpretation, on his part, of the crew's report. In his final letter to the complainant's father (paragraph 27(xiv)) he had summarised the replies to date, and the explanation given for why a home visit had not been made had been a matter of tact.

30. The ALO, who had visited the complainant's father on 4 January, said it was unusual for such a visit to take place so long after the complaint had been made. Having established the details of the complaint, he had made enquiries which satisfied him that the problems with the complainant's mother's transfer had arisen because the ward had not passed on the information about the oxygen. He had discussed his findings with the AHM (see paragraph 31) but had not pursued the matter further, as those involved were hospital employees. He had seen the complainant's father again on 16 January, when he explained the outcome of his investigation and showed him the relevant records. He had then submitted his report to the chief administrator.

31. The AHM confirmed that he had spoken to the ALO about the complaint about the ambulance transfer on a number of occasions. However, the complainant's father's complaint had been against the AS, so his only involvement had been to provide information. He had made enquiries of DHA staff (paragraph 19) and had replied to correspondence on the basis of what he had been told. He accepted in evidence to my officer that there had been inaccuracies in his account of events.

32. The CAO said that his first recollection of the complainant's father's complaint had been when the Member became involved. The complaint should have been handled more carefully, and the paperwork left much to be desired. However, because of industrial action, conditions had been unusual, and much of his administrative work had been delegated to the chief administrator who, in turn, had been put under pressure. The chief administrator had no professional experience but was able to respond to complaints about the actions of ambulancemen because, when necessary, he could seek assistance from a qualified officer. Nevertheless, any future complaints would be investigated and replied to by qualified ambulance personnel.

Findings (c)

33. The complainant's father originally complained to the AS on 4 July 1989 but, despite extensive correspondence, not until January 1990 did the ALO visit him at his home—the scene of the incident—to discuss his complaint. The complainant's father considered such a visit essential in the investigation of the complaint, and that it should have been made earlier. I can but agree. The chief administrator has explained both why he did not arrange a visit earlier, and why he gave a contrived reason for that to the complainant's father. I consider that he made an error of judgement and, had the visit taken place at an early stage, much of this complaint might have been avoided. Bereaved complainants should be given the offer of a prompt visit, rather than have an arbitrary decision made on their behalf.

34. The complainant's father also complained that the AS's responses included inaccuracies and discrepancies. The chief administrator has acknowledged that, because he misinterpreted the crew's report and the records, he wrongly informed the complainant's father that the crew had entered the house, carrying equipment; and that the complainant's mother had been taken to the third hospital from her home. The differing statements about when the crew first saw the cut on the complainant's mother's head also resulted from a misinterpretation of information available to him. The CAO has said that, although administrative personnel without ambulance training could answer complaints, taking advice from qualified officers when necessary, the chief administrator had been under pressure when dealing with the complainant's father's complaint. I do not put all the errors down to that pressure. The chief administrator's lack of practical ambulance experience could well have been a contributory factor. I note that qualified ambulance personnel will be involved in replies to future complaints (paragraph 32). I uphold the complaint.

Conclusion

35. I have set out my findings in paragraphs 13–14, 25–26 and 33–34. I hope the complainant and other members of the family will find reassurance in the evidence of the consultant that the method of transport used to convey their mother to the ambulance after her accident would not have affected her condition adversely (paragraph 12). The RHA have agreed to implement my recommendations in paragraphs 13, 14 and 25, and the DHA have agreed to implement my recommendations in paragraphs 25 and 26. Both the RHA and the DHA have asked me to convey through this report—as I do—their apologies to the complainant for the shortcomings I have identified.

Case No W.25/90–91—Release of confidential information to the press

Background and complaint

1. On 8 July 1989, the complainants' 15 year old daughter was admitted to a hospital (the first hospital), with a severe disorder, and on 4 August she was put on the waiting list for a transplant. Another hospital (the second hospital), was informed about the girl by the first hospital, with which they shared a transplant programme. The girl died at the first hospital on 16 August during transplant surgery.

2. The complainants complained that the health authority which administered the second hospital (the DHA), through a consultant surgeon (the consultant) and others, had acted unethically and against the family's expressed wishes in releasing information which had enabled the media to identify their daughter. As a result, the circumstances surrounding their daughter's death had become the subject of front page headlines in a local newspaper(the first local newspaper), causing them unnecessary additional grief and anxiety.

