INVESTIGATIONS COMPLETED
APRIL - JULY 2002

PART 1 - SUMMARIES OF INVESTIGATIONS COMPLETED

HC 51-I

Investigations Completed

April - July 2002

1st REPORT – SESSION 2002-2003

Presented to Parliament Pursuant to Section 14(4)
Of the Health Service Commissioners Act 1993

Ordered by
The House of Commons
To be printed on
21 November 2002

HC 51-I London : The Stationery Office £?

Contents

		Page
Foreword •	Foreword by the Health Service Ombudsman	iii
Index •	Index to all Cases	v
Chapter 1 •	Hospital, Community Health and Ambulance Trusts	
	Short Reports of selected investigations	1
	Summaries of completed investigatons	14
Chapter 2 •	Family Health Service Practitioners and Health Authorities	
	Short Reports of selected investigations	19
	Summaries of completed investigatons	21

Foreword

Investigations completed between April and July 2002

I publish information about the investigations completed by my office to draw attention to themes and issues arising from them, and to tell the public about our work. This volume contains reports of 39 of the cases completed between 1st April and 31st July 2002. Among them are cases that illustrate two particular issues: the medical care of people with a mental illness, and the need for **independent** clinical advice to support those managing the NHS complaints procedure.

The more significant cases appear in the form of a short report; others appear as summaries of the matters investigated and the findings in each case. Of the 21 short reports, nine also appear in their full text version in a companion volume. They relate to matters that may be of particular interest, or complexity, or both.

The case reports also provide material for educational activities, for these accounts of patients' experience of health care, and the work of NHS staff, cover both good and poor practice, misunderstanding and explanation. The investigations completed covered a very wide range of services and specialties, and illustrate, again, themes which often characterise complaints about health care - failures in communication, failure to support and supervise the work of more junior staff and failures in essential nursing care. Previous investigation reports on these subjects, describing the consequences of such problems and the measures NHS organisations take to help put them right, can be found on the office's website (www.ombudsman.org.uk). These common themes also arise elsewhere: we shall be discussing cases to do with poor clinical record-keeping (E1888/00-01, on page 5) with staff at the National Patient Safety Agency, who are considering the same issue.

Care of people with a mental illness

Complaints about the care of people with a mental illness form an increasing proportion of the complaints investigated by my office. The cases reported here give some indication of the range of issues complained about: the care of a patient who killed herself while an in-patient (E2047/99-00 on page 14); the physical care of patients with a mental illness (E2390/00-01 and E109/00-01 on pages 9 and 14); and visitors' access to mental health units and the way complaints are handled when a problem arises (E1471/01-02 on page 14). In the light of these reports, and others that have gone before, I intend to raise the issue of medical care for people with a mental illness, and of managing complaints in this part of the health service with the National Patient Safety Agency and the Department of Health respectively.

The NHS complaints procedure

Three cases highlight the way in which conveners can make mistakes when handling requests for independent review panels. One of these (E.1615/01-02 on page 11) illustrates the need for independent clinical advice to support the complaints procedure.

Complainants rightly expect NHS staff, conveners and lay chairs to have access to independent clinical advice when considering a complaint. Selecting the right adviser - one who has, demonstrably, no connection with the matter complained about - is essential, as is making a record of the advice given, so that complainants may be sure that all the clinical issues they raise are covered in full.

Inevitably, a publication like this places emphasis on what happens when things go wrong, but it also reports on action taken to put things right. Several case reports describe changes in procedures and practices made as a result of investigating a patient's complaint.

I welcome readers' comments on the publication and on all aspects of the office's work: contact details are on the back cover.

Ann Abraham
Health Service Commissioner for England

November 2002

Index to all Cases

Region/SHA	Body subject to complaint	Main issues investigated	Page number[1]

Hospital, Community Health Service and Ambulance Service

• Eastern: Essex

E.1072/00-01	Southend Hospital NHS Trust	Diagnosis and monitoring in maternity services	1

• Eastern: Norfolk, Suffolk & Cambridgeshire

E.114/01-02	King's Lynn and Wisbech Hospitals NHS Trust	Management of waiting lists and communication	2

• London: London North East

E.745/01-02	Barts and The London NHS Trust	Complaint handling	2
E.1732/01-02	Barts and The London NHS Trust	Complaint handling	3
E.109/00-01	City & Hackney Community Services NHS Trust	Mental health care and independent review	14
E.2047/99-00	Forest Healthcare NHS Trust and Redbridge Healthcare NHS Trust	Referral and mental health care and treatment	14

• London: London North West

E.441/00-01	Chelsea and Westminster Healthcare NHS Trust	Junior staff	3
E.1471/01-02	Hillingdon Hospital NHS Trust	Visiting access	14
E.1951/00-01	St Mary's NHS Trust	Obstetric and gynaecological services and record-keeping	15

• London: London South East

E.209/00-01	Queen Elizabeth Hospital NHS Trust, Greenwich	Diagnosis	4
E.1888/00-01	Queen Elizabeth Hospital NHS Trust, Greenwich	Nursing care and record-keeping	5

[1]Page numbers refer to Part I. Full text versions of those cases where the case number is **bold** also appear in Part II.

• London: London South West

E. 2177/00-01	St George's Healthcare NHS Trust	Treatment and communication	15

• North West: Cumbria & Lancashire

E. 2132/99-00	Chorley and South Ribble NHS Trust	Communication	5

• North West: Greater Manchester

E.1917/00-01	Salford Royal Hospitals NHS Trust	Communication and complaint handling	8
E.82/01-02	South Manchester University Hospitals NHS Trust	Care, treatment and diagnosis	15
E. 215/00-01	South Manchester University Hospitals NHS Trust	Care, treatment, record-keeping, communication and complaint handling	6
E.420/00-01	Wigan and Bolton Health Authority and Bolton Hospitals NHS Trust	Continuing care	7

• Northern and Yorkshire: West Yorkshire

E.698/01-02	Calderdale and Huddersfield NHS Trust	Care and treatment	8
E.2390/00-01	Leeds Community and Mental Health Services Teaching NHS Trust	Care and treatment of physical illness on psychological ward	9

• South East: Hampshire & Isle of Wight

E.2446/00-01	North Hampshire Hospitals NHS Trust	Care, treatment and complaint handling	16

• South East: Leicestershire, Northamptonshire & Rutland

E.401/00-01	Northampton General Hospital NHS Trust	Diagnosis	10

• South East: Surrey & Sussex

E.2275/00-01	East Sussex Hospitals NHS Trust	Treatment and independent review	16
E.279/00-01	The Royal Surrey County Hospital NHS Trust	Care and treatment	16

• South East: Thames Valley

E.1433/01-02	Oxford Radcliffe Hospitals NHS Trust	Treatment and complaint handling	17

• South West: Avon, Gloucestershire & Wiltshire

E.670/00-01	The United Bristol Healthcare NHS Trust	Care and record-keeping	10

E.1375/00-01	Weston Area Healthcare NHS Trust	Ante-natal care	17

• South West: South West Peninsula

E.1763/99-00	Plymouth Primary Care Trust	Assessment for a wheelchair	12
E.1615/01-02	Westcountry Ambulance Services NHS Trust	Care, treament and complaint handling	11

• Trent: Nottinghamshire, Derby & Lincolnshire

E.387/99-00	Nottingham City Hospitals NHS Trust	Care and treatment in maternity services	12

• West Midlands: West Midlands Central

E.856/00-01	Sandwell and West Birmingham Hospitals NHS Trust	Medical cover	17

Family Health Service Practitioners and Health Authorities

• Eastern: Essex

E.166/01-02	A GP in the Essex Health Authority area	Care, treament and response to independent review	19

• Eastern: Norfolk, Suffolk & Cambridgeshire

E.1771/01-02	A GP in the former East Norfolk Health Authority area	Removal from GP list	19

• London: London North East

E.1831/01-02	A GP in the North East London Health Authority area	Removal from a GP list	21

• Northern and Yorkshire: West Yorkshire

E.894/01-02	A GP in the Bradford area and Bradford Health Authority	Communication and removal from a GP list	21

• South East: Surrey & Sussex

E.293/01-02	A dentist in the Surrey and Sussex Health Authority area	Treatment	21
E.2380/01-02	A GP in the West Sussex Health Authority area	Care and treatment	22
E.1096/01-02	West Sussex Health Authority	Complaint handling	22

• Trent: South Yorkshire

E.917/01-02	A GP in the Rotherham Health Authority area	Inapproprite behaviour	22

• Trent: Trent

E.1993/00-01	A GP in the Trent Health Authority area	Referral	20

Chapter 1 • Hospital, Community Health Service and Ambulance Trusts

Short Reports

Case No. E.1072/00-01

Failure to diagnose obstetric cholestasis; failure to monitor a woman and her unborn baby adequately

Complaint against
Southend Hospital NHS Trust

Summary of case
Mrs T, who was 34 weeks pregnant, was admitted to Southend Hospital in August 1999 with raised blood pressure, itching, sickness and high levels of protein in her urine. She had an ultrasound scan and was discharged the following day. A week later she was re-admitted with similar symptoms and was again discharged the following day. On 13 September Mrs T was admitted with raised blood pressure, headache, visual disturbance and protein in her urine. Blood tests and a foetal heart monitor reading (CTG) of her baby's heartbeat were taken. The next morning Mrs T was given medication for the high blood pressure. Her blood pressure was checked at 1.00pm and 8.00pm but no other monitoring of her, or her baby, was carried out. Mrs T went into labour at 9.00pm and gave birth to a son, but he died shortly afterwards. A consultant at another Trust, who subsequently studied Mrs T's records, told her that she had been suffering from obstetric cholestasis, a reversible liver condition specific to pregnancy. Mrs T complained that the Trust had failed to diagnose her condition and had not monitored her or her baby adequately.

Findings
The Ombudsman took advice from two independent clinical assessors. The Trust said that Mrs T's liver function tests had been normal and staff assumed that she was suffering from pre-eclampsia. The assessors said that that was reasonable, given Mrs T's symptoms of high blood pressure and proteinuria (protein present in urine). The assessors said that measurement of bile acids, if increased, would have indicated the presence of obstetric cholestasis, but this investigation was not then immediately available to all trust hospitals. The Ombudsman therefore did not uphold Mrs T's complaint that Trust staff had failed to diagnose her condition. The assessors made the point that in 1999 obstetric cholestasis was not widely understood among obstetricians, and a recent publication by one of the assessors had found that still to be the case. The Trust had since changed its policy and now would carry out bile acid tests. The Ombudsman's clinical adviser - an expert in metabolic conditions of the liver - advised that in making a diagnosis of obstetric cholestasis, it was also helpful to measure the level of gamma glutamyl transferase (GGT), a simple emzyme test available in all clinical biochemisty laboratories. With regard to Mrs T's complaint that she and her baby had not been monitored adequately, the assessors said that she should have been induced sooner in view of her symptoms of pre-eclampsia. If that had happened, closer monitoring of her and her baby would have taken place and foetal distress might have been picked up sooner.

