Maidstone and Tunbridge Wells NHS Trust

Ref: FOI/CAD/ID 3637

Please reply to:
FOI Administrator
Trust Management
Service Centre
Maidstone Hospital
Hermitage Lane
Maidstone
Kent
ME16 9QQ
Email: mtw-tr.foiadmin@nhs.net

31 May 2017

Freedom of Information Act 2000

I am writing in response to your request for information made under the Freedom of Information Act 2000 in relation to letters of complaint 2013.

We request the first 25 type-written letters of complaint that your Trust received after 1st October 2013. If your Trust contains more than one unit, we request that the letters are from across the units.

Anonymity of patient letters: The letters will contain personally identifying information, and we request that all personally identifying information be redacted from the letters (i.e., information about addresses, dates, units attended, sexuality, religion, ethnicity, age etc.). We only request information about the patient's experience of the NHS. We understand that the resultant letters may be heavily redacted.

Why we have selected your Trust: Your trust has been randomly selected. We want a national sample of letters of complaint received by NHS Acute Trusts, and your Trust is an Acute Trust.

Anonymity of your Trust: The name of your trust will not appear in any of our research. The letters which you provide will be aggregated with letters from other Trusts, and will in no way be traceable back to your trust. We are not interested in the identity of any particular Trust.

Please see the following complaint letters:

A.

[redacted]

[redacted], 2013

Dear Sir,

With reference to your response dated [redacted] 2013 I am now writing to make a formal complaint against [redacted] of unfavourable treatment (direct discrimination) against an ethnic Hotel Services Manager of [redacted]

In your letter page 2 middle part you presumed that I acted as [redacted] and you stated that if I'm not happy that I should bring this to my Director to discuss it with [redacted]. Also, you stated that a contractual provision does not entail me an automatic rights and asking me if [redacted] are unhappy about this to formalise this in correct channels.

I accept your words that ' a contractual provision does not entail me an automatic rights' but as you may not know the action of your [redacted] entails a 'White British Hotel Services Manager' to carry out the job but excluded a non white British Hotel Services Manager.

There was no contractual provision issue unless you would like to confirm that a 'criterion' is included putting an ethnic minority in disadvantage which will be against your Human Rights Policy. Therefore, I am bringing this to your attention as this information was not mentioned before either by [redacted]

Thank you for allowing me a full access to Academic Centre at [redacted] Library but why you wanted me to drive 16 miles from [redacted] when you have facilities at [redacted] three miles away from where I am renting is beyond practicality.

You are telling me that I am welcome to use [redacted] as my local hospital of becoming an in-patient or out-patient and sending me away to use the library at [redacted] which is not local.

Also, it was [redacted] who held my access to [redacted] This is the reason why I am making a stand against this unfavourable treatment.

A.

Lastly, I am offended that you ask me not to take conscious steps to facilitate a contact with facilities team as library user. Will I get shot, electrocuted or tortured if I say 'hello' to facilities team. Will you put shackles and ball chain around my legs that I have to seek [redacted] and [redacted] to agree what I have to say to ex colleagues. I thought I live as a 'free men' in United Kingdom, what else you think I will do in library or say to Domestic Team.

This is not a contractual provision issue but it is 'unfair treatment' towards a vulnerable ethnic minority who is under represented in NHS at senior level.

I look forward to hearing from you directly, I appreciate you said you will remind [redacted] of appropriate treatment to your visitors. You also stated that you can not make a conclusion since you were not there.

With due respect Sir I did not expect you to be everywhere. However, I included names of 'witnesses' ([redacted] as it may help you better with your conclusion if it is properly investigated.

Like I said on my first letter I moved on and would not have this complaint if I was treated with respect by [redacted]. Please note that I may bring this complaint to Healthcare Ombudsman. This 'unfair treatment' was caused by [redacted] directly against me. [redacted] only followed instruction from their line manager.

The action taken by your employee caused stress and anxiety that is unnecessary if my right was respected under Article 14 of European Convention of Human Rights.

Kind regards

[redacted]

B

[redacted]

e-mail to [redacted]

[redacted] 2013

Dear [redacted]

Re: [redacted]

May I say I regret having to write this letter of complaint regarding the above.

Firstly, I want to make it quite clear that there is no complaint of any of the medical staff who dealt with [redacted] surgery or stay in hospital. The problem lies solely with the administration team which I feel should be addressed in order to save other patients and their family the stress this caused my [redacted], myself & our family.