Investigation

3. The complainants also complained to me that there had been poor communication between the first and second hospitals with regard to the availability of donor organs and post-operative beds and staffing; and that a transplant co-ordinator at the second hospital had declined the offer of an organ, despite the availability of a bed. Before starting my investigation I explained to the complainants that, in a letter to them, the DHA had given a detailed account of the procedure followed when a transplant was to be undertaken and a record of the action actually taken in their daughter's case. Whether or not the transplant co-ordinator had taken the correct action in declining the offer of an organ, I could see no *prima facie* evidence of maladministration—a prerequisite of an investigation by me—in the arrangements between the two hospitals. Moreover, it seemed from the correspondence that, even had the transplant co-ordinator accepted the offer, the end result would have been the same because another hospital had greater priority and therefore first call on the organ. The DHA had

told them that as a result of this case their guidance notes had been changed, and in the circumstances I did not feel that an investigation by me into this aspect would achieve anything further. Accordingly, in the exercise of the discretion granted to me by Parliament, I decided not to take up this aspect. I obtained the comments of the DHA and examined the relevant documents. My officer took evidence from the complainants, a newspaper reporter and the members of the DHA staff involved.

4. I set out below a summary of newspaper articles, reports and a paid 'intimation of death' notice relevant to the complaint:

(i)	4 August A newspaper local to the area of the second hospital (the second local newspaper)	Discussed the effect of a shortage of donor organs, and of shortages of Intensive Care Unit (ICU) beds on transplant programmes at the second hospital.
(ii)	7 August The second local newspaper	Stated that 'a young girl. . . now in [the first hospital] but awaiting transfer to [the second hospital]' was nearer to death because of a shortage of ICU beds and had missed the opportunity of receiving a suitable donor organ. The article carried quotations from the consultant.
(iii)	10 August The second local newspaper	Referred to 'a teenage girl', awaiting a transplant, who had a diminished chance of survival because of a shortage of ICU beds. This article too quoted the consultant.
(iv)	21 August The first local newspaper	A notice, inserted by the family in the personal column, intimating the death on August 16, 1989. . . in [the first hospital] of their daughter with details of her age and education.
(v)	22 August The second local newspaper	After a distasteful headline the article stated that 'a 15 year old girl, who had missed her chance of a life-saving transplant because of a shortage of [ICU] beds at the second hospital' had died. The consultant was quoted as blaming the shortage of ICU beds at the second hospital for the death and saying that the death was 'wholly avoidable'.
(vi)	23 August A national newspaper	The article included: 'A spokeswoman for the [DHA] transplant team said 'She had been waiting until a second suitable donor organ became available. But when it did there was no bed for her.''
(vii)	24 August A national newspaper	An article referred to the death of a 'girl, aged 15, whose identity has not been disclosed. . .'.
(viii)	24 August The first local newspaper	Included an article which gave the girl's name, her family's name and address, and the circumstances of her death.
(ix)	24–27 August Another newspaper local to the area of the second hospital (The third local newspaper)	Referred to a 15 year old girl who had been waiting at the first hospital for transfer to the second hospital for a transplant but had died because of the lack of ICU beds.
(x)	24 August	Articles also appeared in several national newspapers.

5. The girl's mother told my officer that, during her daughter's illness, the family had maintained contact with the transplant co-ordinator (the first TC) at the first hospital. She had told them that the press had approached her, and she had said categorically that she wanted nothing to do with the press and that no details about her daughter were to be released. On 23 August, the day after her daughter's funeral, the first TC had told her that the press had again been asking questions and that she had telephoned the second hospital to advise them that there was to be no publicity. The girl's mother had again stressed to her that no details about her daughter should be released. Later that day the girl's father had been shocked to see in a national newspaper under an emotive headline a report (paragraph 4(vi)) that a 15 year old girl had died because no intensive care bed was available at the second hospital,and that that was the second time the operation had had to be cancelled because of a lack of ICU beds.

6. The complainants had been very distressed by the newspaper account because they had specifically asked that no details about their daughter should be released. Moreover they had not been aware that earlier a suitable organ had been available but was turned down. They had been confused, particularly as the paper had indicated that the DHA had attributed their daughter's death to a lack of beds. A relative had told them that the story had appeared on teletext the same day and had asked if it referred to their daughter, and whether it was true. The complainants had asked the first TC if the story was correct, and she had replied that it had been thought best not to tell them about the first donor organ.