Remedy
The Trust apologised to Mrs T and agreed to consider the possibility of measuring the GGT levels of patients with suspected obstetric cholestasis. The Trust also agreed to review its protocols on the management of patients with hypertension, suspected pre-eclampsia and severe hypertension in pregnancy.

Case No. E.114/01-02

Management of waiting lists and inadequate explanation of medical terminology

Complaint against

King's Lynn and Wisbech Hospitals NHS Trust

Summary of case

Mrs H was referred to a consultant dermatologist at the Trust by her GP in September 1999 as a result of a growth on her left thumb. The GP wrote in the referral letter that he suspected the growth was a squamous cell carcinoma (a form of skin cancer), although Mrs H was not aware of this. Mrs H saw the consultant dermatologist on 19 January 2000. On 14 April the consultant dermatologist attempted to remove the growth but found it extended too far for that procedure to be successful. He told Mrs H that he believed the growth to be malignant and that it was likely that the thumb would need to be amputated. On 19 April the consultant dermatologist confirmed that this was the case and he referred Mrs H to a consultant plastic surgeon at another Trust. This surgeon amputated Mrs H's thumb on 24 May. Mrs H complained about the delay in treatment between the initial consultation with the GP in September 1999 and the amputation of her thumb in May 2000. She also complained that she was not informed that the growth was malignant until April 2000.

Findings

The consultant dermatologist had given Mrs H a 'soon' appointment as a result of the GP's suspected diagnosis of squamous cell carcinoma. Although ordinarily this would have meant a wait of between four to six weeks, Mrs H had to wait 16 weeks for the first available appointment. There was a subsequent delay of 12 weeks until the consultant dermatologist attempted to excise the growth. The Ombudsman's independent clinical assessor advised that if Mrs H had received appropriate treatment sooner, the amputation of her thumb might have been avoided. The assessor identified three main areas of concern that had contributed to the delays. Firstly, the prioritisation of out-patient and surgery appointments: the assessor considered that it was unreasonable that there was no warning system in place to signal that a potentially serious delay had occurred after the GP's referral; the Ombudsman shared that concern. Second, the assessor concluded that in view of the size of the tumour at the January appointment, urgent surgery should have been performed. The Ombudsman criticised the consultant dermatologist's failure to ensure that this happened. Third, there were problems relating to the limited staffing resources within the dermatology department. While the Ombudsman acknowledged that the consultant dermatologist was working under severe pressure and had limited resources, he concluded that the Trust had failed to provide timely treatment for Mrs H and he upheld the complaint.

With regard to Mrs H's complaint that it was not until April 2000 that she was informed that the growth was malignant, and could therefore spread, the Ombudsman found that Mrs H was told at the appointment in January that the growth was cancerous. However, her understanding from that appointment was that the growth was 'not malignant' and that it would not spread. The Ombudsman concluded that some confusion must have arisen from the terminology used, and that Mrs H had not appreciated that the term 'cancerous' was synonymous with 'malignant'. The assessor confirmed that the risk of spread for the type of tumour that Mrs H had was very low. The Ombudsman therefore found it understandable that the consultant dermatologist wanted to reassure Mrs H. However, in view of the problems that Mrs H suffered subsequently, he concluded that the consultant dermatologist should have made sure at the outset that Mrs H fully understood the subtlety of his explanations. The complaint was upheld to that limited extent.

Remedy

The Trust agreed to take all necessary action to ensure that in future, sufficient warning systems are in place to avoid patients exceeding agreed waiting times. Furthermore, in recognition of the limited staffing resources of the dermatology department at the time, the Trust agreed to review and evaluate the current resources in line with national staffing guidelines.

Case No. E.745/01-02

Inadequate complaint handling

Complaint against

Barts and The London NHS Trust

Summary of the case

In March 2000 Mrs X received in-patient treatment for a fractured ankle at the Royal London Hospital, which is managed by the Trust. In May 2000 Mrs X complained about aspects of her care. She did not receive a response to her complaint until December. The response was inaccurate on several matters of fact and after further correspondence Mrs X remained dissatisfied and on 17 January 2001 asked for copies of her medical records. She was inaccurately informed by the Trust, in March, that she had made a request for an independent review that was out of time.

On 3 April Mrs X asked for an independent review of her complaints based on concerns about nursing care and about the Trust's previous responses to her complaint. The Trust's convener, who did not take clinical advice, turned down the request: the convener explained that she would be

investigating some matters herself so as to make recommendations to the Trust. Mrs X remained dissatisfied.

Findings

The chief executive in his response to the Ombudsman admitted that there had been an unacceptable delay in responding to Mrs X's initial complaint and that the investigation process into her complaint had taken a great deal of time. The Ombudsman agreed with those comments. The Ombudsman highlighted the fact that the convener had not taken clinical advice and he recommended that the Trust should draw its staff and conveners' attention to the recommendations in the statutory directions and guidance that govern complaint handling. The Ombudsman also felt that the Trust should review and if necessary amend its procedure with regard to misleading comments that suggested a complainant who was dissatisfied with the Trusts response to the complaint should meet with the staff involved in the complaint before being able to request an independent review panel. He upheld the complaint in respect of the shortcomings identified above.

Remedy

The Trust apologised for the shortcomings identified in the report and agreed to implement the changes that have been recommended by the Ombudsman.

Case No. E.1732/01-02

Inadequate complaint handling

Complaint against

Barts and The London NHS Trust

Summary of case

Mrs S complained to the Trust in January 2001 about aspects of her treatment at The Royal London Hospital. Mrs S was dissatisfied with the Trust's response and wrote to its chief executive on 29 May 2001, detailing her outstanding concerns. Despite Mrs S writing again to the Trust, in July, September, October and November, she did not receive a full reply. Mrs S subsequently died and Mrs C, a close friend, continued the complaint on her behalf. The Ombudsman decided to investigate the complaint in February 2002. The Trust finally sent Mrs C a full reply on 13 March.

Findings

The Ombudsman found that the Trust's delay in providing a full response to Mrs S's letter of 29 May 2001 was extreme and unreasonable. It was clear that much of the delay was caused by a consultant failing to provide promptly his comments, on which the final reply was based. However, the evidence suggested that other Trust staff took no action on Mrs S's letter between 6 June, when it was acknowledged, and 9 August, when it was sent to the consultant. The consultant provided his comments on 19 February 2002. The reason for his apparent reluctance to co-operate was not explained. While the Ombudsman commended the actions of administrative staff who tried to expedite the consultant's response, he was critical of the fact that senior management were not alerted to the problem at a much earlier stage. The Ombudsman was particularly concerned that Mrs S, and then Mrs C, continually had to prompt the Trust for information about progress. The Ombudsman upheld the complaint.

Remedy

The Ombudsman commented that over the last few years, the Trust's handling of complaints had been a frequent cause of complaints to him. Several of the Ombudsman's investigations had reported on the problems and after each one, the Trust had promised to improve matters. The Ombudsman remarked that this case illustrated that there was still some way to go. The Trust agreed to the Ombudsman's recommendation that it should continue to maintain efforts to improve its complaints handling and to monitor its performance in this area. It was planned that in the meantime, the Ombudsman's staff would discuss with the Trust the areas where improvements need to be made and its plan to put them into effect. The Trust also apologised to Mrs C for the shortcomings the Ombudsman had identified.

Case No. E.441/00-01

Over reliance on junior staff

Complaint against

Chelsea and Westminster Healthcare NHS Trust

Summary of case

In 1997, Mrs Y, who was 72 years of age, had an operation for a circulation problem in her right leg. She then regularly attended a consultant vascular surgeon's out-patient clinic. When Mrs Y reported swelling and pain in her leg on 3 February 1998, the consultant referred her for a lymphangiogram (X-ray examination of the lymphatic system) which was carried out on 5 March. Later that day she went to the A&E department where a senior registrar suggested that she should wear an elasticated stocking. On 16 March, Mrs Y was re-admitted to hospital and within days it became necessary to amputate her leg. Subsequently, she suffered abdominal problems, her condition deteriorated significantly and on 29 April, she was found to have a perforated gastric ulcer. She died in May. The Trust held a critical incident review, which led to some recommendations for improvement. However, Mrs Y's family remained dissatisfied that she had not been

monitored properly after her operation, that she should have been re-admitted to hospital earlier and that while there she was not adequately cared for.

Findings

The Ombudsman took advice from two independent clinical assessors. They advised that although there was no evidence to indicate that Mrs Y had not been monitored appropriately before 3 February, she should have been admitted to hospital that day for more appropriate investigations; the decision not to admit Mrs Y to hospital on 5 March was also inappropriate. The assessors were critical of the standard of record-keeping by the consultant and the senior registrar. The assessors considered that after her re-admission to hospital Mrs Y's nutritional state was not investigated or managed appropriately, and that there should have been further investigation of her symptoms of abdominal pain. On 28 April Mrs Y vomited faecal matter and the senior registrar requested investigations including an abdominal X-ray. Mrs Y was later reviewed by a second registrar, who diagnosed an intestinal obstruction and dehydration; he advised that Mrs Y should be rehydrated intravenously. Neither registrar reviewed Mrs Y again that day. However, the clinical assessors considered that Mrs Y's symptoms, and the abdominal X-ray, were suggestive of a perforated gastric ulcer, and that both registrars should have appreciated the severity of Mrs Y's condition. The Ombudsman found that in considering Mrs Y's clinical management subsequently, the Trust placed too much emphasis on communication failings and on the involvement of a junior doctor. The Ombudsman found that primary responsibility for Mrs Y's clinical management should have fallen upon the two registrars and the consultant, who was responsible for training all his junior staff.

Remedy

The Trust apologised to Mrs Y's family, and agreed to arrange an external review of the work of the consultant's team and to review training arrangements for junior doctors.

Case No. E.209/00-01

Inadequate diagnosis

Complaint against

Queen Elizabeth Hospital NHS Trust, Greenwich (formerly Greenwich Healthcare NHS Trust)

Summary of case

In January 1999 Mr N, who had been unwell for several weeks, collapsed and was admitted as an emergency to Greenwich District Hospital. A doctor in the A&E department suggested a provisional diagnosis of a pulmonary embolism. Mr N was admitted to a medical ward where he was prescribed heparin to help to prevent blood clots. Various tests were performed in order to try to identify the cause of his illness. However, no tests were performed to determine whether or not he had suffered a pulmonary embolism. After a month, Mr N was transferred to another ward and the heparin was discontinued. Mr N died in February. The subsequent post-mortem examination noted pulmonary embolism as the cause of death. Mr N's son, Mr Q, complained to the Trust and in September they requested an independent review (IR) to consider their complaint. It was held in January 2000 but he remained dissatisfied and Mr Q complained to the Ombudsman.

