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Department of Health

To: **Regional General Managers**
District General Managers
General Managers of Special Health Authorities) **for action**
for the London Postgraduate Teaching Hospitals
Administrators of Family Practitioner Committees

Secretaries of Community Health Councils) **for information**

November 1988

Dear General Manager

THE HEALTH SERVICE COMMISSIONER

This letter but not the 'epitomes' it encloses will cease to be valid on 1 January 1989 unless notified separately.

HEALTH SERVICE COMMISSIONER REPORTS

1. DA(83)30 informed health authorities that the Health Service Commissioner would be prefacing his six monthly periodic reports of selected cases with 'epitomes' of the reports included, and that the Department would be making a free distribution of these epitomes to authorities on a trial basis. The latest ccollection of epitomes covering the period November 1987-March 1988 together with the epitomes for the period April-October 1987 are enclosed for your information.

2. As indicated in DA(83)30, we believe there is value in giving this material wide circulation among staff of the authority and in arranging for its use, as appropriate, in training courses and seminars. The Commissioner's own leaflet on his functions may also be useful for training purposes[1].

3. There is no objection to authorities photocopying the epitomes if additional copies are required. Copies of the full periodic reports may be obtained from Her Majesty's Stationery Office:-

April-October 1987 (reference HC 232, ISBN 010 2232881, Price £12.30)

November 1987-March 1988 (reference HC 511, ISBN 010 2511888, Price £18.00)

HEALTH SERVICE COMMISSIONER TELEPHONE NUMBERS

4. Authorities will wish to be aware that, new telephone numbers are now in operation for the Health Service Commissioners' Office in London. The main numbers that Authorities may require to contact the Office are as follows:-

Mr A R Barrowclough QC (Commissioner)	01-276 2010
Mr G V Marsh (Deputy Commissioner)	01-276 2089
Enquiries	01-276 2035
Switchboard	01-276 3000

Yours sincerely

M A HARRIS
Assistant Secretary

[1]The Health Service Ombudsman for England, available on request from the Office of the Health Service Commissioner for England, Church House, Great Smith Street, London SW1P 3EW.

From:

HSI Division
Room A410
Alexander Fleming House
Elephant and Castle
LONDON
SE1 6BY

Telephone: 01 407 5522 Ext 6682

Further copies of this letter may be obtained from DHSS Store, Health Publications Unit, No 2 Site, Manchester Road, Heywood, Lancs OL10 2PZ quoting code and serial number appearing at top right-had corner.

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HEALTH SERVICE COMMISSIONER

FOURTH REPORT TO PARLIAMENT FOR SESSION 1987-88 HC

EPITOMES OF SELECTED CASES FOR

THE PERIOD NOVEMBER 1987 - MARCH 1988

1. INDEPENDENT PROFESSIONAL REVIEW PROCEDURE - W.621/85-86 - W.21/86-87

Matters considered

Administrative arrangements for an independent professional review (IPR) - attitude and manner of the two 'second opinions' - the format and procedure they adopted for the IPR meeting.

Summary of case

A woman first complained to a hospital in March 1983 about treatment she had received there over a three year period under the care of a consultant. The hospital obtained the consultant's comments but by the time the woman expressed her continuing dissatisfaction he had retired. The hospital therefore arranged for two senior consultants, who were also members of the special health authority (SHA) which manages the hospital, to meet her to discuss her complaints. But she remained dissatisfied and in April 1984 asked the hospital to reconsider her complaints. In June the house governor (HG) referred the complaint to the then regional medical officer (RMO) of the regional health authority (RHA) under the provisions of the NHS clinical complaints procedure. The RMO saw the woman in July and agreed that an IPR should be held, but it did not take place until January 1985. The woman complained that the arrangements for the IPR were delayed and unsatisfactory; that the two independent consultants were partisan and adopted an overbearing and hostile manner; and that the format and procedure they adopted for their review did not lead to orderly and full consideration of her complaints.

Findings

I found serious maladministration at every stage of the IPR process; seldom had I come across such a catalogue of mishandling. The RHA acknowledged that the arrangements for the IPR were in part delayed but my investigation revealed woefully inadequate handling by the RMO, and his successor the acting RMO, both before and after the IPR meeting. In his evidence to me the RMO asserted, wrongly in my opinion, that he was not accountable to the RHA for his actions in the clinical complaints procedure. And I found that despite guidance issued by DHSS in April 1984 the RMO mistakenly believed that it was necessary to obtain the consultant's permission before an IPR could be held. I identified a number of other errors on the part of the RMO and the acting RMO: the independent consultants produced an unsigned manuscript report of the IPR on the day it was held but the typed version, which I found to contain numerous transcription errors one of which gave rise to part of the complaint put to me, was not sent to them for ratification and signature; the RMO produced a summarised version of the IPR report which, contrary to DHSS guidance, he himself sent direct to the complainant; he also failed to send a copy of the full IPR report to the HG for consideration and action; and had the RMO and acting RMO given prompt and proper consideration to

constructive written comments provided by the complainant in response to the RMO's IPR summary, some material points which emerged in the course of my investigation would have been identified at the time. As to the conduct of the IPR, I considered that on a small number of occasions the independent consultants' necessary attempts to test the validity or otherwise of the complaints crossed the borderline and gave the appearance of being hostile and overbearing. I concluded that if the RMO had given the two consultants a list of the outstanding clinical issues identified by the complainant and had briefed them accordingly immediately before the IPR meeting, the complainant might well have found the meeting more satisfactory. I also concluded that if the complainant had been made aware of the full content of the IPR report she would have seen that her complaints were more fully considered by the independent consultants than she had believed. Finally I criticised the failure of the independent consultants to speak to the consultant responsible for the woman's care at any stage in the IPR procedure.

Remedy

Both the RHA and SHA apologised unreservedly for the serious shortcomings I found. They agreed to take action to enable the SHA to give immediate consideration to the report of the two independent consultants and to inform the complainant of the full content of the IPR report.

2. SUPERVISION OF PSYCHIATRIC PATIENT - W.691/85-86

Matters considered

Attitude and actions of a senior house officer (the SHO) when admission requested - actions of a consultant psychiatrist (the consultant) concerning 'sectioning' procedures - placement and supervision of an 'at risk' patient - security of ward windows - handling of complaint by the Health Authority - retrospective additions to clinical records.

Summary of case

The complainants took their 22 year old son, who was in a disturbed state, to the accident and emergency department of a hospital and asked the SHO to admit him. After some delay he was detained under the Mental Health Act 1983 (the Act) by the consultant and his family doctor and was admitted to a single room in the psychiatric unit, situated on the third floor, where he was sedated. About eight hours later the son fell through the window of his room and sustained injuries from which he later died. His parents complained, among other things, about the attitude and actions of the SHO who, they said, refused their son admission. They also complained that the consultant gave the mother the wrong form to sign for the section of the Act under which he was to be detained, and later showed insensitivity in seeking her signature on the correct form at the time they were waiting to be notified of their son's death. They complained that their son was not placed in an observation room and was not provided with adequate supervision. Finally they complained that the Authority failed to explain adequately issues they raised about the circumstances of their son's death.

Findings

My investigation revealed that the SHO was ignorant of his powers under the Act and erroneously believed that he himself could not detain the son. I found that as a result he displayed a marked reluctance to be involved in the case, and gave it no more than cursory consideration. I strongly criticised the SHO for his lack of understanding of the Act and for his conduct, which I concluded fell very far short of what it should have been and clearly led to avoidable distress to the parents and delay in the son's admission. I also upheld the complaints about the use of the incorrect form in respect of the detention and the consultant's insensitivity in his efforts to rectify this mistake. I did not uphold the complaint that the complainants' son should have been placed in an observation room, but I found that the requirement for him to be continuously observed was not properly carried out and that at the time of the fall he was out of the hearing of the ward staff. I ascertained that the son had managed to tear out part of the window frame because it contained rot and was of a weak design. In one respect I upheld the complaint about the way the Authority responded to the complaint. I severely criticised the consultant for his failure to identify, as later additions, his amplification following the son's death of the entry he originally made in the clinical notes when he admitted the son.

Remedy

The Authority apologised for the shortcomings I identified. They also agreed to issue clear instructions to their staff about the implementation of continuous observation; to make the necessary arrangements to ensure, as far as possible, that parts of the ward occupied by patients were not out of the hearing of the ward staff; to review their existing maintenance programmes to ensure they met essential safety needs, and to consider ways of ensuring that the ward's windows were safe.

3. OPHTHALMOLOGIST'S REFUSAL TO OFFER A CHILD A FURTHER APPOINTMENT. - W.90/86-87.

Matters considered

Failure by Health Authority to explain adequately an ophthalmologist's decision - offer of a home visit by an ophthalmologist from another health district.

Summary of case

The complainant's five year old son was seen by an ophthalmologist at her local child health clinic (the clinic) where the Authority provided an open access ophthalmology service. The woman found the consultation unsatisfactory because the ophthalmologist's two young children were present in the room during the examination and were disruptive. She expressed her dissatisfaction and said she intended to seek a private second opinion but a year later the woman unsuccessfully sought a further appointment for her son with the ophthalmologist. At first she was told that his name would be placed on a waiting list but when she complained to the Authority she was told that in view of her decision to seek a second opinion privately the ophthalmologist was unwilling to see her son again, and that in his opinion a high street optician would meet her son's needs adequately. The Authority later told her that none of the ophthalmologists

in the district were willing to offer her son an appointment because his condition did not require medical intervention, and because the complaint about the earlier consultation had damaged the necessary trust between patient and doctor. In the course of further correspondence the Authority offered to arrange a home visit by a doctor from another district. The complainant considered that she was being victimised and that her son had in effect been 'blackballed' by the ophthalmologists. She further complained that the offer of a home visit was inconsistent with the explanation that her son's condition did not require medical intervention.

Findings

I found that the Authority's responses to the complainant were confusing and misleading. It is an accepted part of NHS procedure that both doctor and patient have the right to terminate their clinical relationship if the necessary trust between them ceases to exist. But in this case I was not persuaded that the ophthalmologist's decision to withdraw his services was reasonable in the circumstances. Furthermore, the complainant was left unaware of the ophthalmologist's decision until she sought a further appointment for her son some 12 months later. I found that the Authority's statement that none of the other ophthalmologists was willing to see the complainant's son was ill-founded since two ophthalmologists in the district were not approached. And I saw no acceptable grounds for other ophthalmologists employed in the district refusing to offer an appointment. All in all the Authority's inability to provide the service sought by the complainant caused me considerable disquiet. As to the home visit, in my opinion the Authority's offer was made in a reasonable attempt to provide the service which the complainant wished to receive. I did not uphold that complaint.

Remedy

I was pleased to learn in the course of my investigation that one of the Authority's ophthalmologists was persuaded to see the complainant's son. The Authority apologisedfor the shortcomings I found. They also assured me that so long as they continue to provide a self-referral open-access ophthalmology service for children at their clinics the complainant and her son would be able to enjoy the same right of access as any other NHS patient and that their experience would not be repeated.

4. HEALTH AUTHORITY'S MISUSE OF BENEFIT PAYMENTS RECEIVED BY A LONG-STAY MENTALLY HANDICAPPED PATIENT - W.204/86-87

Matters considered

Use made of a non-contributory invalidity pension (NCIP) to buy a patient's clothes - management of increased allowances paid for periods patient spent at home - consultation and communication over use of benefits and change of appointee.

Summary of case

The complainants' mentally handicapped son, aged 34, was a patient in a hospital for 19 years over which time he accumulated savings from his NCIP (which was

replaced in November 1984 by the severe disablement allowance). The NCIP was claimed by the Authority acting as the patient's appointee until the appointment was transferred to his mother. Two months after this transfer the hospital spent over £500 of his accumulated savings in one session to provide him with a set of clothes. The parents complained to me that as NCIP was intended for small personal items the Authority acted maladministratively in using the savings to purchase such a basic requirement. They also complained that the clothes themselves were of poor quality and did not fit and that the Authority failed to consult with the mother (who was then the appointee) before they spent the money. They further complained that increased allowances, paid for periods which their son had spent at home, were retained by the hospital prior to the transfer of appointment.

Findings

I found that when, after his first year in hospital, the patient's NCIP was reduced from the full rate to a 'pocket rate' it could not have been supposed that this reduced benefit was intended to cover anything like the patient's entire clothing needs; and I believed that at that time the general financial responsibility for clothing the patient passed to the Authority. In view of this, and other factors, I upheld the complaint that the Authority should not have used savings from his NCIP to buy him clothes. I was also critical that such a large amount of clothing was purchased by the Authority at one time. I did not uphold the complaint about the quality of the clothes, and at this remove I was unable to establish whether they fitted properly. However, I upheld the complaint that the patient's mother, as appointee, was not consulted before the purchase and I discovered that this was due to a failure in communication within the hospital, which resulted in the ward staff being unaware of the transfer of appointment. As for the complaint about the increased allowances, I ascertained that as the patient was unable to manage the money himself, the Authority had claimed the benefit and simply paid it into his account. In my view this prevented the parents from receiving financial assistance when they required it and I upheld the complaint.