7. On 23 August a reporter (the first reporter) from the the first local newspaper had called at their home. He had said that he would like to write a memorial tribute to their daughter. The girl's mother had told him that they wanted no publicity, and he had left without further comment. On 24 August an article in the first local newspaper (paragraph 4(viii)) had caused the complainants great distress. The girl's mother thought that the first reporter had probably identified them by linking the sensational stories in the national press (in particular, the story on 23 August (paragraph 4(vi)) with the death notice in the first local paper (paragraph 4(iv)). The death notice had included enough information to enable him to trace them through the telephone directory.

8. The complainants said they had been angry that the consultant, whom they had not met, had released to the press the details about their daughter. Having spent much time at the first hospital with their daughter, they had known that the 15 year old girl referred to could only have been her. The consultant had quite unnecessarily released information about their daughter's case as a means of attracting publicity for his own ends, and in so doing had enabled the first reporter to identify her. The DHA had told them in response to their complaint through the CHC that the consultant had spoken to the press. They were angry too that the transplant co-ordinator at the second hospital (the second TC) had also spoken to the press. Their hope had been to keep their grief a private affair. Instead, they had had to cope with relatives, friends and neighbours, who had seen or heard about the story in newspapers or on television, asking about what had happened. Their wishes had been callously disregarded by staff of the second hospital for their own purpose.

9. The first reporter told my officer that he had linked national press reports with the details in the death notice; he had then found the complainants' address from the telephone book. He had not spoken to the consultant, but the second TC had confirmed to him what he had already heard about the availability of beds; she had not given him any personal details about the girl.

10. The consultant told my officer that, in the past, a reporter from the second local newspaper (the second reporter) had been very helpful in persuading the DHA to recognise where shortages existed and facilities needed to be changed. The second TC had appeared on television on 3 August and when discussing another transplant programme, had mentioned that there was a shortage of ICU beds. The shortage of ICU beds had been a major issue for ten years and, after the interview, the second reporter had asked him if anyone had suffered as a result of this

problem. He had confirmed to the second reporter that people, some of whom were young, had suffered as a result. He had probably said that a young girl at the first hospital had missed the chance of a suitable organ because an ICU bed was not available. He could not remember how many reporters he had spoken to by telephone, but he had been interviewed face to face only by the second reporter.

11. Referring to the article of 22 August (paragraph 4 (v)), he would have given the information that a donor organ had not been taken up and that the girl's chances might have been better had a bed been available. He had not said that the death had been 'wholly avoidable'. He felt it had been in order to give the press the information about a 15 year old girl at the first hospital because the public had a right to know the situation, although not at the expense of the relatives. It had not occurred to him that the information would enable the girl to be identified, and he had not been aware that the complainants had asked for no publicity. He accepted that he had probably given too much specific information, although he considered that he had not breached confidentiality. He expressed the view that good press relations were a necessary way of heightening awareness of the transplant programme, which assisted in its development. (Although, in writing to my Office about this complaint, the consultant acknowledged that he might have mentioned a 15 year old girl in his conversation with the second reporter, he made no such admission in a letter to the complainants when he referred to the same conversation.)

12. The first TC told my officer that she had met the complainants when their daughter was put on the transplant register on 4 August. Later a TC from the second hospital had told her that the press were interested in speaking to someone awaiting a transplant and had suggested the family. When she put the proposal to the complainants, they had categorically refused to have anything to do with the press and had said that no details whatsoever were to be released. She had immediately telephoned the second hospital and told them of the complainants' decision—but she could not recall to whom she had spoken. She had not recorded the complainants' instruction in writing but had warned the ward staff about it. After the girl's death she had again been contacted by a TC—she thought possibly the second TC—from the second hospital about a press article which, although it had not named the girl, had given specific details about her. The TC at the second hospital suggested that it would be prudent to tell the complainants, so she had telephoned them on 23 August to warn them about the article. She herself had had no contact with the press about the matter.