Findings

The Ombudsman upheld Mr Q's complaint that the Trust failed to investigate the possibility that his father had been suffering from a pulmonary embolism. The consultant responsible for Mr N's care said that he had believed that Mr N was suffering from an infection, and he had tried to establish the cause of that. He had not considered that Mr N might have had a pulmonary embolism because he had not known about, or seen, the suggested diagnosis of pulmonary embolism - despite the A&E notes being in Mr N's medical file. Similarly, the consultant had not been informed that Mr N had suffered from periods of breathlessness. The consultant confirmed that had he been made aware of the A&E records and all of Mr N's symptoms, then he might have made a different diagnosis. The Ombudsman's independent clinical assessors were concerned that the consultant had not been made aware of all Mr N's symptoms, and they concluded that if the possibility of a pulmonary embolism had been investigated, his death might have been prevented. The Ombudsman shared the assessors' concerns. Mr Q also complained that his father's heparin was stopped inappropriately and not resumed. The assessors advised the Ombudsman that the heparin had been prescribed appropriately on admission, as a preventative measure against the risk of thrombosis when Mr N was immobile. However, when he started mobilising it was reasonable to discontinue this. Furthermore when he was about to undergo a surgical procedure with an associated risk of bleeding, it would have been inadvisable to continue the heparin. After the surgery Mr N continued to mobilise and plans were made to discharge him. In these circumstances the assessors considered that it was correct not to restart the heparin. The Ombudsman accepted that advice and did not uphold the complaint.

Remedy

The Trust agreed to apologise to Mr Q for the shortcoming identified and agreed to implement the Ombudsman's recommendation that all clinical and nursing staff be reminded of the importance of reviewing and sharing all relevant clinical information. The Trust also agreed to the assessors' suggestion that it consider adopting the guidelines on prophylactic anticoagulation developed by the American College of Chest Physicians.

Case No. E.1888/00-01

Inadequate nursing care and failure to keep adequate nursing records

Complaint against

Queen Elizabeth Hospital NHS Trust (formerly Greenwich Healthcare NHS Trust)

Summary of case

In December 1999, Mrs P was transferred from the intensive care unit of Greenwich District Hospital to a medical ward. Mrs P had been diagnosed as terminally ill and had recently undergone a tracheostomy (an operation to create an additional opening in the airway) following respiratory failure. She was nursed in the ward until she died in December. Mrs P's son, Mr P, complained to the Trust about the nursing care provided to his mother, particularly that staff failed to assist with her toiletting needs, failed to prevent and treat her pressure sores adequately, and about a specific occasion when Mrs P had fallen. He also complained about the reliance on bank and agency nursing staff, as he felt that this had contributed to poor communication and record-keeping. Mr P was very dissatisfied with the Trust's handling of his complaints.

Findings

An independent clinical assessor provided advice on the nursing aspects of Mr P's complaints. The Ombudsman found that there was insufficient evidence that Mrs P was taken to the toilet and left unattended, or that staff had failed to respond when she requested a bedpan. However, there was evidence that Mrs P had been incontinent on one occasion and that staff had told her off for that. The Ombudsman said that that was unacceptable. The assessor advised the Ombudsman that Mrs P was at risk of developing pressure sores and he criticised the lack of an appropriate care plan and the delay in providing Mrs P with a pressure-relieving mattress. The Ombudsman agreed that more should have been done to prevent and manage Mrs P's pressure sores, and he upheld the complaint to that extent. The assessor accepted that there were severe staffing difficulties on the ward at the time of these events, compensated for by the use of bank and agency staff. However, he concluded that this situation was not conducive to good patient care or effective communication. The Ombudsman shared those concerns. Trust staff described Mrs P's alleged fall as a 'controlled incident'; staff had supported Mrs P as she stumbled, and then assisted her into a sitting position. The assessor concluded that there was no direct evidence that Mrs P fell. However, he was concerned the incident was not recorded. The Ombudsman found that there was confusion amongst nursing staff as to how and where this incident should have been recorded. He was also concerned that Mrs P's care plan was not revised to include manual handling and risk assessment. He upheld the complaint to the extent of the shortcomings identified. The assessor considered that the nursing documentation was woefully inadequate in terms of content, structure and documentation procedures. The Ombudsman agreed with this view and upheld the complaint. The chief executive accepted that the Trust had failed to investigate Mr P's complaints promptly and efficiently.

Remedy

The Trust agreed to consider what measures could be taken to reduce their reliance on bank and agency staff and what further action they might take to satisfy themselves that their nursing services, including those provided by bank and agency staff, are now effectively organised and managed. The Trust also agreed to review its policies on manual handling assessments and incident reporting and to make sure that all nursing staff, including bank and agency staff, understood these. The Trust agreed to undertake a full review of its nursing documentation procedures to ensure future compliance with relevant professional guidance. It also accepted the need to review and monitor its nurse training arrangements to make sure that both now, and in the future, the high standards of record-keeping expected of nurses is achieved.

Case No. E.2132/99-00

Lack of communication and consensus between a family and a clinical team about the meaning of palliative care

Complaint against

Chorley and South Ribble NHS Trust

Summary of case

Mr P, was admitted to Chorley and South Ribble District General Hospital for urgent treatment after he started to bleed from his bowel. He had been diagnosed as terminally ill five months earlier, and was admitted on a number of previous occasions and had treatment for heart failure and stroke. Mr P's family were closely involved in his care. In the months before this admission, Mr P and his family had a series of meetings with one of the consultants responsible for his treatment, and decided how his condition should be managed in the last weeks of his life. The understanding of Mr P and his family was that he was to be made comfortable and that interventions should be aimed at relieving, rather than attempting to cure, presenting symptoms. There was a

specific discussion between the clinical team and Mr P and his family before the decision that he was not to be resuscitated when further deterioration occurred. In the periods when his consultant was not available, Mr P's illness was managed by a registrar, and Mr P's daughters became concerned by what they felt to be attempts by the registrar to provide Mr P with rehabilitative treatments. During his last admission, Mr P's daughters' confusion and distress about the basis of their father's treatment increased. They were concerned that there was no agreed treatment plan; that no consensus about the meaning of palliative care was established, resulting in inappropriate treatment; that arrangements for consultant cover were inadequate during the admission; and that Mr P was not given adequate pain relief, particularly in the last days of his life. Mr P died in the hospital two weeks after his admission.

Findings

The Ombudsman found that, despite the intervention of the complaints manager several months before Mr P's admission, no agreed treatment plan was documented or implemented. The Trust acknowledged that many of the subsequent problems arose as a result of this omission. He upheld this aspect of the complaint. He also noted that the lack of communication with the family about what constituted palliative care further eroded their confidence in Mr P's treatment. However, he considered that some of the treatments implemented by the Trust and contested by Mr P's family were appropriate, including mobilising Mr P, inserting a naso-gastric tube, and attempting to adjust his pain-relieving medication to maintain an optimal balance of consciousness and pain relief. He found that no inappropriate clinical care was given. The Ombudsman did not uphold the complaint relating to consultant cover.

Remedy

Following Mr P's family's complaints, the Trust established a working party to develop and implement improved policies and practice in areas including communication with carers and the decision not to resuscitate. The registrar (whose clinical judgement was not criticised) attended re-training in communication skills. The Ombudsman endorsed these measures and commended the Trust for its positive response to the issued raised in the family's complaints.

Case No. E.215/00-01

Poor care and treatment, record-keeping, communication and complaint handling

Complaint against

South Manchester University Hospitals NHS Trust

Summary of case

Professor F was admitted to his local hospital following a serious fall at home in which he suffered severe facial lacerations. The next day he was transferred to Withington Hospital for maxillofacial surgery. This was successful but after the operation tests were carried out, the results of which led the medical team to conclude that there was no evidence at this stage that Professor F had had a myocardial infarction (heart attack) or a cardiac event. He continued to suffer respiratory distress, although this was found to have improved by the following day. That evening, Professor F was found to be unresponsive and a 'cardiac arrest call' was put out. However, when the team arrived Professor F was breathing spontaneously and was taking oxygen. No referral was made at this time to a chest physician. Five days later Professor F's oxygen saturation had fallen and a respiratory physician was asked to see him. Following that consultation, he was transferred to another hospital. Professor F's breathing difficulties worsened and he died ten days later. Professor F's family complained about a range of issues related to his medical and nursing care and treatment in the first week of his admission to Withington Hospital, including; the late intervention of a chest physician; oxygen not being properly administered; and the failure to administer drugs. The family also complained about the problems they had identifying the consultant physician in charge; that communication between nursing and medical staff was inadequate; and that the handling of the complaint was inadequate.

Findings

The Ombudsman found that the care and treatment provided to Professor F in Withington Hospital fell below an acceptable standard. Fluid balances had not been properly recorded and there was an unreasonable delay in referring Professor F to a chest physician. He also found that communication between the medical staff, the family and other staff within the Trust was poor, and many such communications were not indicated in the records. The records were also poor in respect of oxygen administration. Medication was not properly administered, and was not offered in an alternative form when Professor F was unable to take it orally. The Trust also acknowledged that there had been considerable delays at every stage of their handling of the complaint. The Ombudsman upheld the complaint in its entirety.

Remedy

The Trust accepted the Ombudsman's findings and recommendations and undertook to improve procedures in the areas identified as inadequate. In particular the Trust undertook to review its policies on multi-specialty care of patients and communication with patients and relatives, to ensure that the ambiguity surrounding responsibility for Professor F's care and treatment would not recur. The Trust also agreed to ensure that its revised record-keeping and medication policies reflected the Ombudsman's criticisms of its management of Professor F's illness.

Case No. E.420/00-01

Continuing care and eligibility criteria

Complaint against

Wigan and Bolton Health Authority and Bolton Hospitals NHS Trust

Summary of case

Mrs T had suffered several strokes as a result of which she had no speech or comprehension. She was paralysed on her right side, required feeding by a tube into the stomach, and was doubly incontinent . Mrs T was discharged from the Trust's stroke unit to a nursing home in another health authority's area (the second authority) in May 2000, so as to be near to her son. Using the Health Authority's criteria, Trust staff assessed Mrs T's eligibility for NHS funding of continuing in-patient care, and concluded that she was not eligible. Mrs T's nursing home care was therefore privately funded. Her son raised concerns with Trust staff about their assessment. He considered that the Authority's decision not to fund his mother's care was inequitable, as an assessment by the second authority said that she *would* have been eligible for funding under the criteria they used. Despite requests for his mother's eligibility to be reviewed, the Authority's decision remained the same. Mrs T's son remained dissatisfied. (Mrs T died during the course of the investigation.)