Remedy

The Authority apologised to the complainants for the failures I identified. They agreed to issue instructions that as soon as it is known that an appointment might change written advice to that effect is sent to all the staff concerned; and that these instructions should indicate how the impending change of appointment should affect their action in relation to patients' funds. They also agreed to review their procedures in regard to the extra benefit to ensure that when this cannot be given to the patient those caring for him when he is away from the hospital are aware that it can be requested by them.

5. HANDLING OF COMPLAINT UNDER THE CLINICAL COMPLAINTS PROCEDURE - W.244/86-87 - W.403/86-87

Matters considered

Delays in dealing with correspondence, arranging an independent professional review (IPR) and notifying the outcome - failure to communicate adequately to the complainant the results of the IPR.

Summary of case

On 10 August 1984 a woman complained to the Health Authority about the treatment she had received from a consultant orthopaedic surgeon (the consultant) but she was dissatisfied with the Authority's response of 24 January 1985. She therefore pursued her complaint through the Regional Health Authority (the RHA) and later requested an IPR, which took place on 9 December 1985. The Authority notified her of the outcome on 20 May 1986. The woman complained to me of excessive delay by the Authority in responding to her letter of 10 August 1984; by the RHA in arranging the IPR; and by both the Authority and the RHA in writing to notify her formally of the outcome of the IPR. The woman also complained that the Authority's letter of 20 May did not adequately reflect either the outcome of the IPR or the severity of her complaint.

Findings

I found that it took far too long for the Authority to reply to the letter of 10 August 1984; that there was an unacceptable delay before the two independent consultants, who carried out the IPR, submitted their report; and that there was then a further delay by the Authority in conveying to the complainant the outcome of the IPR. I did not uphold the remaining complaints. But I saw that the regional medical officer (the RMO) suggested to the Authority that their proposed concluding letter to the complainant, which summarised the outcome of the IPR should be discussed with the consultant. I fully accepted the RMO's assurance that this was intended as no more than a courtesy but I commented on the need to avoid in correspondence any suggestion that the consultant whose actions were the subject of a complaint might be able to amend the Authority's report of the findings of an IPR.

Remedy

The RHA and the Authority apologised for the shortcomings I identified.

6. ACTION TAKEN BY A HEALTH AUTHORITY FOLLOWING A REVERSED PLANNING DECISION - W.259/86-87

Matters considered

Planning procedures - action taken by the Health Authority following decision taken by local planning authority (LPA) - advice received by Authority.

Summary of case

The development control sub-committee of a city council decided on the casting vote of its chairman, who was also a member of the Health Authority, to support a proposal by the Authority to the change of use of a house to a home for six mentally handicapped young people. Following a complaint from a neighbour, an investigation by a Commissioner for Local Administration found that the sub-committee chairman should have declared his non-pecuniary interest as a member of the Authority and taken no part in the sub-committee's consideration

of the matter and that his failure to do so constituted maladministration. Consequently, just over a year after their original decision was taken, the sub-committee reconsidered the matter and formed the opinion that the house was not suitable for its proposed use. The LPA then asked the Authority to join them in referring the matter to the Secretary of State for the Environment (the procedure followed when a LPA objects to a proposed development by a health authority). However, after seeking the advice of the Department of Health and Social Security (DHSS), the Authority declined to do so as there was no provision in the relevant procedures for a LPA to change its mind after making a decision and it would not be in the Authority's interest to request a public enquiry. The neighbour complained that the Authority were acting wrongly in continuing to act in reliance on the LPA's original decision as in doing so they either had not taken into account, or had given insufficient weight to, the fact that the decision was tainted and was not therefore a proper basis for action.

Findings

I found that when the Authority learned of the Commissioner for Local Administration's findings and of the revised decision of the sub-committee their reaction was to seek legal advice on whether there was any provision for the sub-committee to change their decision. They were advised that there was not, and that advice was subsequently confirmed by the DHSS and indirectly by the Department of the Environment. The Authority therefore proceeded with their plans on the basis that they were entitled to rely on the original decision. I considered that neither the Authority nor, at that stage, the DHSS asked themselves, as I believe they should have done, whether the original decision was one on which the Authority could properly rely in the light of the finding that it had been tainted with maladministration. The DHSS subsequently recognised that there was a need to have regard to this aspect of the matter and advised the Authority accordingly. However the Authority persisted in their stance and I considered their conduct as maladministrative and upheld the complaint in this respect. During my investigation changes were made in the planning regulations which, the Authority were advised, meant that their modified proposals for the use of the house no longer constituted a development which they were required to submit to the scrutiny of the LPA. Therefore I could not regard the Authority's eventual decision to proceed with their proposals under the new planning regulations as having been taken with maladministration.

Remedy

In view of the changes in the planning regulations I considered that the only appropriate remedy would be an apology from the Authority in respect of the period during which they acted maladministratively but the Authority did not accept that their actions constituted maladministration and declined to offer an apology to the complainant. I therefore reported this matter to the Parliamentary Select Committee on the Parliamentary Commissioner for Administration.

7. CARE OF AN ELDERLY PATIENT IN HOSPITAL - W.265/86-87

Matters considered

Inadequate nursing care - arrangements for a post mortem examination - unsatisfactory handling of complaint by the Health Authority.

Summary of case

The complainant's elderly father was admitted to a ward of a local hospital with a history of unexplained falls at home for investigation of their cause. Three weeks later he was transferred to another ward for rehabilitation. But he developed diarrhoea, his condition deteriorated and he subsequently died. The complainant alleged that her father's nursing care was inadequate in that he was allowed to fall on the first ward and sustain a head injury; that because of poor liaison between the two wards on his transfer he was nursed on the second ward without cot sides; that treatment for his diarrhoea was delayed for a number of days; and that on one occasion he was expected to finish his supper although his pyjamas were soiled. The complainant also alleged that following her father's death a post mortem examination was carried out despite her expressed wish that one should not be undertaken. She further complained that the Authority's response to her complaint was inadequate in that they failed to explain fully the circumstances of her father's fall and did not respond in writing to the clinical aspects of her complaint.

Findings

I acknowledged that it can be difficult on a busy medical ward to supervise each patient closely all of the time. But given the reason for admission and the fact that I found the fall which gave rise to the complaint was the patient's second fall on the ward I considered that the nursing staff should have made greater efforts regarding the patient's safety. I accepted that the decision about the use of cot sides on the second ward involved the judgment of the nursing staff but I was not satisfied that all of the relevant information about the patient's falls on the first ward, about his head injury and about the use of cot sides was made available to staff on the second ward. I did not uphold the complaint about the alleged delay over treatment for diarrhoea but I criticised a senior house officer (the SHO) for misleading the complainant into believing that treatment had been prescribed but not given. I upheld the complaint about the supper incident. The decision to carry out a post mortem examination was made by a coroner whose actions are outside my jurisdiction. But I criticised the SHO for failing to inform the complainant that she had referred the case to the coroner and for relying on one of the coroner's officers to contact the complainant with the consequence that the complainant did not learn of the post mortem examination until she came to register her father's death. Finally I upheld both aspects of the complaint about the Authority's handling.

Remedy

The Authority apologised for the shortcomings I found and agreed to remind their nursing staff of the need to ensure that patients' specific needs are properly recorded in nursing care plans.

8. CARE OF A PATIENT AND HER BABY IN A MATERNITY UNIT - W.267/86-87

Matters considered

Inability to locate and rupture membranes - failure to sit with patient - failure of gas and air cylinder - inadequacy of foetal heart monitoring - failure by medical staff to examine placenta - unthoughtful action by sister.

Summary of case

The complainant was admitted to hospital with toxaemia of pregnancy. After the birth, which was induced, her baby was taken to a special care unit and was later attached to a ventilator. The baby was transferred to another hospital the following day and died several days later. The woman complained that after a house officer had failed to rupture her membrances there was a delay before a senior registrar arrived and that insufficient significance was then given to the failure to locate the membranes. She also complained that a midwife did not sit with her; that when she was given a gas and air mixture the cylinder did not operate and her husband had to assist in connecting a second cylinder; that she was given conflicting information about the extent of the foetal heart monitoring conducted in the delivery room and that the monitoring machines failed and one machine was operated by an inexperienced student nurse; that her placenta which was described by a midwife as 'not good' was not examined by a doctor; and that on the day of the birth a sister acted unthoughtfully in suggesting that she should be transferred to the ante-natal ward or alternatively that she should share a room with another mother and her baby.

Findings

I was satisfied that the senior registrar was given sufficient information on which to decide how urgently she needed to attend the complainant and I found that her decision on the relative priorities in attending different patients was taken solely in the exercise of her clinical judgment. I saw that the complainant was kept informed of the reasons for the delay and that suitable apologies were offered, but I criticised the doctors for not explaining clearly the management of her labour to her. I accepted that a midwife did not sit with the complainant during her labour and concluded that the complainant's expectations in this respect had been influenced by what she had understood from a previous tour of the maternity unit was the practice. Although I accepted that she was not left alone during her labour and that her condition was monitored regularly I found that the midwife had not communicated effectively with her. I found that hospital staff failed to notice that the gas and air cylinder was empty and I upheld this part of the complaint. I was not persuaded that it was inappropriate to enlist the husband's help with changing the cylinders or unreasonable that he should have been encouraged to give the mixture to his wife. I concluded that a misunderstanding may have arisen over the correct functioning of the foetal heart monitoring machines and I did not find that the monitoring in the delivery room was inadequate or that the Authority's response on this matter had been faulty; nor did I uphold the complaint that the student nurse had performed any procedures for which she had not been trained. However I criticised the way in which information about the complainant's delivery was recorded in her case notes. I was unable to comment on the extent and frequency of foetal monitoring carried out earlier since this involved decisions solely concerned with the exercise of clinical judgment. I did not criticise the midwife for disposing of the placenta after she had

examined it but to the extent that the Authority subsequently changed its policy on the examination of placentae I upheld the complaint. I did not find that the sister had acted unthoughtfully and did not uphold this part of the complaint.

Remedy

I was pleased to report that the Authority's midwifery staff had been instructed to ensure that expectant mothers were given a realistic description of the care they would receive following admission; that an exercise had been undertaken to evaluate the type of information given during the ante-natal period and how it is communicated; that midwifery staff have been reminded of the need for clear communication about monitoring equipment; that a procedure for monitoring the standard of record keeping has been introduced and that there are now organised training sessions in which the importance of good record keeping is emphasised; that revised instructions covering the histological examination of placentae has been incorporated into the hospital's midwifery policy document; and that there has been an increase in the number of single rooms available in the maternity unit. The Authority apologised for the shortcomings I found and expressed their deepest sympathy to the complainant and her husband for the loss of their baby daughter.

9. DISCHARGE ARRANGEMENTS MADE FOR DOMICILIARY CARE - W.286/86-87

Matters considered

Adequacy of arrangements made by the hospital for discharged patients' domiciliary care.

Summary of case

The complainant's elderly aunt, who lived alone, was discharged from hospital on a Friday, in considerable pain, with severe diarrhoea and unable to walk unaided. The complainant learned of her aunt's discharge the following day and when she visited her aunt's house she found her dead. While the complainant was at the house a district nurse telephoned and explained that she had intended to visit the aunt the following Monday. The complainant considered that such arrangements as were made by the hospital for her aunt's domiciliary care were inadequate.

Findings

I found the decision to discharge the complainant's aunt was taken in the exercise of clinical judgment. However, I was surprised that despite unsuccessful attempts by two senior nurses to persuade the complainant's aunt to remain in hospital over the weekend they subsequently failed to ensure that a member of her family was informed of her discharge and was willing to provide the support she needed at home. I also found that due to the absence from the nursing notes of important and relevant information about the patient's domestic circumstances, the ward sister failed to take account of all the relevant factors when she decided the kind of domiciliary care required. I upheld the complaint.

Remedy

The Health Authority apologised to the complainant for their shortcomings and assured me that in future all nursing staff would be made aware of the importance of completing nursing process documents to the required standard. The Authority also agreed to review their procedures for discharging patients towards the end of the week.

10. HANDLING OF A COMPLAINT BY A FAMILY PRACTITIONER COMMITTEE (FPC) - W.374/86-87

Matters considered

Misinterpretation of, and delay in dealing with complaint - inadequate responses - conduct of informal hearing - involvement of chairman of medical services committee (MSC) at the informal stage of complaints procedure.

Summary of case

A woman complained to an FPC about the actions of her family practitioner and a professor of general medicine and following an exchange of correspondence she attended a meeting arranged by the FPC under the informal procedure for reconciling disputes between patients and family doctors. She complained to me that the FPC failed to deal promptly with her complaint, misinterpreted the main substance of it and provided confusing and inadequate explanations. She also complained that at the meeting she was not given sufficient opportunity to state her case.