Following a referral from our doctor [redacted] at [redacted] surgery, [redacted] attended [redacted] on [redacted]/13 and was subsequently requested to attend [redacted] to have an urgent colonoscopy on [redacted]/13. This procedure revealed a large growth and we were informed that "everything will happen very quickly now" by [redacted]. As we heard nothing for over a week we, along with [redacted] from our surgery, contacted the Colorectal nurses to endeavour to get some progress. After being told [redacted] is in the system & we do have other cancer patients" we were eventually told to attend the clinic on [redacted] September 2013. [redacted] was seen by [redacted], who informed us that [redacted] would have to undergo a blood transfusion of 3 units before being able to perform the required operation, which was planned for the [redacted]
We were then seen by [redacted] who said they planned to carry out the transfusion on [redacted] September and we would be contacted by [redacted] on [redacted] September to confirm this. We never received this call and when I contacted [redacted] on [redacted] September I was told that she had just spoken to [redacted] regarding the procedure due the next day and that she would get her to ring me. I did not receive this call and to date have never spoken to anyone called [redacted] or received a so called letter from her that was supposed to have been sent on [redacted] September (how we were supposed to receive this in time for Tuesday morning first thing, when they only ever use 2nd class post, I don't know). We were also informed that we would need to ring [redacted] at 7.00 a.m., to confirm they had a bed for [redacted], on doing this we were then informed that although patients are always told this we would have to wait for them to ring us. A phone call from [redacted]" was received just after 9.00 on 17th telling [redacted] to make [redacted] way to the "Treatment Suite" where the transfusion would be done. On arrival at the hospital we were unable to locate the said suite and asked four doctors/nurses if they could direct us, none of them knew where this was. I then made my way back to the main reception thinking they would be able to direct us. How silly was this, 3 staff on reception not one of them had any idea where this room was. When I suggested they contact the department who would have given us this information it was ignored and I was told they were trying to pull [redacted] details up on the computer but couldn't find [redacted] on the system. After 20 minutes they decided to do as I had suggested and we were then informed that we should make our way to the [redacted] dept. This was easily found and we checked in at their desk at around 10.00. After waiting for an hour with other patients coming in and going into the "treatment suite" I asked at the reception desk how much longer [redacted] would have to wait. ([redacted] was in great discomfort for at least 6 weeks prior to [redacted] surgery and sitting for so long only prolonged [redacted] agony). I was told they were trying to get a doctor to come and see us!

B.

A little while later a female doctor and [redacted] came over to us and asked "I know this may sound like a silly question to you, but why are you here". Can you imagine our grief. At this point I became very annoyed and demanded that they somehow give [redacted] the blood [redacted] needed before [redacted] pre-assessment due on [redacted] September and [redacted] surgery the following Tuesday. Obviously, [redacted] urgent surgery would have had to be delayed with the absence of the transfusion. I would add here that the doctor and [redacted] were very professional and managed to locate the required blood and [redacted] said [redacted] would carry out the procedure [redacted] All this confusion took up another hour or so, so around 12.00 we were told, the only problem now is that this department closes at 18.00 and as each unit takes 3 hours to infuse there was not enough time to give [redacted] all 3 units. Apparently there was nowhere else [redacted] could go in the hospital for this to be done. We, therefore, had to go back the next day for [redacted] to receive the 3rd unit.

When we returned home from the hospital following [redacted] 3rd unit of blood on the Wednesday we had a message on our answer phone asking us to ring [redacted] at [redacted] who said they had been requested to perform an exercise test on [redacted] which would be needed by the anaesthetist on the day of the surgery. This was planned for 9.00 on Thursday 19th. When I informed her that [redacted] pre-assessment was to be done at 8.30 the same day and it would obviously be impossible for [redacted] to be in two places at once she was shocked that as she had been liasing with admin for that department, that they hadn't realised this themselves. An appointment was eventually made by [redacted] for later in the day.

[redacted] attended [redacted] on [redacted] for [redacted] pre-assessment, which all went well, but a chance remark to the nurse who carried this out, about the failure of the administration department to do their job efficiently was met with "I know, it's terrible!"

[redacted] received two letters in the same post, one dated 13th September informing [redacted] that [redacted] was to be admitted on [redacted] early morning & one [redacted] informing [redacted] that [redacted] was to be admitted on [redacted] at 6pm. Again we could not confirm this on the day, as suggested in the letters, but had to await a call from the hospital stating they had a bed available.

From thereon things went extremely well, with [redacted] working wonders. That is until the day of [redacted] discharge. I received a phone call from the hospital on 1st October to say [redacted] could be discharged around 1pm and that [redacted] had been moved to the short stay ward. However, when I arrived at the short stay ward [redacted] was nowhere to be found, on asking where [redacted] was, I was told "someone came and took [redacted] in a wheelchair"! After some investigation I was then told [redacted] had been taken to the discharge lounge, where I found [redacted] waiting for 3 members of staff endeavouring to arrange for district nurses to visit [redacted] at home. As they were having difficulty with this I was then asked if I could administer [redacted] with injections every day to ensure [redacted] did not suffer any blood clots. Never having done injections before I said I was not happy to do this and requested they proceed with the arrangements for a district nurse to attend [redacted] at home. This proved to be of annoyance to the 3 ladies who were more interested in looking at an online site for cheap glasses, they told me they did not have the phone number for our doctor and could not therefore make the necessary arrangements. As I had left my mobile phone in the car, I was unable to furnish them with these details and so suggested they look the number up on Google. Imagine my amazement when none of the 3 knew how to do this, even though they could clearly locate a site for spectacles. After some time (I had been there for around an hour by this time) they did manage to find the phone number, but after my suggestion they spoke to [redacted] at the surgery was completely ignored they had still failed in their task. By this time I was so annoyed I told them to leave it and I would call into the surgery myself on the way home to organise things. This I did and before arriving home (a matter of 10 minutes) [redacted] from our surgery had left a message on the answerphone to let us know that a member from Rapid response would be out later that evening. [redacted] had to have the injections until [redacted]

B.

and the only complaint I have with this was on [redacted] October [redacted] was left at risk for about 5 hours as no one turned up to give [redacted] the required injection. As [redacted] was now mobile and I felt more confident in [redacted] not seeing a district nurse every day, I suggested to the Rapid response nurse who then had to come out to [redacted] later that evening, that I now administer his injections. That way I could be sure that [redacted] was receiving them on time and no longer at risk.

As stated previously the main purpose of this letter is so that hopefully other patients and their families are spared this trauma, it is a stressful enough time without it being made worse than it ought to be.