Findings

NHS policy provides a national framework for assessing eligibility for NHS-funded continuing care. The framework allows that the exact assessment criteria used may vary between health authorities, to account for local circumstances. The fact that different judgements were made about Mrs T's eligibility by two different authorities is not necessarily evidence of maladministration or failure to provide a service. The Ombudsman found that the Authority's criteria reflected the national criteria in most respects, with an emphasis on the need for care to be provided under the direction of a consultant. In practice, the Ombudsman found that the need for consultant input was the sole criterion applied by the consultant concerned, despite national guidance that eligibility criteria should not be applied rigidly so as to exclude other cases. The consultant's interpretation was not surprising given the wording of the Authority's policy and the lack of detailed guidance on its interpretation. Of even greater concern was the lack of any evidence that, in developing and applying their policy, the Authority had adequately taken into account the implications of the Coughlan[1] judgment and the new national guidance in 1999 which followed it. There was no evidence of any positive action in that direction until February 2001, when a letter was sent to trusts on the subject. Even then, the Authority did not seem to have reviewed the policy thoroughly or to have reconsidered Mrs T's case. The NHS guidance on dealing with applications for review of decisions about continuing care gave authorities the right not to convene a panel if the patient fell well outside the eligibility criteria. In Mrs T's case the chairman of the panel declined to convene a panel for that reason. The Ombudsman found that conclusion surprising in the light of Mrs T's disabilities and the fact that the chairman was aware that the second authority had a different view. Mrs T was extremely dependent and required a high level of physical care. The Ombudsman could not see that any authority could reasonably conclude that her need for nursing care was merely incidental or ancillary to the provision of accommodation or of a nature one could expect Social Services to provide. Like Miss Coughlan, she needed 'services of a wholly different kind'. He said that if the Authority had had a reasonable policy, and applied it appropriately, they would have provided NHS care for Mrs T. They failed to provide a service which it was their function to provide. The Ombudsman upheld the complaint against the Authority.

The Ombudsman held the Trust responsible only for their assessment against the criteria they were given. The Ombudsman's clinical assessors said that the Trust staff carried out an appropriate assessment of Mrs T's needs, based on the policy and guidelines provided to them by the Authority. However there was a misunderstanding between the Trust and the Authority about the significance of some of Mrs T's needs. Based on that advice the Ombudsman upheld the complaint about the Trust only to the extent that Trust staff should have sought appropriate advice if they were unsure about how to interpret the guidance provided by the Authority.

Remedy

The Trust agreed to remind staff responsible for carrying out such assessments to record the basis of their decisions clearly in the medical records; and to clarify who was party

[1] **The Coughlan judgment**

Regina v North and East Devon Health Authority, Ex parte Coughlan
Court of Appeal 16 July 1999

Nursing care for a chronically sick patient could, in appropriate cases, be provided by a local authority as a social service, rather than by the NHS, and the patient could, depending on his means, be liable to meet the cost of that care. However, if the needs of the patient were primarily health needs, the health authority was as a matter of law responsible.

to the decision about eligibility for funding. By the time of the report the Authority no longer existed. Greater Manchester Health Authority and the Trust, in conjunction with the new Primary Care Trust (PCT), agreed to ensure that Mrs T's estate was left no worse off than it would have been had the NHS funded her nursing home care. The new Authority also agreed to review, with its associated PCT and local authority colleagues, the eligibility criteria for funding continuing care in operation since April 1996 to ensure that they were (and are) in line with the Coughlan judgement and other relevant guidance. The new Authority agreed, in conjunction with its PCT and local authority colleagues, to establish the feasibility of determining whether there were any other patients who were wrongly refused funding for continuing care, identifying them and making the necessary arrangements for reimbursing the costs they incurred.

Case No. E.1917/00-01

Inadequate communication; poor complaints handling

Complaint against
Salford Royal Hospitals NHS Trust

Summary of case

Mr E was referred to a consultant spinal surgeon at the Trust following a history of chronic back problems. After various tests and investigations, the spinal surgeon decided to schedule an operation to replace one of the discs in Mr E's spine. Before the operation Mr E developed varicose veins and saw a consultant vascular surgeon at his local hospital, who recommended surgery to remove the varicose veins. Mr E wrote to the spinal surgeon to inform him of the proposed vascular surgery; the spinal surgeon replied advising that Mr E's spinal surgery should be postponed until at least six months after the vascular surgery, because of an increased risk of deep venous thrombosis. Mr E complained to his local hospital that the vascular surgeon had not warned him of this risk despite knowing that he was to undergo spinal surgery. However, the vascular surgeon disagreed that there was an increased risk in Mr E's case, and he wrote to the spinal surgeon asking the him to justify his view. The spinal surgeon subsequently wrote a two-sentence letter to Mr E cancelling his proposed surgery. Mr E then complained to the Trust about the lack of explanations from the spinal surgeon. Mr E was dissatisfied with the local resolution process and requested an independent review. In considering the request, in consultation with an independent lay chairman, the associate convener felt that the complaint did not have any clinical elements and therefore made the decision not to take independent clinical advice, before declining to establish an independent review.

Findings

The spinal surgeon acknowledged that his letter cancelling surgery had been inadequate, although he stood by the decision that he had taken not to operate. Both the spinal surgeon and the vascular surgeon accepted that the other's assessment of the risk involved had validity, even if they did not necessarily agree on all issues. The Ombudsman took advice from two independent professional assessors, a vascular surgeon and a spinal surgeon, who provided explanations of the clinical context in which the decisions about Mr E's surgery were taken. The Ombudsman observed that this explanation should have been provided to Mr E by the Trust and, therefore, upheld this aspect of the complaint. On the matter of the failure of the associate convener to take independent clinical advice, the chief executive did accept, in his formal response to the statement of complaint, that the associate convener should have taken appropriate advice. The associate convener however, did not accept this and said at interview that he would take the same decision again in a similar case. The Ombudsman upheld this complaint and was very critical of the associate convener. The Ombudsman was concerned that failure to take appropriate clinical advice appeared to be a pattern among the Trust's associate conveners as during the investigation, other cases where the Ombudsman had upheld complaints involving other associate conveners had come to light.

Remedy

The Ombudsman noted with approval that the Trust was, at the time of the investigation, in the process of designing information leaflets for patients being considered for spinal surgery. He recommended that the process be expedited. The Ombudsman also recommend that the spinal surgeon ensured that in future, full explanations about proposed surgery are provided to, and discussed with, patients. Furthermore, the Ombudsman recommended that where priority of surgical procedures is an issue, that the consultants involved liaise with each other to ensure that the patient benefits from a joint approach and consistent explanations. He also recommended that all of the associate conveners in the Trust attend an appropriate training course, and invited the Trust to consider whether the associate convener in this case should continue to consider independent review requests in the interim.

Case No. E.698/01-02

Delay in being seen by a specialist

Complaint against
Calderdale and Huddersfield NHS Trust

Summary of case

Mrs X's mother, Mrs Y, was diagnosed with diverticulitis (inflammation of a protrusion of the large intestine) in 1998.

In April 2000 she was suffering from constipation and when laxatives failed to help, her GP referred her to a consultant surgeon at the Trust. An appointment was made for her to see the consultant in his clinic on 12 July. On 30 June Mrs Y's condition deteriorated and she was admitted as an emergency to Halifax General Infirmary, which is managed by the Trust. It was planned that she would have a barium enema on 5 July to identify the cause of a suspected bowel obstruction. On 4 July she was given Picolax (a laxative designed for bowel clearance prior to gastric investigations) and four to five hours later vomited a dark brown fluid. Her condition deteriorated and she died on 6 July. The cause of her death was recorded as peritonitis (inflammation of the membrane lining the abdomen and pelvic cavities). Mrs X complained to the Trust on 20 November. She remained dissatisfied with the outcome of local resolution on the basis that the Trust's letters contained conflicting information. She sought an independent review but that was refused on 1 May 2001.

Findings

The Ombudsman found that Mrs Y had been referred to the consultant following a visit to her GP on 15 June. The GP described Mrs Y's symptoms and asked the consultant to reassess her; he did not mark the referral as 'urgent'. This resulted in an out-patient appointment being made for Mrs Y for four weeks later. In fact Mrs Y was admitted to hospital before the date of the out-patient appointment. The Ombudsman took advice from two independent clinical assessors who advised him that a period of four weeks between referral and appointment is acceptable for a referral not indicated as being urgent. Therefore, the Ombudsman did not uphold that aspect of the complaint. The Ombudsman did uphold the complaint that Mrs Y's care and treatment following her emergency admission was inappropriate. He found that Mrs Y's management was unsatisfactory in several respects. Mrs Y was admitted to hospital on a Friday under the care of an on-call consultant surgeon and was not reviewed by the consultant until the following Monday morning, when he referred he to the consultant surgeon. Although she was apparently seen by a doctor over the weekend, that doctor did not make an entry in the notes. Even when Mrs Y was seen by the consultants on 3 July, it appears that they were not given her X-rays to review. The X-rays taken during Mrs Y's last hospital stay were also not reviewed by a radiologist. The Ombudsman's surgical assessors felt that if the on-call consultant had accompanied junior medical staff in a weekend 'ward round' then an abnormality on Mrs Y's abdominal X-ray would have been detected. The Ombudsman was concerned, however, that the abnormality was not detected when the on-call consultant and the consultant surgeon subsequently saw Mrs Y. The surgical assessors concluded that junior staff failed to recognise the seriousness of Mrs Y's condition or to seek a more experienced opinion (consultant radiologist or surgeon). As a result of that, Mrs Y was given Picolax, which was an inappropriate bowel preparation for someone in her condition and which the assessors felt had contributed to her death. The consultant did not recall having seen Mrs Y's X-rays on 3 July and, having reviewed them retrospectively , he felt that a chest X-ray should have been ordered before a referral for a barium enema was made. The Ombudsman's assessors supported that view The Ombudsman also appointed a radiologist assessor, whose opinion supported the findings of the surgical assessors. The radiologist assessor also concluded that the report of the barium enema performed on 29 October 1997 was incorrect, that the barium study showed a stricture in the colon. Whilst that matter was not subject to investigation it had a bearing on Mrs Y's subsequent treatment, which might have been managed differently had the clinical team been aware of the correct diagnosis of a stricture in the sigmoid colon.

Remedy

The Trust reported its attempts to address the problem of a shortage of consultant radiologists. The Ombudsman noted with concern the radiologist assessor's comment that the problem in recruiting radiologists highlighted by the chief executive was a national problem. The Trust agreed to consider the comments contained in the surgical assessors' report concerning the need for ward rounds after weekends to identify newly admitted patients and for clinical notes recorded daily. It also agreed to remind junior staff of the need to seek experienced advice, particularly at weekends when patients have been admitted as emergencies. The Trust also agreed to consider the need for guidelines for junior staff on when they should call the consultant; retraining in the evaluation of abdominal X-rays; and to consider the introduction of multi-disciplinary meeting of surgeons, junior staff and radiologists.