Findings

It was evident that the FPC did not identify the woman's real concerns in the early stages and that the responses and explanations they provided to her reflected misunderstandings. But against the FPC's interpretation of the complaint I did not find that, in general, their responses were confusing and inadequate. However, I did find that the time taken by the FPC to complete the informal procedure was unnecessarily long. And I believed that many of the difficulties which occurred could have been avoided, and the time taken to complete the informal procedure considerably reduced, if arrangements had been made for the woman to meet an administrator or lay member at an early stage to clarify her complaint and to agree on the most appropriate way to proceed. I did not uphold the complaint about the conduct of the meeting, but it seemed to me that the procedure adopted by the FPC in this respect was significantly more formal than that envisaged by the guidelines issued by DHSS and might have contributed to false expectations on the woman's part. I also regarded as inappropriate the FPC's practice of seeking the views of the MSC's chairman on new complaints, because, according to DHSS guidelines, members of the MSC should not be involved in any informal handling of complaints to avoid any suggestion of prejudice if later they have to deal with the complaint under the formal procedure. I recommended that the FPC reconsidered their practice in this respect.

Remedy

The FPC agreed to implement my recommendation, and they apologised for the shortcomings I identified.

11. ADMINISTRATION OF A WAITING LIST FOR INFERTILITY TREATMENT - W.376/86-87

Matters considered

Failure to ensure eligibility for treatment for inclusion on a waiting list - subsequent refusal to provide treatment despite lengthy period on waiting list.

Summary of case

A woman was accepted on a waiting list for possible in vitro fertilisation (IVF) treatment at a Health Authority's IVF unit (the unit). 15 months later, however, she learned that she was ineligible for treatment because her partner's 17 year old daughter was living with them. She and her partner complained that the Authority had failed to ensure that they were eligible before she was placed on the waiting list and that despite being on it for such a lengthy period the Authority had refused to provide treatment for her.

Findings

I found that when the woman was first referred for IVF treatment and accepted on the waiting list, she and her partner were ineligible under the unit's criteria then in force on two separate scores: first because her partner's daughter was living with them and secondly, because they lived outside the designated catchment area. I found, however, that there were serious shortcomings both in the Authority's procedures for ascertaining eligibility, and in applying such procedures as did then exist. I considered that the unit staff were particularly at fault for failing to discover shortly after the woman was first referred for possible treatment that she and her partner did not meet the childlessness criterion and thus correct the earlier error. It was also evident that a consultant who eventually decided that the woman should be removed from the waiting list, did so in the erroneous belief that the partner's daughter came to live with the couple only after they had been accepted on the waiting list. Judged against this background, I believed it was unfair to remove the couple from the waiting list when, through no fault of their own, they had waited for 15 months in the expectation that treatment could be provided. I therefore upheld the complaint and recommended that the couple be restored to the waiting list in the same position, so far as practicable, as they would have occupied if they had not been removed in the first place.

Remedy

The Authority apologised for the shortcomings I had found and told me that they had taken positive action to ensure that the eligibility criteria are know to potential patients and referring doctors at the outset. I was delighted to record the Authority's agreement to restore the couple to the waiting list.

2. CONSULTATION ABOUT A HOUSE FOR MENTALLY HANDICAPPED PEOPLE - W.416/86-87

Matters considered

Failure to consult residents before purchase - inadequate consideration by the Health Authority of residents' views - attitude of Authority's representative at a public meeting - Authority's failure to honour an assurance given at the meeting - inconsistent description of the level of handicap of prospective residents.

Summary of case

The Authority selected a house in a small cul-de-sac as a residential home for five mentally handicapped adults. The complainants, who live in the cul-de-sac, said that they first heard about the Authority's plans from another resident occupying a house on the immediate boundaries of the property in question who had received formal notification from the Local Planning Authority (LPA) about the Authority's proposal. The complainants and other residents objected to the proposal and a public meeting was held, attended by some 70 local residents and five representatives of the Authority. The complainants alleged to me that the Authority failed to consult local residents prior to commencing negotiations to purchase the house or before approaching the LPA; that the Authority gave inadequate consideration to residents' views on their proposal; that at the public meeting one of the Authority's representatives was arrogant and dismissive in his approach; that another of the Authority's officers gave an assurance to the meeting that there would be no appeal if the LPA objected to the proposal, but that this was later ignored; and that the Authority's description of the degree of mental handicap of the prospective residents was inconsistent with a stated need for constant 'awake' supervision.

Findings

The Authority argued that it was impractical and undesirable for them to consult the neighbours of every house they had under consideration before a definite decision to purchase was taken. I found this to be a reasonable and sensible approach and I did not uphold that aspect of the complaint. But I found that once a decision to purchase was made the Authority's policy at that time was that any communication with neighbours should follow the Authority's approach to the LPA and the LPA's notification to residents. I considered that practice ill-judged and likely to give rise, as it had in this case, to unneccessary fears and misapprehensions. I expressed some criticism of the way in which the Authority's representatives dealt with some of the views expressed at the public meeting but I did not find made out the complaint that the Authority gave inadequate consideration to the residents' views. I upheld the complaint about the attitude of one of the Authority's representatives at the meeting and I concluded that the complaint about the assurance was based on a genuine misunderstanding of what was said by the officer concerned. But I criticised her for giving a response capable of misinterpretation. I did not uphold the complaint about the inconsistency of the Authority's description of the degree of handicap of the prospective residents.

Remedy

I was pleased to learn that in view of their experience with this particular proposal and before I was approached by the complainants the Authority had decided to amend their policy so that neighbours are contacted and given comprehensive information as soon as an offer to purchase has been accepted. The Authority apologised to the complainants for the shortcomings I identified.

13. **HANDLING OF A COMPLAINT UNDER A FAMILY PRACTITIONER COMMITTEE'S (FPC) INFORMAL PROCEDURE - W.428/86-87**

Matters considered

FPC's handling of complaint.

Summary of case

The complainant had a back tooth crowned by her dentist who had previously told her that it would cost £30. When she came to pay for the crown she was told for the first time that the crown was gold and she was asked to pay £59. The complainant told me that she abhorred gold fillings and crowns and would not have agreed to the treatment had she known that a gold crown was to be fitted. The complainant complained to the FPC about the cost of the crown and that the dentist had not discussed with her the fitting of a gold crown before carrying out the treatment. The FPC's attempt to resolve the complaint informally extended over a 12 month period and involved more than 50 letters. The complainant complained that prior to the time when her complaint was eventually referred to the chairman of the FPC's dental service committee (the DSC) under the National Health Service (Service Committees and Tribunal) Regulations 1974, the FPC mishandled her complaint.

Findings

I found that the FPC understood the compainant's first letter as a straightforward enquiry about dental charges and dealt with it as such. But it was clear to me that, on any reading, the letter made clear her dissatisfaction with the treatment she had received. Moreover a letter she sent to the FPC two months later should have left no doubt that her major concern was the dentist's failure to discuss the gold crown with her. I recognised, however, that the FPC had doubts about whether the matters complained of could be dealt with through the formal procedure under the regulations, because matters such as attitudes and communication are not covered by a dentist's 'terms of service'. And I considered that it was partly for that reason that the FPC persisted for so long in attempting to deal with the matter informally. But in so far as this was a reason the FPC failed to explain the position to the complainant. I concluded that the FPC should have recognised at a much earlier stage that any hope of reconciling the patient/dentist relationship was a forlorn one, and the only way to make satisfactory progress was to refer the complaint to the DSC. I upheld the complaint. I also criticised the FPC's failure to give the complainant advice at any stage about the procedure for making complaints.

Remedy

The FPC acknowledged that the complaint should have been referred for formal investigation at an earlier stage. They also accepted that complaints should be monitored closely to ensure that the delay experienced by the complainant is not repeated, and apologised for the shortcomings I identified.

14. MANSLAUGHTER OF PATIENT AND BREAKING THE NEWS TO RELATIVES - W.468/86-87

Matters considered

Information about medication - supervision of psychiatric patients - notification of death of patient to relatives - breach of confidence - handling of complaint by Health Authority.

Summary of case

A woman was strangled by another patient in a psychiatric hospital ward one evening but her parents were not informed of her death until the early hours of the following morning when police officers called at their home. The parents complained that the Authority gave them misleading information about her medication, that patients on the ward were inadequately supervised, and that the Authority failed to inform them promptly of their daughter's death and breached confidence by disclosing details of her illness to the media. They also complained that the handling of their complaint by the Authority was dilatory and inadequate.

Findings

The medication assumed great importance in the complainants' minds when they were seeking to understand the circumstances of their daughter's death; the Authority failed to appreciate this and did not give them the full details of the drug regime as they should have done, and to that extent I upheld this complaint. The level of supervision on the ward was reduced from five or six staff during the day to only two during the evening, but the level of activity did not similarly reduce; I considered that the potential danger should have been apparent and that it was an error of judgment to allow this situation to continue for so long, and I upheld this complaint. The fact that the parents were in ignorance of their daughter's death until the early hours of the following morning without doubt added to their distress; although staff on the spot at the time were concerned at the delay, they believed they were forbidden by the police to give any information to the family and while I did not criticise them for obeying the police I did uphold the complaint to the extent that staff failed to press their concern at a more senior level where effective intervention might have been possible. I did not uphold the complaint about the breach of confidentiality, for while a serious and inexcusable breach undoubtedly occurred I was satisfied that this was the unauthorised act of one or more individuals for which I could not reasonably hold the Authority responsible. I upheld the complaint about the Authority's handling of the complaint in certain respects but in my opinion their faults were largely redeemed by their eventual thoroughness.

Remedy

The Authority asked me to convey their further apologies to the complainants, and they assured me that they would further review their nursing shift working arrangements, their procedures for liaison with the police - involving consultation with the two other Health Authorities within the area of that police force, with the aim of introducing common procedures - and the relevant part of their 'Press and Public Relations' policy.

15. DELAY IN AGREEING TO AN INDEPENDENT PROFESSIONAL REVIEW - W.558/86-87

Matters considered

Delay in agreeing that a complaint should be the subject of an independent professional review (IPR).

Summary of case

The complainant wrote to the regional medical officer (RMO) asking him to consider under the clinical complaints procedure a complaint about the care and treatment his late wife had received prior to her death. The regional postgraduate dean (RPD) considered the request on behalf of the RMO in accordance with the Regional Health Authority's usual practice but it was not until more than nine months later that the complainant was informed that there was to be an IPR. The complainant alleged that the delay in dealing with his complaint constituted maladministration.

Findings

I found that the RPD had contributed to the delay when he urged the complainant to take up the consultant's offer to discuss the matter, even though it was abundantly clear that the complainant had no interest in such a meeting. I found also that the consultant, who had been asked to proceed in accordance with the procedure, showed no disposition to do what was required of him and I criticised the RPD for allowing this situation to persist. I found that the Authority's own guidance on the submission of complaints under the procedure was too rigid an interpretation of the intentions of that procedure and I considered that the RPD should have involved the appropriate district general manager much sooner when the consultant would not co-operate.

Remedy

The Authority apologised for the shortcomings I had found. They also undertook to review their procedures to ensure that such delays do not occur in future.

16. CARE OF A MENTALLY HANDICAPPED YOUTH - W.575/86-87

Matters considered

Failure to administer medication - failure to report deteriorating condition to a doctor - failures in communication - failure to make entries in nursing records - delayed examination by doctor - doctor's reluctance to attend failure to take effective action - poor dental hygiene - unsatisfactory handling of complaint.

Summary of case

The complainant's son had been resident in a hospital for a number of years. When he was seen to be dribbling excessively and experiencing difficulty in swallowing he was seen by a doctor who diagnosed mouth ulcers, prescribed medication and asked for observations to be made. His condition deteriorated to the extent that he was referred to another hospital on the following day where he underwent surgery. The complainant believed that the prescribed medication had not been administered, that insufficient action was taken to investigate her son's deteriorating condition and that information about his condition was not properly recorded or conveyed to the night staff. She said that her son was not seen by a doctor on the second day until she complained to a nursing manager and even then the doctor was reluctant to attend to him. She complained that it was not until she persuaded the nursing manager to get a doctor to re-examine her son that he received any effective treatment. She believed that her son's infection had been caused by poor dental hygiene. She complained about inaccuracies in the Health Authority's replies both to herself and to her Member of Parliament and, also, about the way in which her complaint was handled.

Findings

I found that the prescribed medication had been administered, but that there had been serious failures in communication. I criticised the nurse in charge for his failure to inform other members of staff that the doctor had asked for observations to be carried out, for his failure to report the young man's deteriorating condition to the doctor, and for his failure to inform the night staff of that day's events. I also criticised nursing staff for their failure to write the nursing notes for the afternoon and early evening of the second day, until the following afternoon. I accepted that the nurse in charge on the second day had taken action to call a doctor prior to the complainant's visit to the nursing manager but upheld the complaint to the extent that a further breakdown in communication had occurred. I did not uphold the complaint that the doctor had to be persuaded to attend and although I established that no effective action was taken to administer drugs to the complainant's son, I did not find that this arose from any failure on the part of medical or nursing staff. I found that the Authority's replies contained some inaccuracies and I upheld to a limited extent the complaint about the way in which the Authority had handled her grievances.