I would re-iterate that I deeply regret having to complain about [redacted] administration department, but their lack of expertise sadly lets the good work of all the Doctors & nurses down.

I look forward to receiving a response, particularly highlighting how the trust will identify, rectify and manage the administration department in the future. I would be deeply saddened to hear that other patients may suffer as we have.

Yours sincerely

[redacted]

c.c. [redacted]

C.

[redacted]

[redacted] 2013

Dear Sir/Madam

Re: [redacted]

[redacted] has recently been into [redacted] Hospital a[redacted]y for major surgery on [redacted] bowel. [redacted] was first admitted a couple of weeks ago for observation on [redacted] [redacted] was then discharged on [redacted] and re-admitted the same evening and underwent surgery, followed by a stay in ICU.

We visited on Wednesday and were told that [redacted] would be discharged on Thursday. I spoke to a nurse to confirm that [redacted] was well enough to go home ([redacted] lives on his own) and they said [redacted] was. I explained that [redacted] dressing gown (the only clothing [redacted] had with [redacted]) and [redacted] front door key was not in [redacted] room on [redacted] (they had not seen it); we ourselves did make efforts to find it - even visiting ICU to see if it was there. When it could not be found we made the necessary arrangements to have additional keys cut and left in a safe place at [redacted]. I also explained to the OT that [redacted] had no clothes available to return home in, not even a dressing gown. We took no clothes with us as we had expected [redacted] to have a longer stay in Hospital. She said [redacted] would not be allowed to leave in just the hospital shift [redacted] was wearing (with no underwear underneath) and that trousers would be given to [redacted] and [redacted] would be returned home with a blanket to keep [redacted] warm.

The following day when I telephoned, it was decided that [redacted] should stay for another day as [redacted] had an issue with his stomach and he was eventually discharged on [redacted]

C.

CONT...

The reason for this complaint - which I believe to be serious - is that [redacted] returned home in the open-backed shift and was not seen into [redacted] bungalow but left by the front steps. A neighbour phoned me and said she had found [redacted] wandering in "a state of undress and cold" trying to gain access to [redacted] property. [redacted] had to walk along the street to see if [redacted] could get in the backdoor and then try again at the front of [redacted] property to see if [redacted] could find the key by the porch. [redacted] has a brain injury and is vulnerable. A neighbour found [redacted] and took [redacted] in and phoned us. We confirmed that the key was by the porch and she went and found it so that [redacted] could get inside in the warm. This all took some time.

My complaint is - Why was [redacted] not dressed as previously agreed and why was [redacted] not seen into [redacted] property by the member of staff taking [redacted] home and responsible for [redacted]? They could easily have found the key and ensured [redacted] got inside. [redacted] is not able bodied or mentally adept and this is on [redacted] notes. This is the second occasion I have had to complain. Whatever happened to being treated with dignity and care. To be perfectly honest if I had arranged a cab they would have seen [redacted] into the property - being dressed as [redacted] was and in pain. [redacted] is a valued member of our family and we are currently in the process of moving [redacted] nearer to us. Everyone we have spoken to are as disgusted as we are, even if [redacted] tried to refuse help how could you let a brain injured and sick [redacted] walk up a path to [redacted] house with [redacted] clothing blowing open and not waiting to see that [redacted] had gained access to [redacted] home and was in the warm?

Whatever is going on - all this would have taken a few minutes and would not have cost a penny. We were very impressed by the new hospital building and the facilities it houses but without compassion and good procedures it doesn't amount to as much as we first anticipated.

I would like this investigated and I would also like a response and some accountability for the disgraceful way in which [redacted] was allowed to return home. I sincerely hope it does not happen to anyone else in my [redacted] situation. I really thought that after the previous complaint a note would be on [redacted] file offering [redacted] some compassion and dignity.

Yours sincerely

[redacted]

c.c. PALS

[redacted] 2013

Chief Executive

[redacted]

[redacted] 2013

[redacted] 2013

Complaints Department

[redacted]

Dear [redacted]

Re: [redacted]
Hospital No. [redacted]
NHS No. [redacted]

Please find on the attached sheets a brief summary of [redacted] treatment' over the last few years at the Urology Department, [redacted]

I would be very grateful if, having read my concerns, you are able to offer me an appointment to discuss these issues with you further.

Yours sincerely

[redacted]

cc [redacted]

D.

[redacted] Summary of Treatment

- Enlarged prostate for approximately four years;
- Seen by [redacted] team, two biopsies taken – one under local anesthetic; the other, a template, under general, both negative for cancer;
- Prescribed [redacted], managed symptoms well but PSA level remained between 11-13-ish – high for someone of [redacted] age;
- During this 3-4 year period [redacted] was discharged twice from [redacted] as no cancer was present and there was complete disinterest in the fact that the prostate was very enlarged for a [redacted] and could well cause problems in the future. 'Come back when your symptoms become unbearable' was the advice given!
- We managed to persuade them to keep [redacted] on and PSA levels checked every six months. At no time was [redacted] ever offered reduction of prostate by surgery or medication, despite us having collated lots of research re these procedures. Again, it seemed there was general disinterest.

I must also mention the conditions of the [redacted] during this time – chaos best describes it – no proper seating area, only chairs along a corridor, resulting in no dignity. [redacted] was at that time [redacted] for a Trust [redacted] and was often recognized by colleagues as they passed [redacted] sitting in the corridor. [redacted] found this a very humiliating experience for a private and reserved person.