Case No. E.2390/00-01

Inadequate care and treatment of physical illness on a psychological assessment ward

Complaint against

Leeds Community and Mental Health Services Teaching NHS Trust

Summary of case

In October 1998 Mrs X attended an out-patient appointment with her consultant psychiatrist. She complained of abdominal pain. The consultant considered Mrs X's level of agitation was such that admission to a medical ward would not be appropriate; and she was admitted instead to an assessment ward for elderly people with psychological disorder. Two days later Mrs X's husband found her slumped across a table and shaking. He believed that she might have had a stroke and asked a nurse to call a doctor. Mrs X died the following day. A coroner gave the cause of death as septicaemia (blood poisoning due to urinary tract infection), coupled with heart related conditions. An

independent review was held but Mrs X's husband remained dissatisfied. He complained that the care and treatment provided to his wife in October were inadequate.

Findings

The Ombudsman took advice from three independent professional assessors. They highlighted a number of shortcomings in the care and treatment provided for Mrs X. They especially emphasised the failure to perform basic observations of her temperature, pulse, and respiration (TPR) and blood pressure, and failures in communication between staff members and with Mrs X's husband. The absence of the recording of TPR and blood pressure measurements precluded the opportunity to monitor and intervene in the development of her serious illness: if abnormalities had been revealed, appropriate action could have been taken. It was also evident, for example, that record-keeping and the secure retention of essential documentation did not meet acceptable standards. The Ombudsman upheld the complaint.

Remedy

The Trust apologised. They had already taken steps to implement recommendations made by the independent review panel. They also agreed to act on recommendations made by the Ombudsman's assessors. These include training to ensure that nursing staff were appropriately aware of the physical health problems which are likely to arise in older people with mental health problems; and that all such patients who are admitted to assessment wards should have base line TPR and blood pressure measurements taken and recorded as a matter of routine.

Case No. E.401/00-01

Incorrect diagnosis

Complaint against

Northampton General Hospital NHS Trust

Summary of case

In March 1998 Mrs X sustained an injury following a fall. She attended the A&E department at the hospital, and X-rays were taken. She was told she had an ankle sprain. Following her discharge a consultant radiologist reviewed the X-rays and reported that there was no fracture. Mrs X continued to experience pain, and was reviewed later that month by a consultant orthopaedic surgeon. He reviewed the case and felt that the treatment had been appropriate and confirmed that the X-ray showed no fracture. Mrs X's ankle was put in plaster for several weeks, to immobilise it. Once the plaster was removed she underwent physiotherapy and was later discharged. She went back to the consultant in October 1998 and he diagnosed that she may have ruptured the peroneus brevis tendon (a tendon in the lower calf), and arranged for her to have an exploratory operation, which took place in February 1999. In July 1999, on reviewing the original X-rays, the consultant surgeon realised that Mrs X had, in fact, sustained a fracture of the heel bone. However, Mrs X was only told of the missed fracture in September 1999. Mrs X complained that there was an unreasonable delay in diagnosing her fractured heel and this delay denied her the possibility of more effective treatment and caused her unnecessary pain and distress.

Findings

The Ombudsman's clinical assessor told him that there was a very obvious extensive fracture of the heel bone. He was concerned that had been missed by the consultant radiologist and consultant surgeon. Their explanations for this were not acceptable. While it was found that even if Mrs X's fracture had been diagnosed immediately, and treated appropriately, it was likely she would have suffered on-going symptoms, the treatment given was not consistent with accepted practice and the correct early diagnosis would have removed the need for the unnecessary operation. There was very little to support the diagnosis of a possible ruptured peroneal tendon; and there should have been further investigation before arranging the exploratory operation. It was also felt that the consultant surgeon erred in not telling Mrs X personally of the fracture in July 1999. Moreover, the consultant's statement to Mrs X that her treatment would have been no different was inconsistent with his evidence during the investigation that had he seen the fracture he would have managed her significantly differently. The complaint was upheld.

Remedy

The Ombudsman felt that the circumstances of this complaint warranted more than an apology on behalf of the Trust. The Trust did apologise to Mrs X for the short-comings that were identified and also accepted the Ombudsman's invitation to discuss with Mrs X the question of possible financial redress.

Case No. E.670/00-01

Care of patient's diabetes and epilepsy in hospital, and failure to record out-patient consultation

Complaint against

The United Bristol Healthcare NHS Trust

Summary of case

In November 1998 Mr B, who suffers from diabetes mellitus and epilepsy, was admitted to Bristol Royal Infirmary for an aortic valve replacement. His epilepsy and diabetes had previously been well-controlled. After the operation, on

5 November, Mr B was admitted to the intensive care unit, then the high dependency unit and finally to a cardiac ward. He was discharged on 19 November, but was still clinically unstable. Mr B felt dizzy, nauseous and very poorly. On 24 November he was admitted, in a coma, to a second hospital, having had an epileptic attack. Mrs B complained to the Trust about her husband's post-operative care, especially the care for his diabetes and epilepsy. Mr B later had an out-patient consultation in February 1999 at which, Mrs B said, a doctor told Mr B that an error had occurred in his treatment and that he would look into it. However, Mr and Mrs B were later told that the Trust had no record of that consultation. An independent review (IR) panel considered Mrs B's complaints about Mr B's treatment but she remained dissatisfied, particularly as Mr B continued to experience problems with his diabetes and epilepsy.

Findings

The Ombudsman appointed two independent clinical assessors, who advised that the supervision and control of Mr B's diabetes at Bristol Royal Infirmary had been inadequate: staff had failed to monitor and adjust his insulin appropriately. However, the clinical assessors said that staff had managed Mr B's epilepsy appropriately during the period under investigation. The Ombudsman found therefore that the complaint was justified in respect of the management of Mr B's diabetes. As for the missing record of the subsequent out-patient consultation, the Ombudsman noted that he had previously had cause to criticise the Trust for failings in record-keeping. He found that there was no doubt that Mr B had attended the consultation but, despite the IR panel and the Ombudsman's investigation, the Trust were still unable to find any record of the consultation. In upholding this aspect of complaint the Ombudsman also noted that the IR panel had concluded that record-keeping about Mr B's care fell below an acceptable standard.

Remedy

The Trust said that they would continue to carry out the recommendations of an independent review of their diabetes care, which had taken place shortly after Mr B's admission, and they agreed to review how to use available resources to best advantage. In particular, they would consider introducing a diabetes protocol reinforcing the training of junior doctors, and making arrangements for diabetic patients to be seen by a specialist nurse before and after operations. The Trust agreed to keep their diabetes service under review, with the aim of adopting national guidelines and meeting the relevant National Service Framework. They agreed to report back to the Ombudsman on progress towards these ends. They also agreed to provide Mr and Mrs B with the results of an audit into record-keeping and to explain what action had been taken as a result. The chief executive offered his sincere apologies to Mr and Mrs B for the shortcomings identified.

Case No. E.1615/01-02

Inadequate management of a patient; unsatisfactory complaint handling

Complaint against

Westcountry Ambulance Services NHS Trust

Summary of case

Mr and Mrs Z were retired ambulance workers. In March 2001 Mr Z collapsed at home and Mrs Z called for an ambulance. The ambulance crew arrived and carried out an initial assessment but decided that help was needed to carry Mr Z up the steps from his home to the ambulance, so they called for a second crew. About 15 minutes after the first crew arrived at the scene Mr Z suffered a cardiac arrest. The first crew administered oxygen to Mr Z but after a few minutes the cylinder ran out. A second cylinder was brought from the ambulance but the first crew did not have the correct tool to open it. A GP then arrived, followed by the second crew (who had been delayed because they went to the wrong street). However, all attempts to resuscitate Mr Z failed and he died at the scene.

Mrs Z complained to the Trust but remained dissatisfied and in July she wrote to the Trust's chief executive to request an independent review (IR); the chief executive advised Mrs Z that he would investigate her complaint personally. Mrs Z subsequently had a meeting with Trust staff but remained dissatisfied, and she again requested an IR. The Trust's convener advised Mrs Z that before he could reach a decision he needed to raise a number of matters with the Trust. Mrs Z complained to the Ombudsman about the first crew's management of her husband and about the way her requests for IR had been handled.

Findings

The Ombudsman took advice on the clinical aspects of Mrs Z's complaint from an independent professional assessor. Mrs Z believed that the first crew should have taken her husband to hospital straight away. The first crew said that they had intended to do so, but the steps from the house were steep and icy, and Mr Z's condition added to the risk of an accident. They therefore decided to stabilise him and wait for assistance from the second crew. The clinical assessor advised the Ombudsman that it should have been possible to move Mr Z, with caution, immediately after the initial assessment as Mr Z's condition posed fewer risks than they may have thought. However, after Mr Z's cardiac arrest, the first crew had no option but to attempt resuscitation until the second crew arrived. Mrs Z was concerned that the problems with the equipment indicated that the first crew were unprepared. However, the assessor said that those problems were outside the first

crew's control; they could not have been predicted and were not a sign of lack of preparation or competence. The Ombudsman therefore found that the care and treatment given to Mr Z at the scene were appropriate, but he upheld the complaint to the limited extent that Mr Z could have been moved immediately after the initial assessment. The Ombudsman upheld all Mrs Z's complaints about the handling of her request for an IR. There were three aspects. First, the Ombudsman found that the chief executive had not followed the directions on the complaints procedures, which state that any request for an IR should be passed to the convener immediately. Secondly, that when a second request was made, the convener went beyond his role in seeking answers to Mrs Z's complaint instead of referring it back to the Trust formally. Thirdly, the convener failed to take appropriate independent clinical advice on Mrs Z's complaint, relying instead on discussions with the Trust's deputy chief executive of operations - who had been involved in the complaint previously. The Ombudsman noted that in handling the complaint, Trust staff had acted out of a desire to help Mrs Z - a former professional colleague - but they had not followed proper procedures.

Remedy

The Trust apologised to Mrs Z for the shortcomings identified and agreed to ensure that the convener, and all staff involved in complaint handling, familiarised themselves - and complied - with the Directions and guidance on the NHS complaints procedures.

Case No. E.1763/99-00

Inadequate assessment for a wheelchair

Complaint against

Plymouth Primary Care Trust

Summary of case

Miss H suffers from cerebral palsy. In April 1999 Miss H's wheelchair needs were assessed by Mr O of a wheelchair charity. Miss H was assessed as unable to perform certain skills in her standard self-propelling NHS wheelchair, but able to accomplish the same activities in a lightweight folding wheelchair. Mr O advised Miss H to apply to the Trust's Wheelchair Service for a lightweight wheelchair. In July 1999 one of the Trust's occupational therapists assessed Miss H, using the eligibility criteria for wheelchair provision agreed by the Trust's Disablement Services Centre. The Trust acknowledged that Miss H might be able to undertake more activities with a lightweight wheelchair. However, they decided that, at that time, while she met the criteria for a standard wheelchair, she did not meet certain additional criteria to be eligible for a lightweight wheelchair. Mr O appealed to the Trust on Miss H's behalf about its refusal to provide her with a lightweight wheelchair. He said that the Trust had applied inappropriate criteria in assessing Miss H's needs.