13. The second TC told my officer that she had been the senior transplant co-ordinator for the Region for ten years. Her place in the management hierarchy was ill-defined, but she usually went for advice to the director of hospital services (the DHS) or the unit general manager (the UGM) at the second hospital, and she worked closely with the consultant. The role, which she had pioneered, included supporting relatives and liaison with the media to maintain awareness of the programme. She had a good working relationship with the press and was at liberty to be in contact with them on routine matters. There had been no written DHA policy or guidance on dealing with the media but the Regional information officers could be consulted if necessary. She was scrupulous in not giving information to the media without the consent of patients or their guardians. She had never met the girl or her parents.

14. The second TC said she had not spoken to the first TC about the girl until after her death, and she could not recall that anyone from the first hospital had told her that the complainants did not want any publicity. Press interest had arisen in the shortage of ICU beds. On being given the information about a 15 year old girl, they had begun to ask further questions; she assumed that the consultant had released the additional information. The details of the girl's name, age, sex, and diagnosis had been available to herself, the ward staff and the surgeons from 4 August—the date on which the girl had been registered as an urgent but not at that stage emergency candidate for a transplant and her particulars put on the department notice board. The transplant team were usually very cautious about revealing a patient's identity; the problem had arisen because of a breakdown in

communications between the first and second hospitals about the publicity issue; and a breach of confidentiality had occurred in releasing details of the girl's age, location, and diagnosis. She accepted that she had been unwise to give details to the press without first seeking the consent of the parents. The consultant had drawn media attention to the girl's case because his programme was in jeopardy, and publicity had in the past elicited a satisfactory response from the DHA on such issues. However, he would not—she said—knowingly have revealed information which would distress relatives.

15. The UGM told my officer that the DHA did not have a written press policy, but there was a policy for clinical staff on confidentiality. (The policy guidelines dated 15 January 1987, stated that it was a disciplinary offence to disclose information about a patient to someone other than for the purposes of the medical care of the patient, or of research.) The UGM explained that there was a well established understanding among staff, including consultants, that problems should be solved internally rather than by going directly to the press. However, the second hospital had a high profile and was a major source of news in the area. A very open and positive relationship had developed with the press, with articles about the hospital appearing frequently: there had never been any attempt to cover up a story.

16. The UGM could not remember whether he had seen the story in the newspaper on 7 August (paragraph 4(ii)) but, if he had, he would have assumed that the family had given consent. He now thought the details had been too specific, but he had probably not taken particular notice at the time; it was not uncommon for articles to appear averring that transplant patients might die because of a lack of facilities, and that was something to which he had grown used. He had been on leave when the article of 22 August (4(v)) was published. The details about the girl which had appeared in the press had been breaches of confidence, but that had not been attributable to failures in management; the best management procedures would not have prevented the consultant, who often went directly to the press to promote his cause, from making comments about the circumstances of this case. The management of the unit was being formalised, and the second TC had been advised, as a result of this complaint, that she had to consult management on major issues before speaking to the press.

17. The DHS told my officer that he had been the acting UGM when the article of 22 August (paragraph 4(v)) was published. Although he could not say that there had been a breach of confidentiality, the details released had all but given the girl's name to the press. The article had engendered huge press and media interest. He had called a meeting of those involved—the consultant had been on holiday—and had given an instruction that press statements were to be channelled through him. He and the second TC had appeared on television to try to defuse the situation, but during the programme the second TC had made unfortunate remarks which appeared to confirm that the girl had died as a result of a failure at the second hospital. Patients had an absolute right to confidentiality, and he did not think it necessary for either them or their guardians to request that no details about them should be released.

18. The director of administration (the DA) told my officer that he had carried out a detailed enquiry into the complaint in August and September 1989 and had submitted his report to the DHA's chief executive (the CE). The report had concluded: 'Reference in the press to 'a young girl' awaiting a transplant at [the first hospital] (subsequently described as 'a 15-year-old') went against the wishes of [the girl's] family. The linking of this patient's plight to a shortage of [ICU] beds in [the area] was gratuitous and misleading.' The DA said that the consultant and the second TC had given incorrect and misleading information to the press as a result of their own misunderstanding of the situation and that the consultant had, in his view, acted unethically.