- Early this year [redacted] PSA level was again 13-something (no-one could ever agree) so [redacted] suggested an MRI scan followed by an MRI-guided biopsy – [redacted] letter to GP then stated he though it was 'very unlikely' cancer would be found, again dismissive and also wrong as it turns out;
- MRI scan finally takes place and after much chasing of results (no follow-up appointment was given) we were told that there was a small area of concern within the prostate but also a 'grey' area on [redacted] pelvic bone. This led to extreme anxiety until finally (on the day I was having a [redacted] cancer), [redacted] spoke to a nurse [redacted], who said there were no concerns re the pelvic area, only the prostate, and again the attitude was very blasé re the whole thing. This was after we endured a week of distress and anxiety thinking [redacted] had secondary bone cancer (while still reeling from [redacted] cancer diagnosis);
- [redacted] was told he would now have an MRI-guided biopsy, which we were (falsely) led to believe would mean a very small number of biopsies would be taken from the 'grey' area in the prostate gland. Why would there need to be any more than this when both previous biopsies were clear?

D

- [redacted] didn't hear anything for months, then he chased up [redacted] who appeared surprised and said [redacted] would get onto it but left us with the feeling that the procedure hadn't even been ordered;

- A few weeks later [redacted] got a call saying there had been a cancellation and [redacted] was given a date for the procedure to take place;

- The day before the procedure [redacted] phoned the hospital to ask what time [redacted] should go in (no letter had arrived), and no-one seemed to know who he was or what [redacted] was going in for;

- [redacted] arrived on the day and there was no-one available to do the procedure. [redacted] waited around for ages until [redacted] arrived and carried out the biopsy;

- After [redacted] regained consciousness, staff stated there was no-one to look after [redacted] on [redacted] so they wheeled [redacted] in a chair, still groggy, up to Admissions. Admissions were full to bursting and a stand-up argument ensued regarding their unhappiness to take [redacted] on, but they had no choice. They were also cross that the venflon was still in situ. [redacted] was there no time at all and the minute [redacted] passed a thimble-full of urine, they discharged [redacted]. [redacted] was very sore and groggy when I picked [redacted] up;

- The next day [redacted] was very sore but passing urine okay;

- The following day – Saturday 19 October – [redacted] woke early, unable to pass urine and went to A & E where [redacted] was catheterized;

- [redacted] was in absolute agony over the weekend, and rang Urology on Monday and was told catheter would have to stay in for a week. There was no offer of advice re catheter care given. [redacted] was very distressed;

- The nurse rang back on [redacted] October and said she had liaised with [redacted] [redacted] and [redacted] had confirmed that it would have to be a week and an appointment for 'Tried without Catheter Clinic' would be sent;

- On Thursday 24 Octob[redacted] became very ill very quickly. I contacted the Urology Department for some advice, but with no returned call, I took [redacted] to A & E where [redacted] rapidly deteriorated and ended up that evening on ICU with Septic Shock. [redacted] needed to be intubated and was on a ventilator on [redacted] October. [redacted] life was in the balance all the weekend and the distress and pain [redacted] has suffered has been tremendous;

- On [redacted] I re-contacted the Urology Nurse, [redacted], whom I had left a message for the previous day, saying we needed help. She said she didn't get this message and was shocked to hear of [redacted] condition and appeared a tad defensive;

D

- Whilst on ICU on [redacted] when [redacted] was in acute distress, the Urology Team arrived and reviewed, gave biopsy results, and said out of 41 biopsies taken, only one showed a very low grade cancer that would probably not even require treatment! All of this for nothing! They also said [redacted] PSA was probably high as a result of [redacted] enlarged prostate – not cancer – so why wasn't this dealt with before? Then the doctor said [redacted] would prescribe a drug to reduce the size of the prostate – again, why wasn't this done in the three years previous?

- No more than five minutes later the Urology Nurse [redacted] arrived with a [redacted] who turned out, when I asked, to be [redacted], [redacted] didn't see the need to introduce [redacted]. [redacted] then proceeded to talk at us and said when [redacted] was well enough [redacted] would perform laser surgery to reduce the size of the prostate! This is straight after [redacted] colleague said [redacted] would prescribe drugs!

- When I challenged [redacted] said drugs couldn't be prescribed if there was a cancer in situ (which I don't think is the case) and they would also take a long time to work;

- [redacted] then proceeded to do a rectal examination (on a very distressed [redacted]) when one had been done already the day before and shown no abscess, and a CT scan had been ordered to check for an abscess already;

- We were then left with a leaflet about laser surgery! Ironic really as at that stage I wasn't sure [redacted] was going to make it through the weekend;

- Under no circumstance do I want [redacted] to have any more surgical procedures so I will be ensuring that if [redacted] can have drugs instead, that is what we both want;

- Such is my fear that I am going to ensure that it is documented in [redacted] medical records that no consultations take place with Urology without me being present, and as it now seems [redacted] is [redacted] consultant having taken over from [redacted] (no-one informed us of this), I do not want [redacted] any where near [redacted] ever again.

D

Questions

1 Why wasn't treatment to reduce prostate size ever offered at any time in the past three years?

2 Why were we never told that the enlarged prostate itself could be raising PSA levels and it didn't necessarily indicate cancer?

3 Why wasn't an MRI scan offered three years ago? This would have then negated the need for all the ensuing biopsies?

4 Why were 41 biopsies taken from all over the prostate when only one small area was of concern? What is the point of using the MRI scan as a guide in the first place?

5 It appears from the nurse that [redacted] would not even have been seen in a clinic until [redacted] October, six whole days after [redacted] admission to ICU. Surely the Service needs to be more reactive?