Findings

The Ombudsman found it reasonable that the Trust had chosen to apply additional criteria for clients who applied for lightweight wheelchairs, which were more expensive than standard self-propelling chairs. He found nothing to suggest that the way in which the Trust's criteria were decided was at fault, and no grounds for criticising the Trust for including inappropriate factors in the criteria. However, an independent clinical assessor appointed by the Ombudsman (an occupational therapist) was concerned that the assessment of Miss H's needs was not carried out as thoroughly as it should have been, and that the documentation used for the assessment was inadequate for the purpose. The Ombudsman also criticised the Trust's handling of Mr O's appeal against the outcome of Miss H's assessment.

Remedy

In March 2000 the Trust accepted that the documentation of therapy assessments required revision and, shortly afterwards, the acting chief executive told Mr O that the matter would be reviewed. However, at the time of the Ombudsman's investigation the issue was still unresolved. The Ombudsman recommended that the Trust take all steps necessary to expedite that work. The Ombudsman's assessor made a number of further recommendations aimed at improving Trust's Disablement Services Centre's procedures and standards, which the Ombudsman endorsed. He also recommended that the Trust consider developing a documented appeal procedure and notifying clients about that when deciding on their eligibility for wheelchairs. The Trust agreed to the Ombudsman's recommendations and also apologised to Mr O and Miss H for the shortcomings the Ombudsman had identified.

Case No. E.387/99-00

Inadequate management of a protracted second stage of labour

Complaint against

Nottingham City Hospitals NHS Trust

Summary of case

Mrs L was admitted to the Nottingham City Hospital in the early stages of labour, and received an epidural anaesthetic. The second stage of labour progressed slowly and she was given a drug to induce stronger contractions. Mrs L was then assessed by a senior registrar who decided to carry out a forceps delivery in theatre, which took place

after she had been in the second stage of labour for five and a half hours. After one unsuccessful attempt at delivery by a senior house officer and two unsuccessful attempts by a senior registrar, the senior registrar decided to proceed to Caesarean section. The baby was delivered stillborn. Following the Trust's independent review of Mr and Mrs L's complaint about the management of Mrs L's labour, a second opinion on the cause of death was later obtained from an independent paediatric pathologist. The baby was found to have died as a result of a heart attack due to the presence of cerebral tissue in his heart, in a very rare but still recorded complication of both forceps and Caesarean deliveries. After the independent review Mr and Mrs L remained dissatisfied, complaining that the management of Mrs L's long labour, and the care given to the baby subsequent to his birth, were inadequate.

Findings

The Ombudsman's assessors identified several failings in the management of Mrs L's labour, some of which contributed to an unacceptably long second stage of labour. They criticised the senior registrar for initiating the forceps delivery after such a long second stage, and for continuing with the procedure despite the evident complications. An earlier referral to theatre for Caesarean would have been safer and more expeditious under the circumstances. The drug (oxytocin) prescribed to induce stronger contractions was prescribed in an excessive dose, and was not accompanied by an action plan. Nor was the possibility of the baby's head being too large for the pelvis, or being in the wrong position, fully assessed. Delays also resulted from the lack of availability of theatre facilities. An expert pathologist was appointed to advise on histological sections taken from the baby. She found that there was evidence that there were fragments of the brain in the cardiac and pulmonary vessels. She commented that this was an unusual observation. In this case, none of the assessors had had experience of this condition and published papers do not indicate whether or not excessive force must occur at the time of forceps delivery for this rare and unusual complication to occur. There were, also, other contributing factors to the baby's death due to a combination of the delay in the second stage of labour; the attempts at delivery with forceps; and the possible excessive oxytocin infusion prior to delivery. The Ombudsman upheld this aspect of the complaint. The Ombudsman found that after the baby's stillbirth, although the Trust's resuscitation protocol was not followed completely, and there was a delay in the arrival of the paediatric registrar, no more could have been done to save the baby. He therefore upheld the second part of Mr and Mrs L's complaint to a limited extent.

Remedy

The Trust agreed to implement a range of measures to improve the management of second stage labours, particularly those exceeding three hours in length. These included steps towards the provision of additional theatre access to expedite necessary clinical interventions in complex cases. The Trust also agreed to review the way it communicated with parents in the same tragic position of Mr and Mrs L, as well as its own process for reviewing the management of complex cases by its staff. The Trust additionally undertook to consider the provision of two paediatric registrars to cover the two areas of paediatrics and neonatology as the availability of only one registrar could, in other cases, be critical.

Summaries of other investigations

Case No. E.109/00-01

Inadequate care in a mental health unit and failings of independent review

Complaint against

City & Hackney Community Services NHS Trust (now City & Hackney Primary Care Trust)

Summary of case

Mr X complained about matters arising from his mother-in-law, Mrs Y's, admission to a mental health unit. The Ombudsman found that there was some justification for his complaints that she did not receive adequate medication for her pain, or help with her eating and drinking problems. The Ombudsman also upheld Mr X's complaint that a subsequent independent review did not adequately consider his complaints. However, although he criticised aspects of the Trust's record-keeping, the Ombudsman did not uphold complaints that Mrs Y was not assessed adequately on admission, that she was inappropriately informed about a diagnosis of cancer, and that she was then unnecessarily physically restrained. The Trust agreed to review arrangements for monitoring patients' nutritional intake, and to review guidelines for managing patients with recognised medical conditions. They would also ensure that clear records were made of patients' physical condition after restraint.

Case No. E.2047/99-00

Referral arrangements, inadequate care and treatment for mental health patient

Complaint against

Forest Healthcare NHS Trust and Redbridge Healthcare NHS Trust

Summary of case

Mrs K complained about the adequacy of the care and treatment of her daughter, Miss R, in a psychiatric unit: particularly arrangements for her observation, the attitude of nurses, the removal of property and that unreasonable force had been used when she was restrained. The Ombudsman expressed concern about the adequacy of the planning of Miss R's care and the failure to review adequately the need for continuous observations. However, he did not criticise the nursing staff for their efforts to care for Miss R in difficult circumstances. The Ombudsman's main concern was the suitability of the unit to care for such a disturbed patient (who needed more intensive and therapeutic care than staff at the unit could be expected to provide) and the limited efforts to find a more suitable alternative. Miss R was eventually transferred to a psychiatric intensive care unit. That was intended to be temporary, until a longer-term placement was found, but there was confusion about planning for that. Miss R killed herself while in the intensive care unit. The Ombudsman found that Miss R had required a higher level of observation there but that, contrary to what Mrs K feared, strenuous efforts had been made to resuscitate Miss R as soon as she was found. The Ombudsman upheld the complaints in part.

Case No. E.1471/01-02

Visitor refused access to mental health ward

Complaint against

Hillingdon Hospital NHS Trust

Summary of case

The Ombudsman upheld a complaint by Mrs C that the Trust unreasonably hindered her access to a mental health ward. Mrs C had gone with a friend to the Trust's mental health unit to visit two named patients on one of the wards. At the entrance to the unit they were told that neither of the patients were in; however, after gaining access to the ward they found that both patients had been there all the time.

Mrs C also complained that the Trust's handling of her complaint had been unsatisfactory. The Ombudsman upheld both of Mrs C's complaints and recommended, among other things, that the Trust speed up the introduction of written guidelines detailing the grounds on which visitors can be denied access to the mental health unit and the procedures staff should follow in such cases. The Trust agreed to implement the Ombudsman's recommendations and apologised to Mrs C for the shortcomings he had identified.

Case No. E.1951/00-01

Obstetric and gynaecology services; loss of medical records

Complaint against

St Mary's NHS Trust

Summary of case

Ms H complained that the Trust pressurised her into giving birth by caesarean section, rather than by vaginal delivery. She also complained that the Trust failed to clarify whether a repair to a hernia had been undertaken at the time of the caesarean section, and that the Trust failed to diagnose or provide treatment for her subsequent medical difficulties. She was concerned that problems with follow-up treatment had been exacerbated by the loss of her medical records. Having taken advice from an independent clinical assessor, the Ombudsman found that Ms H was given reasonable advice and adequate time to make an informed decision about the method of delivery of her baby. The Ombudsman also found that the Trust had not been approached about whether a hernia repair had been carried out until the time of the Ombudsman's investigation although the information that subsequently came to light clarified that no such procedure had been performed. The Ombudsman found that the standard of care after Mrs H's delivery was reasonable, although at the time it was more difficult to assess her problems because of the loss of her medical records. There was no evidence that Ms H's subsequent medical difficulties were related to the caesarean section and it became apparent that these were probably related to events that predated that. Ms H's missing records were found after the Ombudsman began his investigation. Whilst the Ombudsman was satisfied that the Trust made considerable efforts to find the records, the Trust acknowledged that they had experienced longstanding difficulties in this respect and put into place a number of measures to address those. The Ombudsman upheld Ms H's complaint only in so far as it related to the loss of her medical records. He recommended the Trust assess the effectiveness of the measures introduced and report back to him on that. The Trust apologised to Ms H and agreed to act on the Ombudsman's recommendation.

Case No. E.2177/00-01

Unforeseen complications of a hysterectomy

Complaint against

St George's Healthcare NHS Trust

Summary of case

Mrs A underwent a hysterectomy in December 1999. She was discharged from hospital and several days later experienced urinary incontinence and other distressing symptoms. She was readmitted to hospital and tests confirmed a vesico-vaginal fistula (connection between the bladder and the vagina). Further surgery was performed to repair the hole in her bladder. Mrs A complained that she had not been advised of possible complications prior to surgery. She further complained that the damage to her bladder had been caused in the course of the hysterectomy and that this had not been adequately dealt with at that time. Having taken advice from two independent clinical assessors, the Ombudsman found that the incidence of vesico-vaginal fistula is so rare that it was reasonable that this specific risk had not been discussed with Mrs A prior to surgery. The assessors also advised that there was no evidence of damage to Mrs A's bladder having occurred at the time of surgery. They concluded that the fistula was likely to have occurred post-operatively, probably due to development of a small area of ischaemia (a lack of blood supply) and that the standard of care provided to Mrs A was reasonable. The Ombudsman did not uphold the complaint.

Case No. E.82/01-02

Unsatisfactory care and treatment and delay in diagnosis

Complaint against

South Manchester University Hospitals NHS Trust

Summary of case

The Ombudsman did not uphold a complaint made by Mr M that the diagnosis of his wife's rare, malignant tumour (from which she, sadly, died in June 2000), should have been detected earlier. If it had been found , then Mr M considered that his wife's prognosis would have been more positive. The Ombudsman's professional assessor found that, when an appropriate examination was conducted in March 1999, no indication was found that the tumour was present at that time. The assessor found that, although the

cancer may have been present at that time, it would not have produced any symptoms or signs until late in its progression. The Trust had already apologised that further investigations were not conducted to identify the cause of Mrs M's symptoms in December 1999. This resulted in a delay in diagnosis until May 2000 when the tumour was revealed. However, the assessor stated that such rare tumours are silent in their progression and present at a late stage. He concluded that the care and treatment Mrs M received were satisfactory and, regrettably, that if a similar patient presented today, he could recommend no different approach.