Remedy

The Authority apologised unreservedly for the shortcomings I identified and assured me that all staff would be reminded of the need for, and importance of good communication and of the need for sufficiently comprehensive and timeous entries in nursing records. They also undertook to complete their review of dental hygiene in their long stay hospitals.

17. PATIENT IDENTIFICATION PROCEDURES - W.580/86-87

Matters considered

Patient identification procedures - confusion of medical records - notification of results of investigation - handling of complaint.

Summary of case

The complainant's stepfather underwent gastroscopy as an out-patient at a hospital, to which he was admitted a few weeks later after being examined at another hospital managed by the same Health Authority. He went home after three weeks and a consultant paid him a domiciliary visit. A few days afterwards he was re-admitted to hospital where he subsequently died. His stepson complained that the identity bracelet used during the gastroscopy bore the wrong surname; that after that examination, the hospital wrongly informed the family practitioner that the patient was not suffering from cancer; that the records of another patient were issued for use when his stepfather was first admitted to hospital and that the Authority wrongly claimed that he was confused at the time; that his identity bracelet showed the wrong date of birth and the error was not promptly corrected; that the consultant was given the records of another patient of similar name for his domiciliary visit; and that the Authority's investigation and replies to his complaints were dilatory and unsatisfactory.

Findings

I found that the wrong surname was shown on the first identity bracelet but that the results of the gastroscopy had been properly communicated to the family practitioner. I criticised the Authority for issuing the wrong medical records but I found that the suggestion that the patient was confused was based on medical evidence and I dismissed this complaint. I upheld the complaint that the wrong date of birth was shown on the second identity bracelet and I criticised the Authority for allowing the wrong set of medical records to be issued for the second time. I found that their handling of the complaint was dilatory and unsatisfactory, and I expressed my deep concern at their failure to ensure the full and prompt separation of the two patients' records.

Remedy

The Authority apologised for the shortcomings I had found and introduced warning labels to be affixed to records where a risk of confusion of identity was recognised. They also undertook to remind their staff of the importance of checking the identities of patients and their records.

18. THE ACCURACY OF A HEALTH AUTHORITY'S RESPONSE TO A COMPLAINT - W.627/86-87

Matters considered

Health Authority's response to queries raised by a former patient.

Summary of case

A woman complained that the reply she received from an Authority to questions she had raised about events following her confinement was inaccurate. She was dissatisfied with explanations about: (a) the actions of a midwife who had accompanied her when she was re-admitted to hospital; (b) whether or not she was given an episiotomy during a dilation and curettage operation (a D & C); and (c) about remarks which she later overheard a senior midwife make to other midwives.

Findings

Because of a conflict in evidence, I was unable to establish precisely how the midwife had reacted during the journey to the hospital, but in the light of the way in which this aspect was put to the Authority I did not criticise them for not dealing with it in more detail. However I considered that there was sufficient information available to the Authority from their own staff to cause them to pause before rejecting the woman's account of the midwife's behaviour out of hand and to that extent I upheld this aspect of the complaint. Although I found the woman was wrong in her belief that she had been given an episiotomy during the D & C I was not surprised that she could not accept the Authority's response in this regard as it was based, erroneously, on the supposition that her query related to her confinement rather than the D & C. I did not uphold the complaint about the overheard remarks by the senior midwife as I was satisfied that their purpose had been misinterpreted. I commented that in view of the numerous misunderstandings it was a pity that the woman had not accepted the Authority's offer of a meeting.

Remedy

The Authority apologised for the shortcomings I identified.

19. CARE AND DEATH OF A RESIDENT IN A PSYCHIATRIC HOSPITAL - W.663/86-87

Matters considered

Resident allowed to wander around hospital in soiled clothing - failure to recognise and treat gastric problems and weight loss - failure to inform next-of-kin of patient's deteriorating condition prior to death - unacceptable explanation of patient's injuries - delay in viewing body.

Summary of case

The complainant's brother was a resident in a psychiatric hospital. The complainant alleged that his sister had, on a number of occasions, found their brother wandering around the hospital with his clothes smothered in faeces. And, the complainant said, staff at the hospital failed to recognise and treat his brother's gastic problems and progressive weight loss about which his sister had expressed concern. The complainant alleged that he and his sister had not been informed of their brother's deteriorating condition and consequently they were not present when he died; that there was a delay before they were able to view their brother's body; and that injuries his brother had sustained prior to death were not consistent with the Health Authority's explanation of their cause.

Findings

I was satisfied from my investigation that nursing staff did not deliberately allow the complainant's brother to wander around in soiled clothing but I found that no additional precautions had been taken when he suffered from sickness and diarrhoea. I also considered that the complainant's sister did not receive a sufficiently satisfactory or sympathetic explanation from nursing staff in response to her complaints. I found that the brother's sickness and diarrhoea were reported to and investigated by medical staff whose conclusions resulted from the exercise of their clinical judgment. However I found that nursing staff failed to report the relatives' concerns about their brother's weight loss to senior nursing and medical staff, and did not keep medical staff fully informed of the problems the brother was experiencing. I was very concerned at the inadequacy of the brother's nursing and clinical notes and in particular about the loss of his weight records. The circumstances of his death caused me considerable disquiet. Despite a doctor's instruction to nursing staff to observe the man closely I found a failure to react positively to his deteriorating condition. On the evidence I could not exclude the possibility that a greater awareness and a more reactive approach by a charge nurse when the man was clearly more than a little unwell might have prolonged his life. I also found that nursing staff failed to notify the relatives of their brother's deteriorating condition. I found acceptable the Authority's explanation of the main injuries but I criticised the failure to inform the complainant and his sister about their brother's injuries before they viewed his body. The complainant believed that hospital staff deliberately delayed the viewing in the hope that those injuries would appear less severe but I was not persuaded that this was the staff's intention. Finally, I found that when they were informed of their brother's death the complainant and his sister were not given the option of viewing his body on the ward that evening.

Remedy

The Authority apologised for the shortcomings I found. They agreed to issue a reminder to nursing and medical staff about the importance of maintaining a proper standard of record keeping and another about the hospital's policy on notification to relatives of unwell patients and the need to follow this procedure. The Authority also agreed to issue to nursing staff instructions about the information to be provided to relatives of deceased patients on arrangements for viewing.

20. FAILURE TO PROVIDE BED FOR CARDIAC PATIENT - W.279/87-88

Matters considered

Provision of hospital bed after decision to admit a patient - transfer of patient to a hospital managed by another Health Authority - appropriateness of escort - failure of a casualty officer to communicate with relatives - inadequate handling of complaints.

Summary of case

The complainant's mother suffered from angina and was admitted to the accident and emergency (A and E) department by emergency ambulance. The Health Authority did not have a bed available in the hospital in which the A and E department was situated and approximately 30 minutes later the patient was transferred to a second hospital, (managed by another Authority), where she died shortly after arrival. Intensive care beds were available however in another of the first Authority's hospitals but the policy then in force did not envisage admission of coronary care patients to them.

Findings

I upheld the main complaint that the Authority had not provided for the situation which arose in this case but I found that the decision to transfer the patient to the second hospital was made solely in the exercise of clinical judgment which I could not question. I criticised the casualty officer concerned for failing to communicate with the relatives but found that the decision to send a nurse rather than a doctor to escort the patient was defensible. I did not uphold the complaint about the handling of the complaints.

Remedy

The Authority apologised for the shortcomings and undertook to review their procedures for improving communication with the ambulance service when beds are unavailable and for the management of bed allocation.

21. CARE OF AN ELDERLY PATIENT - SW.30/86-87

Matters considered

Failures in nursing care - incorrect prescription of drugs - misleading information given to relative - refusal of request for an independent professional review (IPR).

Summary of case

A 74 year old man was admitted to hospital with an irregular heart beat. His condition slowly deteriorated and he died three weeks later. His wife complained that he was forced to walk to the toilet although suffering from gout and in pain; that he was given incorrect medication; that he was left all night in a soiled bed, and that she was given misleading information when her husband was admitted. She also complained that the Health Board's chief administrative medical officer (the CAMO) did not give proper consideration to her request for an IPR of her husband's treatment.

Findings

I could find no positive evidence that the man was suffering from gout when he was walked to the toilet, and in any event medical staff assured me that his early mobilisation was more important than some discomfort. I found that the nursing staff were acting on instructions and in the man's best interests and I did not find this complaint made out. I found as a matter of fact that incorrect medication had been prescribed and given, although the medical opinions I obtained suggested that it had caused him no harm. I could not find any reason for this mistake; although I criticised the doctor concerned I concluded that it was an isolated human error. The man was found one morning to have stained his bed during the night, but I could find no evidence that the staining was substantial or that the nurses could reasonably have been aware of it and I did not find that he was deliberately left in a soiled bed. I considered that when the man was admitted his wife was inadvertently misled by being given an optimistic prognosis without any mention being made of the underlying serious problems which might affect her husband. It was my opinion that the CAMO's approach to the question of an IPR was at fault because he gave weight to considerations which I considered to be inappropriate. I found that he based his decision on his own views that the information which would be available to the independent consultants was inadequate, that the confusion over the medication had not been harmful and that even an IPR would not change the complainer's mind, all these considerations being matters for the independent consultants themselves to determine.

Remedy

The Board agreed to ask consultants to remind junior medical staff of the need to take care when giving information to patients' relatives and the CAMO agreed to reconsider the request for an IPR. The Board apologised to the complainer for the shortcomings I found.

22. **FAILURE TO CARRY OUT A HOSPITAL POST MORTEM EXAMINATION - SW.39/86-87**

Matters considered

Arrangements for delivering post mortem consent form to mortuary - premature release of body to undertakers - unsatisfactory explanations by the Health Board.

Summary of case

After the death of a baby the parents were anxious to know the cause of death and gave permission for a hospital post mortem examination to be carried out. Twelve days after the baby's funeral the parents were visited at home by a doctor and informed that the post mortem had not been carried out because of an administrative failure. The parents were not satisfied with the reasons given by the Board for this failure.

Findings

My investigation showed that the post mortem was not carried out because the consent form did not reach the mortuary until the morning of the funeral, having remained in the hospital's internal mail system for a day. I found that ward staff were not aware that the system was unsuitable for the transmission of urgent documents to the mortuary; that nursing and medical staff, who were aware that the form had not reached the mortuary, did not deal with the situation with sufficient urgency; and that the mortuary technician, who was aware that agreement had been given to a post mortem, failed to seek advice before releasing the body to undertakers. I upheld this complaint. I also found that the Board's handling of the complaint was flawed in so far as they did not involve two doctors who were known to the parents in providing explanations to them.

Remedy

The Board apologised for the shortcomings found. They had already introduced revised procedures relating to post mortem examination request forms which should prevent any similar situations arising in future.

23. INFORMAL HANDLING OF COMPLAINT ABOUT DENTAL CARE - SW.40/86-87

Matters considered

Health Board's use of informal complaints procedure - failure to advise complainer's right to formal procedure - delays in Board's response - failure to respond to complainer's questions.

Summary of case

A woman wrote to her Health Board about the quality of dentures supplied by her dentist. She was eventually refunded for these and obtained a new set of dentures from a different dentist. She complained that the Board treated the matter informally without reference to her and without informing her of her right to have it considered formally in accordance with the relevant Regulations. She also complained about delays in handling and about the Board's reluctance to answer direct questions put in her letters to them.

Findings

I did not criticise the Board's initial decision to seek an early resolution of the woman's problem using an informal procedure. However it was clear that they failed to advise her of this, or of the alternative formal procedure and her right to choose which method should be pursued. I found that the Board persisted with their informal procedure beyond the point where it became inappropriate and I agreed with the woman's view that had she not written to ask what was happening the delays would have been even longer. I also found that her specific questions were not answered.

Remedy

The Board apologised for the shortcomings identified and undertook to review their complaints procedures accordingly.

24. UNSATISFACTORY DISCHARGE ARRANGEMENTS - SW.82/86-87

Matters considered

Communication with relatives and between members of staff - suitability of patient's clothing - consideration given to domestic situation - arrangements for community support.

Summary of case

A man who was discharged from the surgical unit of a hospital was readmitted the following day to the hospital's geriatric unit. He subsequently died in hospital. His wife complained that she was given no warning of his discharge and that he arrived home wearing pyjamas, a dressing gown and slippers. She also complained that no arrangements were made for her to receive help from the community services in caring for her husband.