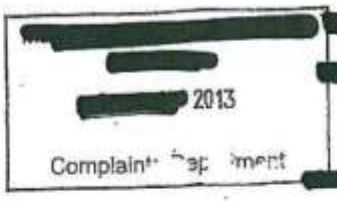
6 I believe that the biopsy and subsequent catheterization are directly responsible for putting m[redacted] at risk for no valid reason, and I feel extremely angry at this. This could have been avoided totally if more care, attention, information and proper intervention had been delivered at any time over the last three years.

When [redacted] is out of danger and facing what will probably be a long recovery, I would like to meet with you and discuss the concerns I've highlighted. I would also like to ensure that someone other than [redacted] or [redacted] is responsible for [redacted] care, as I have no faith in either one of them. If this is not possible I will be requesting treatment elsewhere.

[redacted]

[redacted]

From: [redacted]



[redacted] 2013

Subject: Complaint about mismanaged birth and undiagnosed hypotonia

Dear Sir/Madam,

My name is [redacted] and I'm writing to you regarding my [redacted] who was born on the [redacted] 2012 in [redacted].

[redacted] is 22 months old now and [redacted] development is really behind. [redacted] is not walking yet, not talking and has problems with eating as well.

When [redacted] was born (normal delivery) everything seemed to be fine although it was a problem with the heart rate during labour, the umbilical cord was around [redacted] neck, there was meconium in the water and [redacted] did not cry immediately. The apgar scores have been 9 and 8.

I had problems with breastfeeding; [redacted] could not latch on properly and got tired of sucking very quickly. I went to the breastfeeding clinic in [redacted] for some help. One of the ladies there told me that [redacted] is tongue tie that is why [redacted] cannot latch on properly. We have been referred to [redacted] hospital in a week time where we had surgery. We still had problems, so I started to use a nipple shield for every feed that really helped us both.

[redacted] eyes have been always very strange for me [redacted] only opened them a tiny bit while other babies usually have big eyes, wide open. I mentioned this to my GP a few times as well as for the midwife and health visitors. I was always told that as [redacted] gets bigger the eyes will open up as well. I have once seen a different GP at [redacted] surgery who also thought that the eyes need to be checked [redacted] referred us to the eye clinic at [redacted]. We have been told there that the eyelids are in the pupils, especially the right eye and we have to go back on a regular basis to make sure this is not affecting [redacted] vision.

Then whe[redacted] was 16 months old we realised that something must be wrong as [redacted] still was not putting weight on [redacted] legs. [redacted] was only commando crawling at that time, only using one arm and one leg.

I asked our local GP [redacted] to examine [redacted] nd refer us to a paediatrician. [redacted] did not find anything unusual, but [redacted] has referred us to [redacted] to see a paediatrician [redacted]

[redacted] (we visited [redacted] on the [redacted] 2013) wanted to run some test, blood test and hip x-ray and we've been advised if [redacted] is still not putting weight on [redacted] legs in the next 2 months then we should investigate this further and see a neurologist. [redacted] also said that [redacted] will arrange us physiotherapy although the waiting list is long so I might want to find someone private.

Approximately in a week time I have asked [redacted] in an email about the results of the blood test and hip x-ray and [redacted] confirmed on the same day that everything is normal ([redacted]/2013). In a month time ([redacted]/2013) [redacted] contacted me while we have been away in Hungary that they have seen something on the hip x-ray, so we have to go back and see [redacted] as soon as we are back. I was surprised as on the [redacted] I was reassured that all the results are fine. I contacted [redacted] a few times from Hungary [redacted] spoke to an orthopaedic doctor and to the radiologist and at the end they have agreed that the x-ray is fine. We should not go back after all. I felt confused and went through lots of stress.

We have been recommended a German physiotherapist who is specialised in children and have had 2 sessions with [redacted]. [redacted] was showing us some exercises that we should have practiced at home every day and that would encourage [redacted] to crawl on four knees.

I and my husband been concerned about [redacted] development and we did some research about muscle weakness and possible treatments. This is how we found a therapy called Deveny method, it was recommended to us through some Hungarian friends. We decided to take [redacted] to Hungary and do some physiotherapy (Deveny Method) there with [redacted]. The therapist quickly realised that [redacted] has hypotonia. [redacted] treated [redacted] 4- 5 times a week for 4 weeks. [redacted] recommended us to see a neurologist and an orthopaedic doctor. The neurologist was really worried and referred us to some further examinations to the Hungarian children hospital in Budapest ([redacted]). We spent 5 days there and they have been doing various examinations on [redacted]. We also discussed the pregnancy and the birth with one of the main neurologists of the hospital. When [redacted] heard about the circumstances of the birth: [redacted] did not cry immediately when [redacted] came out, the cord was around [redacted] neck and that there was meconium in the water [redacted] knew that this is what caused the hypotonia.

Due to the muscle weakness [redacted] could not feed properly, [redacted] still has problems with food (textures) I have to pure everything. That is why [redacted] eyelids are hanging as well. All these are due to general muscle weakness in the body. The orthopaedic doctor in Hungary though the hips are fine, but [redacted] has flat feet (fallen arches) [redacted] needs to wear special orthopaedic shoes.

They also did the appropriate tests to make sure that [redacted] does not have Myasthenia and cerebellar hypoplasia as [redacted] was showing some of those symptoms too. Luckily those tests were

negative but we were told that if they would have been positive and it would have been left untreated for 2 years would have had irreversible consequences.