Case No. E.2446/00-01

Complaint about aspects of care and treatment and complaint handling

Complaint against

North Hampshire Hospitals NHS Trust

Summary of case

Mrs W complained to the Ombudsman that staff had failed to adequately manage her husband's paracentesis (drainage of fluid through a tube inserted into the abdomen) or to maintain a satisfactory fluid balance on his last admission to hospital in December 1998. She also complained that although Mr W was known to be a vegetarian he was not consulted about the use of an animal-based infusion; and that, after Mr W's death, tissue was removed from his body without staff having first obtained her consent. Mrs W further complained that the Trust's handling of the complaint following an independent review (IR) panel was unsatisfactory. The Ombudsman did not uphold the first three aspects of Mrs W's complaint. His independent clinical assessors said that by the time Mr W was admitted to hospital he had severe ascites (a build up of fluid in the abdomen) which had been managed appropriately. The assessors were satisfied that the paracentesis was not the precipitating cause of Mr W's death and suggested other reasons for his sudden deterioration and death. The Trust agreed to remind all staff of the importance of accurately recording fluid balance levels and to consider the assessors' suggestion of introducing a patient information leaflet on ascites. In respect of the use of an animal based infusion, the Ombudsman found that the Trust staff had changed the infusion when Mrs W drew the matter to their attention, although without consulting her husband about that. The Ombudsman's assessors advised him that staff had responded appropriately to Mrs W's concerns about the animal based infusion and that it would have not have been appropriate to have discussed the matter with Mr W at that time, due to his deteriorating condition. The Ombudsman also found that the Trust had apologised to Mrs W in August 2001 about not consulting her before tissue samples were removed from her husband's body. The legal position was that the Coroner had given consent for the removal of samples from Mr W's body. The Ombudsman was satisfied that the Trust had responded adequately to the recommendations of the IR panel on this aspect of her complaint. The Ombudsman upheld Mrs W's complaint about the Trust's handling of her complaint following an (IR) panel. He found that there were delays in sending Mrs W the action plan based on the IR panel's recommendations and an unacceptable delay of over five months in providing her with the recommended apology.

Case No. E.279/00-01

Inadequate medical and nursing care in hospital

Complaint against

The Royal Surrey County Hospital NHS Trust

Summary of case

The Ombudsman partly upheld complaints by Mrs A and Mrs B, about record-keeping and the way in which resuscitation decisions were made, arising from their mother's care in hospital during August and September 1998. However he did not uphold their complaints about nurse staffing levels, discharge arrangements, pressure area and mouth care, restrictions on visiting or the management of anaemia. The Trust agreed to audit the implementation of new guidance to staff about record-keeping.

Case No. E.2275/00-01

Inadequate treatment and unsatisfactory independent review

Complaint against

East Sussex Hospitals NHS Trust (formerly Eastbourne Hospitals NHS Trust)

Summary of case

The Ombudsman upheld a complaint by Mrs B that her late mother, Mrs C, received inadequate treatment at Eastbourne Hospital. Mrs C was being treated for constipation and a urinary infection when her blood pressure dropped and she suffered a cardiac arrest. The Ombudsman found that indications of Mrs C's deteriorating

condition had not been recognised or acted upon by nursing staff, and that a junior doctor had failed to seek advice or arrange further assessment. He also noted that Mrs C's nursing records were inadequate. The Trust agreed to implement recommendations made by the Ombudsman's clinical assessors that Nursing and Midwifery Council guidance on record-keeping is reiterated to nursing staff; that all staff are made aware of action to take on discovering any untoward observation result; and that detailed statements are obtained from clinical and nursing staff should either an unexpected death occur or a complaint be made. The Trust further agreed to issue a protocol for the circumstances in which junior doctors should alert their consultants about a patient's condition. The Ombudsman also upheld, to an extent, Mrs B's complaint about the conduct of the independent review panel held to review her concerns about her mother's care. He found that the panel had not interviewed the relevant consultant physician and had made a factual error in its report. It was also evident that the Trust had not followed up the panel's recommendations with the staff directly involved. The Trust agreed to ensure that follow-up action is taken on all future independent review panel recommendations.

Case No. E.1433/01-02

Inadequate treatment and complaint handling

Complaint against

Oxford Radcliffe Hospitals NHS Trust

Summary of case

Mr and Mrs X's baby daughter, Miss X, suffered from a rare genetic syndrome that caused heart problems. Miss X died in November 1997 a few hours after an operation on her heart. Mr and Mrs X said that the Trust had not taken account of the syndrome in their daughter's treatment, gave inadequate explanations and communicated poorly about the heart condition and cause of death. They also complained that the Trust's handling of their request for an independent review of their complaint was unsatisfactory. The Ombudsman did not uphold the clinical or communication aspects of the complaint but he found serious maladministration in the convener's handling of Mr and Mrs X's request for an independent review because of her lack of understanding of basic procedures and delay. The Trust apologised for their shortcomings and agreed to review their complaints handling training.

Case No. E.1375/00-01

Failures in ante-natal care

Complaint against

Weston Area Healthcare NHS Trust

Summary of case

The Ombudsman upheld complaints by Mr and Mrs G that it was unreasonable not to allow Mr G to accompany his wife to the ultrasound scan. The Ombudsman also found that Mr and Mrs G should have been told about the Trust's policy not to terminate a pregnancy after 12 weeks. The Ombudsman did not uphold the complaint by Mr and Mrs G that it was unreasonable not to proceed with the termination. On 24 January 2000 Mr and Mrs G attended the hospital for an ultrasound scan. The radiographer refused to allow Mr G to accompany his wife into the scan room. On 31 January Mr and Mrs G attended the hospital expecting the termination to be carried out on that day. Mrs G claimed that she wanted to go ahead with the termination. The consultant gynaecologist refused to carry out the termination due to what she perceived as Mr and Mrs G's indecision about whether to proceed with the termination. The consultant said that Mrs G was approximately 12 weeks into her pregnancy, and that the hospital did not carry out terminations after 12 weeks. The Ombudsman's clinical assessors were of the view that a more sympathetic approach should have been taken, and that Mr G should have been allowed to accompany his wife for the scan. The advisers also agreed that Mr and Mrs G should have been told about the cut-off of 12 weeks for terminations when they attended for the scan. However the advisers felt that it would have been inappropriate for the consultant to proceed with the termination, as Mrs G appeared to be initially undecided about whether to proceed or not.

Case No. E.856/00-01

Inadequate medical cover

Complaint against

Sandwell and West Birmingham Hospitals NHS Trust

Summary of case

Mrs X was admitted to Sandwell General Hospital in July 1999 with heart failure. Three days later, in the afternoon, her family noted a change in her condition and informed the nurses. Mrs X deteriorated during the early evening, and her grandson, Mr Y, asked a nurse to call a doctor.

Although nurses bleeped medical staff on several occasions, Mrs X was not seen until midnight when she was diagnosed with a stroke, a chest infection and dehydration. A house officer was on duty that evening until 9.00pm, and a second house officer was on duty from 8.00pm onwards, but the Trust said that both house officers had been unable to attend Mrs X as they had been busy with patients in A&E. The Ombudsman upheld Mr Y's complaint, saying that a wait of six hours for a doctor to attend was unacceptable. The Trust agreed to review its level of medical cover, its protocols on junior staff approaching senior staff when a doctor was unable to attend promptly, and its protocols for staff dealing with distressed relatives.

Chapter 2 • Family Health Service Practitioners and Health Authorities

Short Reports

Case No. E.166/01-02

Failure to provide adequate care and treatment and to respond to the recommendations of the IR Panel

Complaint against

A GP in the Essex Health Authority area

Summary of case

On Saturday 3 July 1999 Mrs E visited her former husband, Mr E, in his sheltered accommodation. She found him in bed, unable to pass urine and in pain. Mrs E tried to telephone Mr E's GP, Dr R, but there was neither a reply nor a recorded message that allowed her to leave a message or directed her to another number. The GP was contacted via the ambulance service and agreed to visit Mr E. After almost two hours Dr R had not arrived so the ambulance service tried to contact him again but were unable to as his mobile telephone was switched off. Another doctor was asked to visit and arrived at the same time as Dr R. The second doctor left and Mrs E explained to Dr R that Mr E needed to go to hospital. Mrs E said that Dr R had not examined Mr E. Mr R said that he had carried out an examination but had not been able to feel Mr E's bladder. Mrs E felt it was only at her insistence that he arranged for Mr E to be admitted to hospital. Dr R said that he arranged Mr E's admission to hospital largely because there was no one to look after him at home. When admitted, it was confirmed that Mr E was suffering from urinary retention with incontinence due to overflow of urine from the bladder. Mrs E complained to Dr R about the difficulties she experienced trying to contact him and the time it took him to visit Mr E on 3 July; his failure to examine Mr E and his reluctance to arrange for Mr E to be admitted to hospital. Mrs E was granted an independent review (IR) which took place in March 2000. It made a number of recommendations in relation to Dr R's contact arrangements and record-keeping. The South Essex Health Authority later contacted Dr R on several occasions enquiring about the action he planned to take in response to the panel's findings, but Dr R did not respond.

Findings

Both aspects of the complaint were upheld. The Ombudsman's independent clinical assessors criticised Dr R's contact arrangements and the delay in his visiting Mr E. They also concluded that it was unlikely that Dr R had conducted an adequate examination. The assessors said that there were inadequacies in Dr R's referral letter to the hospital and in his clinical records, which did not adequately record his visit on 3 July or previous visits to Mr E. On the basis of their advice, the Ombudsman concluded that the care Dr R provided on 3 July 1999 fell far short of the standard Mr E was entitled to expect.

In relation to Dr R's response to the IR panel's recommendations, Dr R failed to provide an adequate explanation during the course of the investigation as to why he did not respond to the former Health Authority's requests for information, despite being sent five letters over a period of 11 months. This meant that although Mrs E's complaint had been investigated and aspects of Dr R's practice found to be wanting, she was not informed of the ultimate outcome.

Remedy

Dr R said that since the panel reported he had made a number of changes to his contact arrangements, including making more use of the deputising service and buying a new mobile telephone. He also said that he has improved his record-keeping. The assessors made a number of recommendations relating to Dr R's practice which Dr R agreed to implement with support from the Health Authority.