Findings

A ward sister was certain that she had informed the woman of her husband's impending discharge and that she had asked her if she could bring in outdoor clothing. However the woman insisted that the sister had never spoken to her. I considered that the evidence available to me provided an insufficient basis for a finding that the woman was not told the discharge was to take place. While I considered it desirable that patients should be discharged wearing outdoor clothing, I found nothing intrinsically wrong in a patient being discharged wearing pyjamas, dressing gown and slippers provided the patient was comfortable, warm and decently covered. In this instance the patient's son was content to take him home in his car without outdoor clothing. I found there was very little evidence of effective multi-disciplinary co-operation in respect of this patient's discharge and that due to failures in communication between staff no arrangement was made for the complainer to receive assistance from the community services. I upheld this part of the complaint. I was also critical of failures of the staff to record steps taken in respect of the man's discharge.

Remedy

The Health Board apologised for the shortcomings I found. They undertook to ensure that guidelines to be followed when discharging elderly patients would be brought to the attention of staff, and to advise nursing staff to record arrangements made regarding the discharge of patients.

25. ACQUISITION OF A HOUSE FOR MENTALLY HANDICAPPED PEOPLE - SW.83/86-87

Matters considered

Consultation with neighbours - account taken of residents' concerns - suitability of the property - method of selection.

Summary of case

A Health Board planned to change the use of a house to accommodate patients discharged from a hospital for the mentally handicapped, and they wrote to advise the immediate neighbours of their proposal and to invite their views. Written comments were received from neighbours and meetings were held with individual sets of neighbours before the Board proceeded with their plans. The neighbour whose semi-detached house adjoined the house in question complained, on behalf of himself and others, that the Board's decision was taken without adequate consultation with local residents and that the Board ignored their worries and adopted the stance that the scheme would go ahead whatever was said. He also complained that the Board did not give due consideration to the suitability of the property, but selected it purely on the grounds of administrative expediency as they already owned it.

Findings

I found that the Board appreciated the need to tell the neighbours of their plans for the house and were prepared to consider any objections raised. However the initial notification was inadequate in that it was restricted to only the immediate neighbours and contained little information. This approach left room for fears and speculation which, I suspected, prejudiced the Board's subsequent efforts at consultation. While I accepted that the Board were prepared to reconsider their scheme if valid objections were raised, I considered that they did not adequately convey this to the neighbours who were thus given the impression that the Board's attitude was inflexible and that they were faced with a fait accompli. I found that there was a pre-planned exercise to select a suitable property and that a number of houses were considered. It was true that the house in question was already managed by the Board, but so were several others which were considered but rejected as unsuitable. I concluded that administrative expediency was not a deciding factor in the selection of the house and I did not uphold this part of the complaint.

Remedy

The Board apologised for their shortcomings. They also agreed to review the consultative procedures to be adopted in any future projects of this kind.

HEALTH SERVICE COMMISSIONER

THIRD REPORT TO PARLIAMENT FOR SESSION 1987-88 HC

EPITOMES OF SELECTED CASES FOR

THE PERIOD APRIL - OCTOBER 1987

1. ADMISSION, TREATMENT AND SUPERVISION OF A MENTALLY ILL PATIENT. - W.490/85-86.

Matters considered

Failure to admit patient despite previous medical history - failure to heed warnings about the side-effects caused by the medication prescribed - inadequate level of supervision provided by the nursing staff.

Summary of case

After the complainant's son had in-patient psychiatric treatment and was discharged home he continued to take medication but again became depressed. The complainant alleged that when his wife tried to have their son readmitted for further treatment she was told that there were no beds available. But, when the son presented himself at the hospital he was admitted immediately. The complainant said that nursing staff ignored his wife's warnings that a drug prescribed for their son had previously caused him to suffer serious side-effects. The complainant and his wife alleged also that the inadequate level of supervision provided by the nursing staff enabled their son to take his own life while still a patient.

Findings

Although the initial decision not to admit the son was a clinical one the evidence persuaded me that the duty doctor was not in possession of the full facts when she made her decision and that had she been she might have come to a different conclusion. I was satisfied that the decision to prescribe a drug which had previously caused side-effects was taken solely in the exercise of clinical judgment, that the concern of the mother was not ignored and that the side effects were brought promptly to the attention of a doctor. I found that despite the consultant's initial assessment that the patient represented a suicide risk and required close nursing supervision, there was no reference to this risk in the nursing notes nor any evidence that the nursing staff were fully aware of the views of the clinical staff in this respect. I was therefore severely critical of that very serious failure in communication.

Remedy

The Authority apologised for the shortcomings and assured me that they would give urgent consideration to defining and promulgating the respective responsibilities of medical and nursing staff for the assessment of suicide risk and the determination of the appropriate nursing supervision and the communications required for that purpose. They undertook also to review the nurse staffing levels required on psychiatric wards.

2. ARRANGEMENTS FOR THE WITHDRAWAL OF ADDITIONAL HOURS OF BUSINESS PROVIDED BY A CHEMIST. - W.535/85-86.

Matters considered

The statutory basis for a Family Practitioner Committee's decision that a chemist should no longer be required to provide additional hours of business and the way in which the decision was taken.

Summary of case

For over 30 years the complainant contracted with the appropriate statutory authority to provide dispensing services outside the defined minimum hours of business. When another chemist opened a shop in the vicinity and offered to provide dispensing services during extended hours, the Family Practitioner Committee initially gave the complainant a week's notice that he was no longer required to provide additional hours of business but after representations were made, the implementation of the decision was deferred. The complainant told the Committee that their original decision to vary his obligations was inappropriate because contrary to his terms of service and the scheme for the provision of dispensing services, they had failed to consult the Local Pharmaceutical Committee (LPC) and to give him three months' notice of the change. Subsequently the Committee consulted the LPC and gave the complainant three months' notice of the change in his contractual obligations. Later the complainant drew the attention of the Committee to the view of the Secretary of the Pharmaceutical Services Negotiating Committee that it was not possible for the Committee to contract with a chemist to provide dispensing services outside the defined normal business hours and that if the arrangement with him was terminated, the Committee could not guarantee a dispensing service in the district. The Committee considered that there was nothing to preclude a chemist entering into a contract with them which included hours of business over and above the minimum hours of business stipulated by the Committee.

Findings

I considered that the discontinuance of the complainant's obligations to provide additional hours of business did not constitute a change in the Committee's scheme for the provision of dispensing services or an alteration of the complainant's terms of service. I concluded that the complainant was therefore incorrect in his contention that the provisions of the statutory regulations dealing with these matters should have been observed when discontinuing the arrangements with him but I criticised the Committee's original decision to withdraw the arrangement with the complainant at short notice and without consulting the LPC. I formed the view that under the terms of their scheme for the provision of dispensing services the Committee could not enforce against any chemist any agreement to provide services outside the minimum hours defined by the Committee, except in so far as it related to additional hours specified in their scheme and appropriate payment was made. However as it was possible that a complaint might lead to a ruling on this issue by the Committee's pharmaceutical service committee or by the Secretary of State on appeal, I decided that it would be wrong for me to make a finding on the issue.

Remedy

The Committee asked me to convey to the complainant their apologies for the shortcomings I found. Furthermore they assured me that they will not refrain from submitting their view on the enforceability of additional hours of business to the test of the service committee procedure should the occasion arise.

3. PROBLEMS ARISING FOLLOWING THE ADMISSION OF AN ELDERLY PATIENT FACED WITH SUDDEN AND EXTREME DIFFICULTIES IN SPEAKING. - W.577/85-86.

Matters considered

Release of house keys to relatives - charges for taxi visits home - unnecessary loan of hospital bed - inadequate discharge arrangements - unsatisfactory handling of complaint by Health Authority.

Summary of case

Following a road traffic accident the complainant's 84 year old brother was admitted to hospital with head injuries and a fractured femur. Three months later the medical staff responsible for his care decided that although he had suffered some brain damage affecting his ability to communicate, it was appropriate to consider his discharge home where he lived alone. Six months elapsed however before that discharge was effected. The complainant, who was herself elderly and lived 100 miles from her brother's home, complained that on his admission to hospital staff refused to release his house keys to either herself as next-of-kin or her daughter to enable them to attend to the immediate security of the house, with the result that the social services department of her brother's local authority had to undertake this task under Section 48 of the National Assistance Act 1948. She also complained that her brother was charged, without prior consultation, for taxis used to take him on regular visits home as part of his rehabilitation programme; that on discharge he was loaned a bed which, on delivery, he refused to accept but for the conveyance of which he was nonetheless charged; that hospital staff failed to keep her informed about plans for her brother's discharge and mistakenly believed there was a lack of agreement among the family about the place of discharge; that the family were given insufficient time to finance the repair and refurbishing of his house before he was discharged; and that the Authority's response to her complaints was inadequate and inaccurate.

Findings

I could find no corroborative evidence to support the complainant's claim that she requested the keys but I was persuaded on the balance of probability that within 24 hours of the accident the complainant's daughter and her husband asked for them during a visit to the hospital and that their request was refused. The hospital staff were aware that the complainant was the next-of-kin and lived some distance away and I considered that if there was doubt about releasing the keys to another relative the hospital should at the very least have established the complainant's wishes by telephone. I accepted that if the family had been able to use the keys to gain early access to the property, social services involvement might not have been necessary. I found that the charges for taxis should have been met by NHS funds as an expense properly incurred in connection with the man's treatment. My enquiries about the bed showed that the relevant action was taken by medical social workers based at the hospital but because they were employed by the local authority their actions were outside my jurisdiction. As to the discharge arrangements I found that the complainant's daughter was adequately informed of the hospital's proposals and advised her mother to the degree she thought necessary. But I found that there was confusion among hospital staff about the family's views as to the place of discharge. I also found that the family's perception of the work required on the house differed from that of the consultant concerned. I concluded that his perception of the patient's needs at home, which he conveyed to the complainant's daughter, stemmed solely from the exercise of his clinical judgment which I could not question. Finally I found that the Authority's investigation of the complaints was superficial and delayed.

Remedy

The Authority apologised for the shortcomings I identified. They also agreed to reimburse the complainant's brother for the cost of the taxis used in transporting him home.

4. SEXUAL CONTACT BETWEEN PSYCHIATRIC PATIENTS. - W.626/85-86.

Matters considered

Failure to safeguard female patient - failure to inform parents promptly of incident - failure to notify police - examination of patient - attitudes of staff - refusal to release examination results - remarks made by administrator in response to complaint.

Summary of case

While she was an informal in-patient in a psychiatric unit a young woman had sexual contact with a male patient. Her father complained that both before and after the incident his daughter was inadequately protected from the male patient who, he had learned, had been molesting female staff and had a criminal record. He further complained that he was not informed of the incident until the following day although he had in fact telephoned the hospital on the evening in question. He said that as the hospital staff failed to call in the police and his daughter was bathed following the incident, an unimpeded examination by a police surgeon could not take place. The father was also aggrieved by subsequent events when, he said, he was given conflicting accounts of an examination given to his daughter; a second examination was unnecessarily delayed and reports of both were denied him; a staff nurse was rude and unhelpful; a consultant was rude and threatened to withdraw treatment; and an administrator made an unsubstantiated slur on his daughter's character by suggesting that she had consented to what had taken place.

Findings

Although it was clear from the evidence that the male patient had previously displayed unpredictable and disruptive behaviour and had been sexually threatening towards female patients and staff, it seemed that his behaviour had been improving and I found that by the time the incident took place it had been agreed that his supervision should be less restrictive. I did not believe that at the time in question the staff had any reason to anticipate that such an unfortunate incident was likely to occur, and I believed they were maintaining the level of observation of the woman which was considered appropriate. However I was concerned that the levels of observation in force at any given time were not recorded clearly in the patients' medical and nursing notes. Following the incident staff decided to inform the woman's parents, although not as a matter of urgency. I considered this was wrong as I felt that once it had been decided that the parents ought to be informed they should have been told at the earliest possible opportunity. As it was, the opportunity was missed when the father telephoned the hospital that evening. The staff involved apparently decided that the incident did not necessitate the police being called, their decision being largely influenced by the fact that the woman appeared to have suffered no injuries, did not appear distressed and apparently had indicated that what had taken place was with her consent. However it was recorded that both the woman and the male patient had told staff that anal intercourse had taken place and I considered that the staff dealing with the matter had failed to appreciate that, if true, this constituted a criminal offence. In my opinion the staff should therefore have referred the matter to the district administrator in accordance with DHSS guidance. It followed that until a decision on involving the police had been taken at a higher level the woman should not have been allowed to take a bath. I upheld complaints from the father about delay in transferring the woman to another ward following the incident and about the attitude of a staff nurse, who I found had made a particularly insensitive and unprofessional

remark. Finally I thought that the administrator dealing with the complaint was somewhat insensitive in stating in a letter to the father that the woman had told a doctor she had consented to the sexual act, without going on to refer to the doubts which existed about the woman's mental state at the time.

Remedy

The Health Authority apologised for the failures I identified and agreed to ensure that staff were aware of departmental guidelines for handling such incidents and to review procedures for calling in the police. They also agreed to advise staff of the need to ensure that levels of patient observation be clearly recorded.