When we returned from Hungary, we had appointment for the eye clinic. The eye clinic and the children clinic has the same reception desk at [redacted] I wanted to talk to [redacted] briefly and explain [redacted] what happened in Hungary, what the results are and that we need more physiotherapy here. [redacted] said that since [redacted] hasn't got any problems with the hips physiotherapy is not a matter of urgency! I told him that [redacted] was diagnosed with hypotonia, but [redacted] reply was that there are many hypoton children. Last time I have seen [redacted] back in [redacted] said that [redacted] will refer us to physiotherapy, but the waiting list is very long so I should look for someone private. I asked [redacted] for a new appointment and I also asked [redacted] to arrange visit with a neurologist and an orthopaedic doctor [redacted] said it would be too much to start with.

Our next appointment with at [redacted] with a paediatrician was [redacted] 2013. We have seen a female doctor [redacted] as [redacted] was away. I told [redacted] about our trips to Hungary and how desperate we are to get treatment here for [redacted] promised me to arrange physiotherapy and speech therapy with the [redacted] At the end of [redacted] we have received a letter from the [redacted] that we had to sign and send back. We did not hear about them since then. On the [redacted] I gave them a call to check whether they have received our signed letter and how long we still have to wait to be seen. I was told that there are 12 children on the waiting list before [redacted] Probably we won't be seen this year.

I cannot put [redacted] to a nursery as [redacted] is too big now for the babies group and not ready yet to be in the toddlers group. [redacted] is frustrated as [redacted] can see other children walking and talking. And we parents are extremely worried and upset that we don't get the support we need from the NHS. Time is ticking [redacted] is getting 2 years old now and [redacted] is so behind in many areas of development, [redacted] does not behave as a baby. We have received no support,

Financially it has also put us into a difficult situation. Not just that we have to pay for all he flights to various countries to get proper diagnostics and some treatment, to pay for the tests and treatments, consultations, hotels, car rental, taxi, etc. I have created a business in 2008 which was improving significantly, generated really god profit, now since I have to be with [redacted] jetting around the EU I wasn't able to go back to work yet. The company not just stopped expanding but losing clients and money and I can't find any employee who would replace me (and my skills) 100%.

I have the following complaints:

1. First of all I don't understand how they did not pick up in the hospital that [redacted] has the umbilical cord around the neck prior to delivery. In other countries they do the appropriate checks before the labour starts and if the cord is around the neck risking oxygen supply they process a caesarean delivery. If they would have picked it up and would have done a caesarean my daughter would not be hypotone.

2. After delivery when it was clear that [redacted] had the umbilical cord around the neck no further tests has been done, Hypotonia was not diagnosed. In other countries in similar situations

treatments are started to at day 1 to stimulate the muscles and the directly or indirectly damaged or delayed brain functions.

3. No further tests were done to filter out Myasthenia and cerebellar hypoplasia in spite of the symptoms were obvious. Luckily the tests we arranged privately abroad has been negative but if they would have been positive and it was left untreated for 18 months would have left [redacted] with irreversible consequences

4. I am also really upset also that once the lack of oxygen incident happened, [redacted] other conditions - ptosis, flat feet hasn't been picked up by the doctors, midwives and health visitors.

At the first place with a caesarean the damage could have been avoided if they would have picked up that the umbilical cord is around the neck. Even after they should have realised that [redacted] has hypotonia right after [redacted] was born and this should have been treated from an early age. Now [redacted] is nearly 22 months old and still not walking nor talking nor eating proper food!

We have took [redacted] for a complex examination (again abroad) to an Early Child Development Centre where they did various tests and apparently [redacted] cognitive skills, [redacted] sensory skills and movement skills are at the level of a 10-15 months baby at the age of 20 months. We also have to feed [redacted] like an 8-10 months old baby. Due to the ptosis anywhere we go everyone makes comments about how sleepy [redacted] is and [redacted] will sleep in 5 minutes.

The multiple mistakes [redacted] and the employees caused a family tragedy for us. We lost a lot of money, stress and a baby which behaves as half of [redacted] age and we still don't see how this delay is going to be reduced and finally eliminated.

Please investigate the above case and get back to us with the results.

Yours Sincerely,

[redacted]

[redacted]

[redacted] 2013

[redacted]

Dear Sirs

[redacted]

Date of Birth [redacted]
Hospital Number: [redacted]
NHS Number: [redacted]
[redacted]
Surgeon: [redacted]

Dear Sirs

I am writing this letter in relation to my late [redacted] who passed away at the [redacted] on [redacted] 2013.

It is very hard to write this letter but I am very angry with the hospital for allowing [redacted] to be released from [redacted] on [redacted] when you knew how ill [redacted] really was and advised to wait for an appointment to see [redacted] in two weeks.

I spoke to [redacted] secretary on [redacted] who then passed me over to [redacted] who informed me the cancer had returned, [redacted] could not have another operation and would be referred to [redacted] (another two week wait) and [redacted] would refer [redacted] to the Hospice.

[redacted] from the Hospice came and saw [redacted] on [redacted] July and [redacted] could see how poorly [redacted] was and was very supportive. We saw [redacted] on the [redacted] who basically said [redacted] was too ill for chemo but if [redacted] got better phone [redacted] secretary for another appointment. Luckily the Hospice was able to take [redacted] in the following day for respite only but [redacted] never came out. The Hospice tried everything they could for [redacted] and also involved [redacted] who done everything [redacted] could to help [redacted] but by now it was too late.