19. The CE told my officer that he had worked hard with senior medical staff on the question of publicity. Discussions had been held about the wisdom of contacting the press on questions of resource allocation at the expense of damaging public confidence and he had issued a memorandum to that effect. (In a notice dated March 1986, the CE reminded all staff that, unless their normal duties required them to do so, they should not reveal to any person or organisation—including the press—any details about patients; and that any breach of confidentiality would be viewed extremely seriously.) The consultant had been fully aware that he was required to consult the hospital management rather than take a problem to the press for resolution. The level of detail published in the press on 7 and 22 August—age, location, and diagnosis—was in his opinion a definite breach of confidence. Any consultant should have known that it was unacceptable to release such details about a patient. He would have expected action to be taken by management at the second hospital when the article appeared on 7 August; someone should have spoken to the consultant at that stage. After receiving the DA's report, he and the DA had met the consultant to discuss its contents. He had made it clear that the consultant's behaviour was not acceptable, that it did not help to improve resources and that it had created distress for the family. The consultant had accepted the criticism and had apologised. The complainants had a just cause for complaint.

Findings

20. I am left in no doubt from the above evidence including a letter which he wrote to my officer during my investigation that the consultant released information to the press about the girl's age, location, diagnosis and prognosis and also about the organ that had been available but not used, because no ICU bed was available. There is equally no doubt that that information led ultimately to the story about the girl, in the local paper, which caused the complainants so much distress. The consultant's deliberate decision to give the press details of the girl's case amounted—regardless of his apparent lack of awareness of the parents' wishes—to a direct contravention of the DHA policy on confidentiality. The CE has said that the consultant can have been in no doubt that to release such specific information about a patient was an unacceptable breach of confidence (paragraph 19). It was very distressing for the parents unexpectedly to have the story of their daughter's death spread about but that was compounded by their learning from press reports that an organ had been available but not used: that was information of which they had not been aware and which, I have been told—but I do not comment upon (paragraph 3)—subsequently proved to have been erroneous. The organ in question had been used for another emergency patient. Except in very exceptional circumstances—and this was not one of those—details of a patient should not be released to the media or others, on any account, without the explicit consent of the patient or guardian; that axiom was disregarded in this case. I have found no cause to question the final conclusion in the DHA's report (paragraph 18).

21. I note that the CE has cautioned the consultant about his actions in this particular case, and the second TC also has been counselled. The CE has said that action should have been taken by the second hospital management to contain the story when it first appeared on 7 August. No such action was taken and I recommend that the DHA's procedures should cover such situations. I also invite the DHA to satisfy themselves that all their staff are aware of their responsibilities in respect of confidentiality. I uphold this complaint.

Conclusions

22. I have set out my findings in paragraphs 20 and 21. The DHA have agreed to implement what I have recommended in paragraph 21, and they have asked me to express to the complainants through this report, as I do, their apologies for the shortcomings I have found and the additional distress caused to them by the events I have investigated.

Schedule I

Glossary of the more commonly-used acronyms

A and E department	Accident and emergency department
AS	Ambulance service
Board	Health Board
CAMO	Chief administrative medical officer
CANO	Chief administrative nursing officer
CHC	Community health council
CN	Charge nurse
DGM	District General Manager
DHA	District Health Authority
DHSS	Department of Health and Social Security
DNS	Director of Nursing Services
DOH	Department of Health
DSS	Department of Social Security
EN	Enrolled nurse
FHSA	Family health services authority
FPC	Family practitioner committee
GP	General practitioner
HO	House officer
IPR	Independent professional review
MWC	Mental Welfare Commission
NA	Nursing auxiliary
NHS	National Health Service
NO	Nursing officer
PM	Post mortem examination
RGM	Regional general manager
RHA	Regional health authority
RMO	Regional medical officer
SCM	Specialist in community medicine
SHO	Senior house officer
SN	Staff Nurse
SR	Senior registrar
SW	Social worker
UGM	Unit general manager

Schedule II

Investigation Time

Case Reference No	*Summary of Complaint for investigation issued*	*Report issued*
W.375/88–89	23.11.89	22. 3.91
W.194/89–90	6.11.89	19.12.90
W.206/89–90	27. 3.90	30.11.90
W.212/89–90	11.12.89	21.12.90
W.258/89–90	24.11.89	31. 1.91
W.369/89–90	4.12.89	27.12.90
W.411/89–90	3.10.90	22. 3.91
W.417/89–90	6. 4.90	28. 3.91
W.478/89–90	9. 1.90	18. 3.91
W.599/89–90	16. 5.90	28. 2.91
W.652/89–90	19. 6.90	27. 3.91
W.668/89–90	10. 5.90	21. 3.91
W.25/90–91	31. 5.90	26. 2.91

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