5. THE RELEASE TO A DOCTOR OF INFORMATION ABOUT PATIENTS CONTEMPLATING OR ENGAGED IN CIVIL LEGAL PROCEEDINGS. - W.648/85-86 and C.405/86.

Matters considered

The refusal of a Health Authority to release to a doctor the records of patients treated in an accident and emergency (A and E) department of a hospital and the charging of the doctor for the provision of records of patients treated in other departments.

Summary of case

A retired consultant orthopaedic surgeon who provided medical reports on accident cases at the request of solicitors and insurance companies complained that contrary to circular HM(59)88 issued by the Ministry of Health in 1959, the Authority refused to allow him access to the records of patients treated in an A and E department and charged him for the supply of records of patients treated in other departments of the hospital. The Authority took the view that circular HM(59)88 required them to consult the appropriate consultant about the release of records and, in the case of A and E patients the consultant was of the opinion that as such records were only shorthand notes of a junior doctor's finding in an emergency situation, it was unwise to release them without further explanation which could be given if the patient's advisers requested a medical report from the appropriate consultant. As to charging for the supply of other records, the Authority required £5.75 for the supply of a patient's case notes and x-ray films irrespective of the numbers involved. The complainant asserted that circular HM(59)88 provided that no charge should be made for the supply of information of that nature unless substantial additional expenditure was incurred in providing it. The Authority considered that the time and materials involved in retrieving the records, interpreting, copying and posting them involved additional expenditure for which, in the light of the more rigorous approach to expenditure now prevalent in the NHS compared with the position when circular HM(59)88 was issued in 1959, they were entitled to seek some recompense.

Findings

I recognised that A and E records being made by junior doctors might not be as accurate or as comprehensive as they should be but I was also mindful that medical advisers like the complainant are chosen for their experience and expertise and I considered it unlikely that they would be misled if such records were

released to them, especially as it was open to the appropriate hospital consultant to add an explanatory note when the records were released. I found that the Authority were not justified in refusing to release the A and E records to a patient's authorised medical adviser. As to the making of a charge for the supply of information to the complainant it seemed to me that when circular HM(59)88 was issued, it must have been recognised that compliance with such requests would always involve some appreciable administrative costs, but the policy decision was that as a general rule a charge should not be made for the costs involved. I therefore concluded that the Authority's practice of making a standard charge of £5.75 was not in accordance with circular HM(59)88 and when I put this to the Authority, they told me that in future no charge would be made for this service unless there were appreciable additional administrative costs and that all outstanding accounts rendered to the complainant would be cancelled.

Investigation of the actions of the Department of Health and Social Security (DHSS)

As the complainant through his Member of Parliament had secured the views of the DHSS on his grievance, I also investigated in my capacity as Parliamentary Commissioner for Administration the actions of DHSS who told me that circular HM(59)88 left it to health authorities to determine what constituted significant additional expenditure incurred in the provision of such information and what charge, if any, should be made. I considered that by issuing circular HM(59)88 it was recognised that this was an issue on which a consistent national policy was desirable and that the DHSS had a responsibility for ensuring that the policy was followed. In response the DHSS told me that circular HM(59)88 did not seek to lay down rules but that their approach to the management of the NHS had evolved since that circular was issued and that new guidance would be issued to health authorities indicating that it would be for them to decide whether or not to levy a charge for the supply of such information.

Findings

I criticised the DHSS for not having explained their new approach much earlier.

Remedy

The Authority agreed to bring their policy on the release of A and E records in line with my recommendation. The DHSS told me that revised guidance will be issued shortly about patients engaged in legal proceedings. I recognised that the Authority, in common with other health authorities, will be at liberty to review their future practice in the matter in the light of the new guidance from the DHSS.

6. PROVISION BY THE HOSPITAL EYE SERVICE (HES) OF NHS CONTACT LENSES. - W.707/85-86.

Matters considered

Failure by the HES to provide patient with contact lenses under the NHS.

Summary of case

In 1972 and 1978 the complainant underwent operations at one hospital for the removal of cataracts from both eyes, after each of which he was provided

with a contact lens through the NHS. However, when he moved home and attended a second hospital in 1984 a consultant ophthalmic surgeon there refused to prescribe contact lenses under the NHS because in his view the complainant could wear spectacles. The complainant returned subsequently to the first hospital where he was provided with a form HES1 which he took to a local optician who supplied him with new contact lenses under the NHS, but told him that he should have the lenses checked 12 months later when the complainant would require another form HES1. However, when the complainant's family practitioner tried to arrange an appointment for him at a third hospital a consultant ophthalmologist there said that he could not accept the complainant as a contact lens patient. In subsequent correspondence the Health Authority explained that following a review of expenditure it had been decided to restrict ophthalmic services provided at the third hospital to those which could not be obtained through the general ophthalmic service (GOS). The complainant considered however that as the service which he required could not be obtained through the GOS the Authority had failed in its duty to provide a service which some other hospitals continued to provide.

Findings

I did not uphold the complaint that the Authority failed to provide a service which it was their function to provide, but I considered that there were shortcomings in the explanations given to the complainant.

Remedy

The Authority apologised for the shortcomings I identified.

7. FAILURES IN SPEECH THERAPY SERVICE. - W.783/85-86.

Matters considered

Delay before regular speech therapy treatment commenced - intermittent nature of treatment once started - aspects of treatment.

Summary of case

The complainants' 2½ year old son was referred to the Health Authority's speech therapy service (STS) because of severe communication difficulties. The parents complained about the delay in starting regular treatment; the lack of concern on the part of the Authority over this; and that before regular treatment started they received no advice on how to help their son. They further complained that after regular treatment commenced their son missed a number of appointments due to the Authority's failure to provide cover for absent staff. They also complained that they were not provided with a clear diagnosis or expert advice on their son's problems.

Findings

I found that absences through sick leave of the Authority's speech therapists and an inability because of limited resources to cover those absences were the main reasons why the boy's treatment was either delayed or interruped. However, I considered that the Authority gave due consideration to the STS's needs in

the allocation of their resources and I found no maladministration in this respect. And I did not consider that the Authority showed a lack of concern over the delayed treatment. I also found that the speech therapists' opinions over the boy's diagnosis and treatment stemmed from the exercise of their clinical judgment which I could not question. But to an extent I upheld the complaint that before regular therapy commenced a speech therapist who was first responsible for the boy's treatment, when supplying leaflets to the boy's parents on home exercises, failed to provide sufficiently clear explanations. I also upheld to a limited extent the complaint about the early treatment because the speech therapist's failure to maintain proper records led to the boy having to be reassessed and thus a short delay.

Remedy

The Authority apologised and implemented my recommendation that they should monitor records kept at their clinics to prevent a repetition of this incident.

8. AMBULANCE SERVICE TRANSPORT ARRANGEMENTS FOR A CANCER PATIENT. - W.7/86-87 and W.77/86-87.

Matters considered

Delays in transport home - handling of complaints by the Health Authority and the ambulance service.

Summary of case

The complainant's mother received periodic out-patient courses of chemotherapy and radiotherapy for cancer at a hospital between August 1983 and April 1985. Over that period she experienced difficulty with arrangements made by the ambulance service for transporting her to hospital. The complainant said that during one particular period at the end of March 1985 his mother's journeys home after treatment were delayed by up to four and a half hours even though mini-cabs were used. He was also dissatisfied with the Authority's handling of his complaint and with the time taken by the ambulance service to provide information to enable the Authority to reply to him.

Findings

I found that on five occasions during the week in question the complainant's elderly and frail mother experienced delays of between two and a half and four and a half hours from the time the ambulance service control was notified that she was ready for collection until her arrival home. These intolerable delays were the result of the then woefully inadequate manpower rostering system operated by the ambulance service. That system allowed shortages of ambulance crews to occur at times of known peak demand. When, as frequently happened, the ambulance service was unable to cope at peak periods the services of a local mini-cab company were used. But on the days in question between one hour 20 minutes and three hours elapsed before instructions were sent to the mini-cab company to collect the complainant's mother and other patients. And I found that such delays were by no means unusual. By the time of my investigation the rostering arrangements had been revised to provide more

personnel at critical periods, but I criticised the ambulance service for allowing an obviously deficient system to persist for so long. I shared the complainant's view that he was entitled to expect a response from the Authority's chairman when he had written to him personally expressing dissatisfaction with the way his Authority's officers had dealt with the complaint. I also found that the ambulance service's response to the Authority's request for information was delayed.

Remedy

The ambulance service and the Authority apologised for the shortcomings I found. They also agreed to monitor and review the level of service provided to patients like the complainant's mother to ensure that all possible steps were taken to minimise delays.

9. DELAY IN RESPONDING TO A COMPLAINT. - W.15/86-87 and W.220/86-87.

Matters considered

Delay in meeting with consultant - an unsatisfactory meeting - handling of complaint by the Health Authority and the Regional Health Authority (the RHA).

Summary of complaint

The complainant's 89 year old mother was discharged from a hospital to the old people's home where she lived following a four week admission under the care of an ear, nose and throat (ENT) consultant. The next morning she fell at the home and was taken to the hospital's accident and emergency (A and E) department complaining of a painful back and, according to the complainant, with blood around her mouth. She was examined and discharged back to the home. Later she was found to be haemorrhaging, returned to the A and E department and was admitted to the hospital where she died later that night. The post mortem examination gave the cause of death as a ruptured aneurysm. Shortly after her mother's death, the complainant alleged to the Authority that if the aneurysm had been detected at the first attendance at the A and E department her mother would have been admitted then and her death might have been prevented. The complainant met the ENT consultant two weeks after making her complaint but had to wait a further seven weeks before she met the A and E consultant whose department was central to her complaint. She also complained that at the latter meeting the A and E consultant was unfamiliar with her mother's case history, unresponsive to her concerns and unhelpful; that the records of her mother's first A and E attendance were not available at the meeting; and that on her first attendance her mother's previous clinical records were not obtained, and that a discharge letter was incorrectly addressed. She further complained that the Authority's response to her complaint was inaccurate and inadequate and that the RHA, to whom she also complained, failed to reply.

Findings

My investigation revealed a sorry tale of maladministration on the part of the Authority in failing to respond fully and promptly to the complaint. I accepted that the A and E consultant could not meet the complainant without seeing the

patient's clinical records, but I considered that nine weeks was an unreasonable and insensitive delay and that greater priority should have been given to arranging the meeting when the records were found. I did not uphold the complaint that the A and E consultant was unfamiliar with the patient's case history but I considered that she should have adopted a more sensitive and sympathetic attitude towards the complainant when they met. I did not uphold the complaint about the absence of the A and E records at the meeting. The decision of the doctor in the A and E department not to call for the patient's previous clinical records when she first attended there was taken in the exercise of clinical judgement on which I may not comment, but I upheld the complaint about the discharge letter. I found that the complainant had to wait 22 weeks for the Authority's response to her original complaint made through her solicitor and that the long-delayed reply did not answer all her concerns. I found the delay unacceptable and that it should not have been necessary for the complainant to enlist the help of solicitors in order to elicit a response from the Authority. The RHA confirmed that they had received and acknowledged the complainant's letter of complaint and admitted that due to the absence of a system for monitoring correspondence they had failed to reply.

Remedy

The Authority and the RHA apologised for the shortcomings I found. The Authority agreed to impress upon staff the need to address discharge letters correctly and to remind staff of the necessity to observe procedures for recording the movement of clinical records. They agreed also both to review their procedures for dealing with complaints to ensure that future complaints are handled thoroughly and expeditiously and to make an act-of-grace payment to cover the legal expenses incurred by the complainant in pursuing her complaints with the Authority.

10 DISCHARGE OF AN ELDERLY PATIENT FROM HOSPITAL LATE AT NIGHT. - W.26/86-87.

Matters considered

Decision to discharge at an unreasonable hour - failure to take account of patient's home circumstances.

Summary of case

An elderly woman was referred to hospital because her family practitioner (the FP) believed she might need surgical treatment and she arrived at about 4.30 to 5.00 pm. She was seen by a surgical senior house officer (the SHO) and subsequently examined by a surgical registrar who decided that she should be discharged. At 10.38 pm an ambulance was ordered to take her home but it did not arrive at the hospital until 12.14 am. The woman's niece complained that the decision to discharge her aunt in the early hours was unreasonable and that in doing so the hospital staff failed both to take account of her aunt's home circumstances and to arrange adequate support for her.

Findings

I accepted that the decision that the woman did not need in-patient treatment and could be discharged was taken solely in the exercise of the registrar's clinical judgment. However, I saw no evidence that, despite the lateness of

the hour; active consideration had been given to her admission for social reasons even though there was a written hospital policy to that effect. I expressed surprise that although the SHO believed that the woman required a geriatric rather than a surgical referral he had not at the time requested a geriatric assessment and I concluded that when the nursing staff became aware that the ambulance would be delayed they should have told the SHO to enable him to make other arrangements. I found that the hospital failed to take account of the woman's home circumstances and to arrange adequate support when they discharged her. My investigation revealed that the social service support on which the SHO said he had relied in sending the woman home was not, in fact, available to her and I found it unsatisfactory that the community night nursing service was not alerted to the discharge and that the FP was not informed that she had been returned to his care. I therefore upheld the complaints.