So my complaint goes back to why [redacted] was sent home from [redacted] on [redacted] when the hospital knew how ill [redacted] was and told to wait two weeks for an appointment and was never referred or seen by [redacted]

Yours faithfully

[redacted]

[redacted]

G.

[redacted]

[redacted] 2013

Dear Sir / Madam

Re: Delivery of a baby [redacted] at [redacted]
(Hospital number [redacted])

We are writing to make a complaint and to suggest a change of procedures as a result of our experience following the birth of [redacted]

Exactly a year (to the date) before, we had the traumatic experience of [redacted] after a period of labour in excess of 24 hours. Despite receiving counselling, we were extremely nervous about labour and ensured that there was a SANDS sticker on the cover of the maternity notes as well as clarity about this in the Birth Plan. So we presumed that all staff that we would come into contact with would be aware of our past trauma.

Staff in the delivery unit were mostly aware of this sensitivity and handled it well during what was a routine labour. We would particularly like to mention [redacted] who was superb – professional but also a great comfort. Unfortunately, just after delivery, a member of staff who hadn't been present for the birth popped her head around the door and asked if it was our first baby.

The problems were mostly in the post-natal ward where staff were obviously not aware of this or had misheard / been misinformed as on three occasions we had staff congratulating us on [redacted] and saying what a co-incidence it is that we would be celebrating [redacted] on the same date. At a time of great joy at the birth of [redacted] this was obviously distressing to hear and served to bring up emotions that remain raw and upsetting. We want to emphasise that we do not blame staff for what seems to be a procedural problem and suggest that the post natal notes should include a SANDS sticker or equivalent or at least a space on the cover to write something that all staff will pick up on.

We want to emphasise that this situation caused a lot of distress to both of us and would like you to write to let us know in what way procedures were at fault and in what way, if any, they will be changed so that this does not happen to another couple.

Yours faithfully

[redacted]

[redacted]

[redacted] 201[redacted]
Complaints Depar[redacted]

[redacted]

[redacted] 2013
Chief Executive

[redacted]
07 OCT 2013
Complaints Department

[redacted]

'atient – [redacted]
)ate of Birth [redacted]

)ear Sir / Madam,

am writing to complain about the treatment received at [redacted]
013.
ly partner and I took our [redacted] to A+E after [redacted] suffered a blow to the head by a orse, and after a long wait were advised that although they don't like to CT scan young hildren because of the risks it was advisable to do so in [redacted] case.

became apparent during the CT scan that the scanner had broken, and they were only ble to obtain half the required images but were happy to let [redacted] return home on the utcome of these, at no time was it suggested that [redacted] had been exposed to more radiation ıan he should have been.

'esterday to my shock I received a mobile phone call from a member of staff at the ospital, advising me that [redacted] had been exposed to far more radiation than [redacted] should ave been, and an investigation has been held to look into this, this is the first time I had een made aware of this and some 4 weeks after the scan had been done.

have been offered an appointment with a radiologist at the hospital to answer any uestions which I will attend once I have the full details outlined in writing.
.s I hope you appreciate I am totally appalled that this could have happened and have poken to my solicitor for advice and want some clear answers as to:

how and why this could have happened
What consequences this could have for [redacted] in later life
Why I wasn't made aware earlier than 4 weeks later

H.

I would be pleased if you would carry out a full investigation into my concerns and provide a response in accordance with the NHS complaints procedure.
I look forward to your reponse and please don't hesitate to contact me if you require any further information

Kind Regards

[redacted]

[redacted]

Home URL

[redacted] September 2013

I attended an appointment with [redacted] at [redacted] Hospital at [redacted] I had earlier been rung twice that morning to change the appointment from the original 3.45, on arrival I was given drops in my left eye and seated in the waiting are, I was shown into [redacted] room where he seemed distracted and even annoyed, his only conversation was to say that while the treatment would only try to stop degeneration it would not make it better and could make it worse then with an irritated flourish asked me to sign it, he then without any explanation as to what was going to happen quit roughly forced something into my left eye I assumed to keep it wide open and then proceeded to firmly position my head in the frame, one again with no explanation as to what I may expect other than telling me to watch the green light with my good eye he proceed to start the treatment, I wrongly assumed that I would only see the Laser in the eye that was being treated instead there was 10/15 rapid flashes that was worse than trying to look at the sun into my good eye as well as my bad which made hie instruction to watch the green light impossible and the shock caused involuntary movements that it was very difficult to control, he sharply told me several times not to blink with my

good eye but I can assure you that it was an impossible feat to not blink, I wondered later if the machine was not set up properly as I cannot believe anyone could do what was required with the laser flash going into both good and bad eyes, he continued roughly repositioning my head and then bursts of 20/30 flashes at a time were put into my eye, the trauma caused me was hard to describe as I am a strong man with a very high pain threshold but this was almost beyond what I could stand, my eyes were streaming as was my nose and after a few minutes I had to ask him to stop for a moment so that I could blow my nose, he continually berated me for moving and in the end told me he had done the "best he could" and that the treatment was over, I had tried to explain that the object he put in my eye was painful and that the flashes in my good eye made it impossible not to blink but other than a short mumbled apology for any pain caused as I left the room he showed not the slightest understanding of the trauma he had caused.

I have had several treatments over the years and never been treated with so little respect compassion or indeed care, if it had even been explained what I should expect and some reassurance during the treatment I am sure it would have helped but what I am afraid I am left with is an eye that is worse than it was because my trembling must have caused dozens of miss-hits and as the treatment seemed to continue with no break for approx 15 mins I almost felt assaulted ;

Please accept my apologies for bothering you with this and I am loath to cause anyone any for of retribution, but I also feel its my duty to at least try to minimize any future risk to patients as I would sincerely not want anyone to feel as powerless over what was happening to them as I was.