Case No. E.1771/01-02

GP list removal

Complaint against

A GP in the former East Norfolk Health Authority area

Summary of case

In January 2001, Mrs A contacted her family's GP surgery to request a repeat prescription for her husband, who required regular prescriptions. She was advised that the prescription would be posted, and left a stamped addressed envelope at the surgery that evening. However, the prescription did not arrive, and a week later she rang the surgery but staff refused to issue another prescription. Mrs A was extremely upset and her call was put through to another receptionist, who arranged for Mrs A to collect a prescription from a local pharmacy. The following day, Dr B, Mrs A's GP, wrote to the Health Authority requesting the

removal of Mrs A, her husband and son from his list on the grounds that Mrs A had been demanding and aggressive to staff on the telephone. Mrs A wrote to Dr B setting out her version of events and asking him to reconsider his decision, at least as far as her husband was concerned; Dr B refused.

Findings

The Ombudsman upheld Mrs A's complaint. Guidance to GPs from the General Practitioners Committee says that patients should only be removed from a GP's list after careful consideration and not in the heat of the moment. Dr B told the Ombudsman that he had warned Mrs A about her behaviour previously. However, Mrs A denied that, and there was no formal record of previous incidents. At the time of these events, Dr B was under pressure and had been suffering from ill-health himself. Nevertheless, the Ombudsman considered that he had acted hastily in removing Mrs A and her family from his list. Dr B now recognised that. Following the complaint, Dr B's practice had introduced a policy on the removal of patients, which said that patients should be allowed time to 'modify' their behaviour before a decision was made to remove them from the list. However, the Ombudsman was concerned about that policy and pointed out that sometimes a GP, or practice staff, can be at fault when disagreements occur.

Remedy

Dr B agreed to implement the Ombudsman's recommendation that in future, concerns about a patient's behaviour should be recorded formally and brought to the patient's attention. Dr B also agreed to review the practice's policy to ensure that a balanced view was taken of incidents and that equal consideration was given to feelings on both sides with a view to resolving matters at the earliest possible stage. Dr B apologised to Mrs A for the short-comings identified.

Case No. E.1993/00-01

Inadequate referral

Complaint against

A GP in the Trent Health Authority area

Summary of Case

Mrs B saw Dr K with severe pains and bleeding in her pelvic area. She had been trying to conceive for the previous three months and her period was seven days later than expected. Dr K examined Mrs B. Although Dr K considered the possibility of an ectopic pregnancy, he did not undertake a pelvic examination because of the risk of causing damage. No pregnancy testing equipment was available at the surgery at the time. He diagnosed spasmodic dysmenorrhoea (period pain) and prescribed a painkiller used to treat period pain. Mrs B, who had never approached a doctor with period pain, told Dr K that her pain was worse than that. He told her she should go to hospital urgently if her condition became worse. He also arranged a surgery appointment for the following day. Mrs B started taking the painkiller. When another GP saw Mrs B the next day, the pain was much less and no further action was taken. However, two days later Mrs B was in so much pain that her husband took her to hospital and she underwent emergency surgery. She was found to have a ruptured ovarian abscess. The ovary and the fallopian tube on the left side had to be removed. The remaining tube was left damaged by the infection and Mrs B is now infertile.

Findings

The Ombudsman found that Dr K could not have reasonably been expected to make a diagnosis of a rare condition such as an ovarian abscess. His examination of Mrs B, and decision not to perform an internal examination, were also acceptable. However, he criticised Dr K for diagnosing period pain, when Mrs B had never presented with period pain before. He went on to criticise Dr K for failing to refer Mrs B immediately to hospital for further tests, given his differential diagnosis of ectopic pregnancy. A diagnosis such as ectopic pregnancy should have informed his immediate management of Mrs B's symptoms, because pregnancy should have been assumed in a fertile woman with a late period. Furthermore, pelvic pain and bleeding were also pointers to the possibility of ectopic pregnancy. However, they noted that Mrs B's positive initial response to the painkiller was extraordinary given the severity of her infection.

Remedy

Dr K apologised to Mrs B for the failings identified by the Ombudsman. During the investigation Dr K reconsidered his management of Mrs B's presentation. In future presentations like Mrs B's, he undertook to first perform a pregnancy test. If this proved positive, he would discuss the situation with the gynaecologist on call. Should it prove negative, he would propose performing a gentle examination, which would influence his decision about the urgency of further investigation. This undertaking was accepted as reasonable by the Ombudsman. He also agreed that in future cases where his differential diagnosis included a life-threatening condition, he would refer the patient immediately to hospital.

Summaries of other investigations

Case No. E.1831/01-02

Removal from a GP list

Complaint against

A GP in the North East London Health Authority area

Summary of case

The Ombudsman upheld Mrs T's complaints that, in February 2001, her GP had acted unreasonably in removing her from his list after she had made some criticisms of the way the surgery was organised, and that the practice had failed to follow NHS guidance on the handling of complaints. The practice agreed to remind all staff of the need to follow proper procedures and to consider all options before removing patients from their list.

Case No. E.894/01-02

Poor communication and removal from GP list

Complaint against

A GP in the Bradford area and Bradford Health Authority

Summary of Case

Mr Q complained that his GP, Dr X, refused to prescribe a hay fever injection without offering an adequate reason. When he complained about the matter he was removed from the GP's list. The Ombudsman accepted the advice of an independent clinical assessor that whilst the decision not to prescribe an injection was clinically reasonable, the manner in which the decision was communicated to Mr Q was unreasonable. That complaint was upheld. The Ombudsman found that Dr X removed Mr Q from her list without giving an adequate reason and in contravention of all relevant professional guidance and upheld that aspect of the complaint. Dr X's handling of the complaint was found to be both inadequate and unprofessional. There had been unacceptable delays in answering correspondence, and the response to the original complaint had been unacceptable in its tone and content. The Ombudsman found that the Authority failed to appreciate the seriousness of the practice's actions and their own role in the matter - particularly with regard to issues of patient confidentiality, communication skills and knowledge and understanding of the complaints procedure. The complaint was upheld. Both Dr X and the Authority apologised for the shortcomings identified. The Authority agreed to oversee the Ombudsman's recommendation that the practice should establish a system to audit their handling of complaints and undertake further training in complaint handling and communication skills.

Case No. E.293/01-02

Treatment of gum disease

Complaint against

A general dental practitioner in the Surrey and Sussex Health Authority area

Summary of case

The Ombudsman did not uphold Mr C's complaint that his dentist failed to provide appropriate treatment for his gum disease and failed to refer him to an appropriate specialist. Mr C had been registered with the dentist between 1973 and 2000 and had received advice and treatment on a number of occasions. The treatment provided by the dentist before 1 April 1996 was outside the Ombudsman's jurisdiction. In 2000 the dentist's dental hygienist advised Mr C that his gum disease had worsened and some teeth were becoming loose. Mr C subsequently attended another dentist who advised him that he was suffering from advanced gum disease due to lack of appropriate dental care over many years. The Ombudsman's independent clinical assessor explained that in order to control periodontal disease, it is essential that the patient has at least an adequate standard of oral hygiene. The clinical assessor concluded that although some dentists would have carried out more extensive treatment, the reasons provided by the dentist for not doing so were acceptable, and that the treatment provided by the dentist was reasonable. The assessor also said that specialists will not accept a patient who has failed to achieve an adequate standard of oral hygiene, and that referral to a specialist would not have achieved a different outcome for Mr C. However, the assessor considered that the monitoring and recording of Mr C's gum disease fell short of an acceptable standard. The dentist now undertakes more regular monitoring of gum disease within his practice, and agreed to review his method of recording consultations.

Case No. E.1096/01-02

Inadequate complaint handling

Complaint against

West Sussex Health Authority

Summary of case

The Ombudsman upheld a complaint by Mr A that, after complaining to a GP practice about his care and treatment, Mr A was told by the GP that his complaint had been submitted outside the time-scale set out in the NHS complaints procedure, and that he would not consider the issues Mr A had raised. The Health Authority told Mr A that the convener had decided that there were no grounds to waive this time limit. The Ombudsman found that the Health Authority had acted contrary to the complaints procedure in that it should have asked the GP to reconsider his refusal to deal with the complaint. If that refusal had been maintained the Health Authority should then have advised the complainant to request the convener to consider setting up an Independent Review to consider whether, under the circumstances, a refusal to waive the time limit was justified. The Health Authority apologised to Mr A for the shortcoming the Ombudsman had identified and agreed to adhere to the complaints procedure in future. Mr A's complaint about the GP was investigated separately: Case No. E.2380/01-02 (please see below).

Case No. E.2380/01-02

Failure to give adequate care and treatment

Complaint against

A GP in the West Sussex Health Authority area

Summary of Case

Mr A complained that when he returned to his former GP as a temporary resident, the GP was unsympathetic and asked him to leave the building. Mr A complained that this had resulted in an unnecessary subsequent deterioration in his mental health that required treatment. He also complained that, when he later complained to the GP about his treatment, the GP refused to respond. The Ombudsman found that in the absence of a contemporaneous medical record and any independent witnesses to the consultation, it was not possible to determine whether the GP's responses had been clinically satisfactory. However, the GP apologised if the brevity of the consultation, and his advice that Mr A should return to his usual GP for further treatment, had upset Mr A. He also agreed that, in future, he would follow up 'temporary residents' by communicating more fully with a patient's GP. The Ombudsman also found that the Health Authority had not properly advised the GP of key parts of the complaints guidance, which were not typically made available to GPs. The complaint was not upheld. However, the GP agreed to revise his practice complaints protocol to ensure that, in future, full consideration is given to complaints, in line with all available NHS Directions and Guidelines. (Note: Mr A's complaint about the Health Authority was investigated separately: Case No. E1096/02, please see above.)

Case No. E.917/01-02

GP's inappropriate behaviour

Complaint against

A GP in the Rotherham Health Authority (now Rotherham Primary Care Trust) area

Summary of case

The Ombudsman was not able to make any finding on a complaint from Mrs N that her mother's GP, Dr L, was threatening and bullying to Mrs N. Both Mrs N and her mother, Mrs G, who suffers from dementia, were registered with the same GP practice of three doctors. In January 2000, the practice split into two separate practices sharing the same premises. Mrs N completed the forms to transfer herself and her mother to the single doctor practice. On 31 March 2000, while visiting the practice to collect a repeat prescription for herself, Mrs N was informed that her mother had visited a GP from the other practice. The practice manager made enquiries of the receptionist of the other practice and asked Mrs N to complete a new registration form. Mrs N was doing this when Dr L came into the office and, in an aggressive and bullying manner, accused the practice manager of taking his patient away. On intervening to try to explain the position Mrs N was subjected to a response from Dr L which she found was threatening and intimidating. Although the Ombudsman was not able to make any finding on the complaint as put due to differing accounts of the incident given by the witnesses, he did have some concern about Dr L's exchange with Mrs N. He made a recommendation, which Dr L agreed to implement, about how he deals with patients, or their representatives, in future.

Health Service Ombudsman
Millbank Tower
Millbank
London SW1P 4QP

Telephone: 0845 015 4033
Text Telephone: 020 7217 4066
Facsimile: 020 7217 4940
Email: OHSC.Enquiries@ombudsman.gsi.gov.uk
Website: www.ombudsman.org.uk