Remedy

The Health Authority apologised and agreed to review their guidance about the discharge of patients, particularly those in need of support, and issue instructions to prevent similar failures occurring again.

11. INADEQUATE CARE OF AN ELDERLY PATIENT ON TRANSFER TO A NEWLY UPGRADED WARD. W.104/86-87.

Matters considered

Unsatisfactory conditions on the upgraded ward - inadequate nursing care on transfer - failure in communication between wards and staff involved in the transfer.

Summary of case

After 12 days in hospital the complainant's elderly mother was transferred to a newly upgraded ward where she died four days later of broncho-pneumonia. The son complained that the upgraded ward was not ready to receive patients in that heating and lighting levels were inadequate and there was no bedding available. He also complained that the standard of nursing care on the upgraded ward was unsatisfactory in that only two nurses were on duty; his mother was kept out of bed with inadequate covering for several hours; her temperature and pulse were not monitored; her liquid intake/output was not recorded; and that there was a failure in communication about the unsatisfactory conditions on the upgraded ward.

Findings

I found that the Health Authority's arrangements for opening the upgraded ward were loose and flawed and that consequently the complainant's mother and other elderly patients had been caused considerable inconvenience and discomfort when they were moved on a particularly cold winter's day to a newly upgraded ward which was wholly unprepared to receive them. I found that there was no bedding available, that the heating was totally inadequate and that the elderly patients were left sitting out of bed with inadequate covering for many hours. I also found that at times there were insufficient nursing staff available to look after the patients and deal with the problems encountered that day, and that

there was a failure to communicate the seriousness of the situation to senior officers and to other wards and staff involved. I was unable to establish the frequency of the observations made on the complainant's mother that day because the hospital had destroyed the relevant records, but given the circumstances on the day, I considered it unlikely that the fluid balance chart had been maintained. I did not uphold the complaint about the lighting.

Remedy

I was pleased to report that the Authority had already introduced new procedures for ward reopenings and had spent a substantial sum on additional bedding. The Authority apologised for the shortcomings I found. They also agreed to review their procedure about the disposal of transitory records in cases where a complaint had been lodged and reference to them might be helpful.

12. DISCHARGE ARRANGEMENTS FOR AN ELDERLY PATIENT. - W.114/86-87.

Matters considered

Inadequate notice of discharge - failure to ensure that patient could gain access to her home - patient's condition on discharge.

Summary of case

The complainant's 81 year old mother, who lived alone in an upstairs flat, was admitted to hospital following a fall at home. Three weeks later the complainant was informed of the possibility that her mother might be discharged and was asked to telephone the ward at a stated time the next day. Before that time, however, the complainant received a telephone call at work from the hospital informing her that her mother was on the way home by ambulance. She explained that there was nobody at her mother's flat and that the ambulance would inevitably arrive before she could. When the daughter got there she found that the ambulance had called and returned her mother to hospital because the ambulance crew had been unable to gain access. Her mother finally arrived home in a very distressed state. Three days later she was admitted to another hospital in a confused state. The daughter considered that her mother was discharged home without adequate notice to the family, that her mother's return journey to the hospital could have been avoided and that she was sent home with a pressure sore and in such a condition that she could not admit nursing and social services staff to care for her.

Findings

I found that the notice of discharge was wholly inadequate and that the way the decision was conveyed to the complainant was unsatisfactory and led to her mother's unnecessary return to hospital. I also found that the Health Authority gave the complainant misleading information about the sequence of events at the time of her mother's discharge. I concluded that the decision to discharge the patient, taken by the consultant responsible for her care, was made in the exercise of his clinical judgment and was outside my jurisdiction but that his decision was reached on the incorrect assumption that proper arrangements had been made for the patient's domiciliary care. I criticised his failure to make positive enquiries to confirm both that that was the case and that she would be able to manage at home, which, in the event, she could not do. I

also found that although the nursing staff were concerned that the mother's condition made her unsuitable for discharge they failed to express that concern to the consultant or to senior nursing staff. And I found that the district nursing service was not informed of the discharge until 24 hours after the event and that consequently the mother had no nursing care during that period. These failures caused me considerable disquiet.

Remedy

The Health Authority apologised for the shortcomings I identified. They agreed to carry out a thorough review of their discharge arrangements and related instructions to staff, and to review the way their senior staff investigated complaints involving nursing staff.

13. TRANSFER OF MEDICAL RECORDS BETWEEN FAMILY PRACTITIONER COMMITTEES. - C.571/86 and W.159/86-87 and W.411/86-87.

Matters considered

Serious and unnecessary delay in the transfer of medical records - failure to give a satisfactory explanation for the delay.

Summary of case

In April 1985 the complainant and her husband moved from the area of one family practitioner committee (the first FPC) to that of another (the second FPC). They registered with a local family doctor on 24 April but their medical records were not transferred until early October. They learned that the transfer had been effected through the National Health Service Central Register (the CR). The complainant alleged that the delay in transferring her records prevented her from making an early decision about alternative treatment available to her. She was also dissatisfied with the explanations for the delay given by the fist and second FPCs and the CR.

Findings

Given the drawbacks of the manual system of transfer which was then in use I was persuaded that the times taken by CR and the first FPC were not wholly unreasonable and I did not uphold the complaints against them. But I did against the second FPC which acknowledged their own poor performance and the absence of a satisfactory explanation for their contribution to the delay. I found that the explanations given by the bodies taken together gave a reasonable and detailed account of the procedure used and the reasons why delay could occur. But the second FPC's response understated the time taken by them and I was not persuaded of the first FPC's estimate of the time taken by their staff. To that extent I upheld the complaint against both FPCs.

Remedy

I concluded that there was no reasonable prospect of a significant improvement in the average time taken until all FPC registeries were computerised, but the second FPC reported a significant improvement in response times as a result of computerisation of their registry and improved procedures. However the second FPC aplogised for the unnecessary delay caused by them in the transfer of the medical records in this case and both FPCs apologised for the failings in their responses to the complainant.

14. FAILURE TO ENSURE THE AVAILABILITY OF MEDICAL RECORDS AND TO REIMBURSE OUT OF POCKET EXPENDITURE. - W.281/86-87 and W.389/86-87.

Matters considered

Failure to ensure the availability of medical records before surgery - failure to reimburse expenses - handling of complaint

Summary of case

A Health Authority (the first Authority) accepted the referral by another Authority (the second Authority) of the complainant who required a coronary by-pass operation. The complainant alleged that the second Authority failed to send his medical records to the first Authority in time for his surgery with the result that it was postponed. He believed the second Authority should reimburse the expenses incurred by himself and his family in connection with his abortive admission to hospital. He also complained that the handling of his complaint by the second Authority was dilatory.

Findings

I found the second Authority had a procedure for ensuring that all relevant records were sent to other authorities but as a consultant's regular secretary was on holiday the angiogram, which was vital to the consultant surgeon in the first Authority, was not sent and I criticised the second Authority for their failure to ensure that this procedure worked effectively. However, I found that the absence of the angiogram was immediately noticed by the consultant surgeon but although he instructed his secretary to request it I found no positive evidence that the request was in fact made in advance of the complainant's planned operation and I believed that the first approach to the second Authority was made two days after the complainant's admission. I therefore considered the first Authority was responsible for the complainant's abortive admission and wasted expenditure and I recommended that they make an ex gratia payment to the complainant. I also found that there were inexcusable delays in the handling of the complaint by the second Authority.

Remedy

The first Authority agreed to reimburse the complainant and assured me that all requests for information from other authorities were now properly documented. The second Authority assured me that they would review their procedures and both Authorities asked me to convey their apologies to the complainant.

15. DELAY IN TREATING CHILD. - W.323/86-87.

Matters considered

Delay in examining child - procedures for the reception and initial assessment of patients in a casualty department - failure to review medical staffing of department in relation to mounting workload - handling of complaint by Health Authority.

Summary of case

A three year old girl who had fallen and hit her face on a stone step was taken by her parents to a hospital's casualty department. The parents, who were concerned that the child might have suffered a head injury, complained that although they gave the receptionist full details of her accident and subsequent condition and were assured that a doctor would come straightaway, no doctor or nurse attended to their daughter, or even spoke to them, for over an hour. They further complained that the Authority's reply to their complaint was inaccurate.

Findings

There was general agreement that the girl waited nearly an hour before being seen by a doctor. But at the time only one doctor was on duty, his colleague having gone off ill, and he had to deal with two major emergency cases before he could attend the girl. I was satisfied however, that he was informed both that she was awaiting attention and of a nurse's assessment of her condition. His decision as to the order in which he should attend to the patients awaiting treatment was, in my opinion, taken solely in the exercise of his clinical judgment and I could not question it. I found that a nurse spoke to the father within about half an hour of the family's arrival at the hospital and explained the reason for the delay to him. However several aspects of this complaint concerned me. The observations of the girl were made by a nurse passing the cubicle in which the girl was sitting on her mother's knee, whereas both the senior casualty officer in charge of the department and the deputy director of nursing services said in evidence that a nurse should have examined the child at the outset and spoken to her parents. It seemed to me that this would have been prudent action to take. Furthermore it seemed to me that if a patient's condition was not assessed on arrival by a qualified nurse an undue and unfair burden was placed on the casualty clerk who initially saw the patient. I also expressed concern that no attempt was apparently made to review the medical staffing situation in relation to the mounting workload after it was known that one of the doctors had gone off sick. I found that there were inaccuracies in the Authority's reply to the complaint due to inadequate investigations having been carried out.

Remedy

The Authority apologised to the complainants. They also agreed to review their procedures for the reception and initial assessment of patients arriving in the casualty department and for the investigation of complaints.

16. LOSS OF JEWELLERY. - W.325/86-87.

Matters considered

Loss of three rings belonging to a comatose patient.

Summary of case

After his wife suffered a stroke the complainant cared for her at home until his own state of health made this no longer possible and she was admitted to hospital where, nine months later, she suffered a further stroke which rendered her unconscious and she died within a few days. When visiting his wife shortly

after this stroke the complainant found that her wedding and engagement rings and an eternity ring, all of which he had seen her wearing earlier that day, were missing. He complained that the Health Authority failed to take reasonable steps to ensure the safe custody of his wife's rings following her stroke, to accept responsibility for their loss, and to provide a satisfactory response to his complaint.

Findings

As soon as the absence of the rings was reported a thorough investigation should have been instituted but this was not done. Given this failure by the Authority it was not to be expected that my own later investigation would lead to the discovery of the rings and it has not done so. Although, generally speaking, health authorities cannot be regarded as responsible for the loss of valuables which their patients choose to retain in their own possession, in my judgment this is not a universal rule and in the case of patients who - like the complainant's wife - become so incapacitated as to be unable to safeguard their valuables, there is some obligation on the health authority themselves to safeguard the articles. Initially of course there may well be more urgent priorities, in particular provision of the appropriate medical and nursing care, but once the immediate urgencies have receded health authority staff ought in my view as a matter of routine to enquire whether the patient has valuables and, if so, move them into safe custody. The possibility that in this case the rings were stolen by a member of the Authority's staff cannot be excluded, and given this possibility and the inadequacy of the enquiries made by the Authority which may have contributed to the failure to trace them, this was a case in which in my judgment the Authority should have made amends to the complainant for their loss. I upheld his complaints.

Remedy

The Authority had already, in the light of this case, taken steps to improve their procedures. They apologised for the shortcomings and agreed, following my report, to make an act of grace payment for the lost rings.

17. INCIDENTS RESULTING IN INJURY TO A PATIENT. - W.350/86-87.

Matters considered

Failure to foresee that a patient's behaviour could lead to injury to another patient - failure to take adequate preventitive measures to ensure that further injury was not caused - unsatisfactory staffing levels on ward.

Summary of case

The complainant's mother was injured when another patient stumbled and fell on top of her while she was asleep in bed. She was injured again some months later when the same patient pulled her off a toilet. The complainant believed that the other patient, whose erratic behaviour was well known, should not have been on a ward where most of the patients were very elderly. He also alleged that the hospital failed to move the other patient after the first incident and that his mother who was not independently mobile had been left on the toilet unattended when the second incident occurred. He alleged also that the number

of nursing staff on the ward was inadequate because it was only possible to provide basic care.

Findings

I found that the first incident was an accident which could not have been foreseen or prevented, and that the action taken subsequently by the ward staff was adequate. And I thought that the ward staff had no reason to suspect that the patient would interfere when the complainant's mother was left unattended on the toilet. I commended the ward staff for their prompt action following both incidents but I concluded that with existing staffing levels it was not possible for the ward team to provide a more comprehensive service to patients. To the extent that this made it difficult to ensure that the patient was not able to assault the complainant's mother I upheld the complaint.

Remedy

The Authority apologised for the distress caused by the incidents and assured me that they would continue to review nurse staffing levels at the hospital with regard to making improvements.

18. INSENSITIVE TREATMENT OF RELATIVES FOLLOWING A SUDDEN DEATH IN HOSPITAL. - W.398/86-87.

Matters considered

Nursing care on a coronary care unit - information given by nursing and medical staff to relatives in the absence of a diagnosis - insensitive treatment of close relatives following a sudden death - failure to explain adequately the cause of the sudden death - procedures for communicating results of post-mortem examination to relatives - complaints procedure.

Summary of case

The complainant's husband, aged 46, was admitted as an emergency to a coronary care unit (the CCU) on recurrence of severe abdominal pain for which no diagnosis had been made despite previous episodes of in-patient treatment. He was transferred that evening, still in pain, to a medical ward where further tests were planned but died suddenly 24 hours later before major tests had been undertaken and without a diagnosis having been confirmed. The complainant alleged that her husband was nursed in a cramped side room on the CCU which was used as a store-room and nursing staff failed to keep him warm; nursing staff on the ward failed to take her husband's condition seriously and could not tell her what tests and treatment he had received; and a junior doctor was unhelpful and abrupt. She was particularly distressed when, having been summoned to the hospital, a sister told her in the ward corridor about her husband's death and no doctor afterwards came to explain his death to her. She believed that he had had a massive heart attack but subsequentl learned from the certificate of cause of death that he had died as a result of an intestinal infarction and a strangulated congenital hernia. When later she separately met the two consultants involved with his care neither of them had his medical records nor could they answer her questions. She further complained that the Health Authority never gave her a full explanation about her husband's care and that their final response was also inaccurate.

Findings

I found that the alleged store-room was in fact a specialised single room containing essential equipment and supplies required by the patient's acute condition, but I upheld the complaint that nursing staff failed to keep him warm. I found no evidence that the nursing staff either withheld or gave inaccurate information, but I criticised them for their lack of sensitivity to the complainant's anxiety about her husband's severe pain when no diagnosis had been made. I did not find the complaint about the junior doctor's attitude made out. I upheld the complaint about the insensitive way the complainant was informed of her husband's death and I was very critical of the failure of a registrar and a junior doctor who attended her husband that night to see her and of the failure of the Authority to invite her back to the hospital at a later date to meet the registrar. I upheld the complaint about the failure to explain the cause of death but was pleased to note that following the complaint the Authority revised their procedures relating to notification of post-mortem examination reports. I found their handling of the complaint unsatisfactory, principally due to their failure to involve nursing staff at the outset and the lack of liaison between the unit and district headquarters and the absence of a designated officer at the unit.

Remedy

The Authority apologised for the shortcomings found and undertook to review their complaints procedure.

19. NURSING CARE AND COMMUNICATION. - SW.39/85-86 and SW.13/86-87.

Matters considered

Nursing care - cause of pressure sore - communication with complainer - examination of children at school - handling of complaint by Health Board and Central Legal Office (CLO).

Summary of case

A woman was an in-patient in hospital for three weeks while her daughter, who normally looked after her, and her daughter's family were on holiday. On her return home the community nurse found that she had developed a serious pressure sore. The woman's daughter complained that this serious sore had developed due to a lack of nursing care in hospital. Eventually the woman was admitted to a second hospital for treatment to her sore and while she was there she was in contact with scabies. As a result her daughter's children were examined at school by a nurse. The daughter complained that she was not informed that her children were to be examined at school and that they were embarrassed and humiliated by being singled out for this without warning. The daughter, both in person and through a solicitor, put her complaints to the Board, but she was dissatisfied with their response and she complained that subsequent letters sent by her solicitor were not answered.

Findings

It was acknowledged that during her stay in the first hospital the complainer's mother developed blisters behind both knees which subsequently burst, but I

believed that these were quickly noticed and appropriate action was taken to try to prevent the condition worsening. While I could not be sure what had caused the problem in the first place, it appeared that the most likely culprits were the wheelchair edge and the ambu-lift sling which was used to lift the patient in and out of bed. I was not persuaded that the sores arose due to a lack of nursing care. I was unable to resolve differences of view between the hospital nurses, who considered the sores were superficial at the time of the patient's discharge, and the community nurses, who subsequently found them to be severe. I was satisfied that the examination of the complainer's children in school was carried out in a discreet manner designed to avoid causing them embarrassment. It had been decided that the complainer should be informed of this in advance, but when it was found that she could not be contacted by telephone it was left that she would be told when she next visited her mother in hospital. In the event she did not do so until after the children had been examined. I considered that much more effort should have been made to contact the complainer. It also seemed to me that little, if any, thought was given to the possibility of seeing the children at home. I found that there was unnecessary delay in dealing with the complaint due to the CLO's failure to be specific about the information they required to enable a reply to be prepared and the Board's failure to supply information. And when the question of legal proceedings was subsequently raised the solicitor was left believing that he might still receive a response to his earlier letter setting out the complaint, although this was not the CLO's intention.

Remedy

The Board and the CLO apologised to the complainer for the failures I had identified and the Board agree to set down clear guidelines in respect of nurses and health visitors visiting children at home rather than examinations being carried out in schools as in this case.

20. COMMUNICATION WITH RELATIVES. - SW.83/85-86.

Matters considered

Information and explanations given to relatives - support offered to relatives at time of patient's death - procedures for collection of death certificate.

Summary of case

A man who had been in hospital several times during the summer of 1985 was readmitted in October 1985. He died there shortly afterwards and the post mortem revealed that he had died of cancer. His wife complained that she was not kept adequately informed about his condition and care during his final stay in hospital; that the family were not warned of his declining condition shortly before his death; that after his death no-one spoke to the relatives to offer support or explanations; that the death certificate was handed to the family in a public place and by a man they took to be a van driver; and that despite meeting with doctors she had never had an explanation of her husband's illness and cause of death.

Findings

The associate specialist responsible for the patient's care suspected that he had cancer, but had no histological evidence to confirm his diagnosis. He thought

that the consultant then responsible for the man's care had spoken to the relatives during previous admissions and he decided that until he had such evidence it would not be appropriate for him to seek to speak with the complainer, but I found that he gave insufficient thought to the concern of the relatives and I upheld the complaint. I found that the patient's condition, which was very poor but stable, had given no indication that his death was imminent until very shortly before it occurred, and therefore I did not uphold the complaint that the family were given insufficient warning. Although the ward sister spoke to the relatives after the patient's death and tried to console them, they did not feel they had received adequate support or explanations. I considered that the family should also have had the benefit of a discussion with a doctor, and, as I found that the house officer who should have spoken to them failed to do so, I upheld this complaint. I was satisfied that the death certificate was given to the relatives by a mortuary attendant. However I found that in doing so he failed to identify himself or indeed to tell the relatives that what he was giving them was the death certificate. I considered he should also have informed them that it was possible to speak to the pathologist, if required. As for the explanations given to the complainer, I did not uphold this complaint as I found that the Board arranged meetings promptly and that the clinicians involved provided as much information as they were able, but I commented that they were hampered in this by their lack of automatic access to the post mortem report prepared at the request of the Procurator Fiscal.

Remedy

The Board apologised to the complainer for the shortcomings I found and agreed to give consideration to the issue of revised instructions on the handing over of death certificates. I recommended that clinicians who are unable to explain adequately the cause of a patient's death to relatives in cases where a post mortem examination has been carried out at the request of the Procurator Fiscal, or who need information for clinical purposes, should approach the Fiscal and enquire if he is prepared to make any disclosure of the report.

21. COMMUNITY NURSING CARE OF ELDERLY PATIENT. - SW.9/86-87.

Matters considered

Adequacy of community nursing care - circulation of allegations against patient's husband - actions of a nursing officer - effect of increased number of nurses on continuity of care and communications - handling of complaint - attitude and remarks of a director of nursing services.

Summary of case

An elderly physically disabled woman suffering from senile dementia had been cared for at home by her husband with the help of the community nursing service for over 10 years. Her daughter complained that a change in the nursing regime led to a deterioration in care accompanied by the circulation of false allegations of lewd behaviour against her father. She maintained that the actions of a nursing officer (NO) were variously surreptitious, insensitive and unreasonable and that increased numbers of visiting nurses led to problems with her mother's catheter and ostomy appliance, made security and continuity of care impossible

and caused communication difficulties with the family practitioner. The daughter also complained that the investigation of these matters by a director of nursing services (DNS) was inadequate, that the DNS's attitude was inappropriate and that she made offensive remarks.

Findings

I found that the problems between the family and the community nurses stemmed mainly from a decision by the nurses that the woman's bathing should be limited to a bed bath. The disagreements between the family and the nurses over this led to breakdown of mutual trust and confidence and in turn to a decision that the woman should be visited by different teams of nurses. I did not uphold the daughter's complaints about nursing care, except for the unsettling effects on her elderly father of large numbers of different nurses visiting the house. I found that the DNS's inadequate investigation of the allegations against the father led to over-reaction on her part and caused unnecessary distress. I agreed that the NO acted thoughtlessly on one occasion, but I did not consider her behaviour insensitive. I criticised the DNS for lack of tact and insufficient acquaintance with the facts.

Remedy

The Board agreed to consider their recording system for nursing treatments and procedures, and apologised for the shortcomings identified.

22. LOSS OF VALUABLES IN HOSPITAL. - SW.18/86-87.

Matters considered

Circumstances of loss - procedures for safeguarding patients' property - Health Board's refusal to accept responsibility.

Summary of case

A woman who was about to undergo surgery was told that her four rings would have to be removed before she went to the operating theatre. As she had not been required to remove her rings on previous occasions when she underwent surgery she had not anticipated this. Her four rings were removed and placed in her locker drawer with her wrist watch. When she recovered from the anaesthetic following her operation she found she was wearing her watch, but only two of her rings. A search by staff failed to find the two missing rings. The woman complained of the Board's refusal to accept responsibility for the loss of the rings.

Findings

The woman was aware that valuables taken into hospital should be handed over for safe-keeping, but in the light of her previous experience she had not expected that she would have to remove her rings. I found considerable disagreement over the exact circumstances surrounding the removal of the rings, but there was no dispute that they were removed at the insistence of a staff nurse and

that they were placed in the locker drawer. In my view, once it was decided that the patient had to remove her rings responsibility fell on the hospital staff to ensure their safe-keeping while the patient was unable to look after them. This they failed to do. There was again some conflict of evidence about the return of the rings and, unfortunately, the nursing auxiliary who handed them back to the patient did not notice how many there were. She said she merely handed over what was in the drawer. Thus there remained some doubt as to whether the two rings went missing before or after being given back to the woman. However it was clear that the rings, whether two or four, were returned to the woman relatively soon after her return from theatre and at a time when she should not have been expected to look after them. From this, together with my finding that the staff were responsible for safeguarding the woman's valuables while she was unable to do so herself, I concluded that the Board should accept responsibility for the loss and should make financial recompense to the woman.

Remedy

The Board apologised for the shortcomings I identified and agreed to give urgent consideration to my recommendation about the provision of lockfast facilities at ward level. They assured me that a current review of procedures for safeguarding patients' property would be completed as quickly as possible. They also agreed that if the woman quantified her loss they would make an appropriate payment to her as an act of grace.

23. RESPONSIBILITY OF A HEALTH AUTHORITY FOR THE ACTIONS OF A GRANT-AIDED VOLUNTARY BODY. - WW.21/85-86.

Matters considered

Responsibility of a Health Authority for the actions of a body funded mainly by grant aid from the Authority - interpretation of agency.

Summary of case

The complainant was dissatisfied by certain actions of a voluntary body whose major source of income was in the form of grants from the Authority. He submitted his complaints to the Authority who replied that it would not be appropriate for them to investigate the complaints but said that the voluntary body had its own complaints procedure and that an investigation would be undertaken if a written complaint was submitted to that body. The complainant complained that the Authority failed to investigate his complaint against the voluntary body, which was an agent of the Authority.

Findings

I criticised the Authority for giving different responses at different times on the issue of whether it was appropriate for them to investigate the complaint, but to determine what their response should have been it was necessary to consider the relationship between the authority and the voluntary body. I established that the funding provided by the Authority to the voluntary body was derived from the exercise of powers conferred by section 23 of the National Health Service

Act 1977 which permits the Secretary of State to arrange with any person or body, including a voluntary organisation, for the provision of services. The exercise of those powers was delegated to the Authority and under the arrangements made by the Authority the voluntary body were providing "services under the Act" which it would otherwise have been for the Authority themselves to provide. I considered that in such circumstances the Authority could not relieve themselves of their responsibility for monitoring the provision of services by the voluntary body to see that they were of an adequate standard and in my view that responsibility included a duty to enquire as far as they were able into complaints about the services provided by the voluntary body. The Authority refused to accept my findings and conclusions and accordingly I reported the matter to the Select Committee on the Parliamentary Commissioner for Administration.