Sincerely yours,

[redacted]

[redacted]

[redacted](Withheld numbers barred).

[redacted] 2013

[redacted]

[redacted] 2013
Complaints Department

With Regards to [redacted]

We wish to make a formal complaint regarding failure to diagnose Multiple sclerosis for the past 6 years. [redacted] has been under the care of this trust for 6 years and has been wrongly treated and diagnosed with everything from "Migraine Related Limb Pain" by [redacted] to Reflex Sympathetic Dystrophy, to which [redacted] has under gone surgery having a spinal cord stimulator implanted. Despite seeing various and numerous Doctors in [redacted], [redacted] has now only been diagnosed as having MS by [redacted]

[redacted] is now having Physiotherapy and hydrotherapy privately at [redacted] at our own expense and we feel the Trust should be paying for this.

We find this completely remarkable as [redacted] have both asked on numerous occasions could [redacted] have MS, and every time we were told "NO", this is not acceptable and we feel the trust should and will be held responsible for the pain and distress [redacted] has endured for the past 6 years.

WE require an apology or a review in the way MS is diagnosed within the trust

WE require your comments regarding this matter and a full copy of [redacted] Hospital file.

Yours

[redacted]

K.

[redacted]

[redacted]2013

[redacted]

Dear Sirs

Formal Complaint: [redacted]

I was diagnosed with medullary carcinoma of the thyroid on [redacted]2013. In the course of 'prepping' me for the necessary surgery another lump was found in my chest cavity. Investigation of this second lump was assigned to your Trust.

I now have to write regarding the treatment that I have received under [redacted] in respect of this second lump. I was listed for an endoscopy and fine needle aspiration on [redacted] 2013. I was informed on the morning of the [redacted] in the endoscopy unit that the consultant that I had been listed under was only able to perform endoscopies and not able to do an endoscopy with a fine needle aspiration and that I was being re-listed. I must note for the record that I find it very difficult to believe that the clinician who writes up the lists does not know what procedures the different members of the team are and are not able to perform. Anyway, I was notified shortly after th[redacted] that the procedure had been re-listed for the end o[redacted]. I spoke to the nurse manager of the endoscopy unit and PALS and pointed out that, as I was being investigated for cancer, the wait was unacceptable in the circumstances. I was then re-listed for the following week and the procedure went ahead.

On the [redacted] I attended [redacted] clinic in [redacted] for the results of the procedure and was informed unequivocally that the second lump was benign and that I would be followed up in 6 months with a repeat EUS with a CT scan. This was confirmed in [redacted] letter of [redacted]2013.

On [redacted] I attended [redacted] for Genetic counselling in respect of the medullary carcinoma of the thyroid and, after speaking with [redacted] I agreed that my case regarding the second lump that [redacted] clinic investigated be referred to the [redacted] team as they had reason to believe, based on the information that they had on file, that the second lump might not be benign. They did inform me that it was possible that on receipt of the whole file, they could decide that no further action other than that suggested by [redacted] team need be taken and they would let me know either way. I received a telephone call yesterday informing me that I had been booked in for a molecular imaging scan on [redacted] and a CT scan on [redacted]r. I believe that these scans have been booked as emergencies from my discussion with the officer yesterday.

K.

My complaint is:

- That on the [redacted] did not receive the procedure and that the explanation that I was given for this is unbelievable.
- That the result of the procedure was inconclusive and that [redacted] did not have sufficient information to inform me that the lump was benign.
- That by informing me that the lump was benign a three month delay in determining the nature of the lump has been caused and consequently delayed any treatment that is required.
- That one consequence of the delay is a potential adverse repercussion on my work. If the investigations had been completed and the nature of the lump determined in [redacted] I could have had the necessary treatment whilst I was already signed off on the existing 'fit note'. This consequence could well result in my losing my job if any treatment I undergo requires me to take further time off work under a 'fit note'.
- More importantly for my health if, as it is suspected, that the lump is cancerous, the delay could result in my untimely demise!

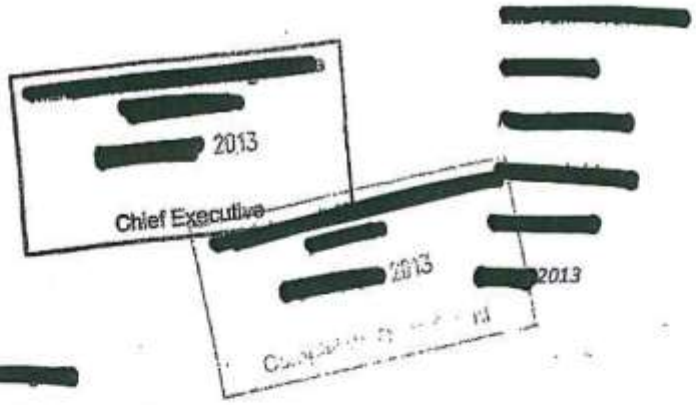
I look forward to hearing from you regarding this matter.

Yours faithfully

[redacted]

[redacted]

L



Dear

Hospital procedure for dealing with bereaved relatives

Our purpose in writing to you is to bring to your attention our concerns with the process for dealing with bereaved families at . This appears to indicate a lack of procedure, process and protocols in dealing with bereaved families and consequently a failure to meet accepted standards of service delivery in regard to treating people with dignity and respect.

Firstly we must stress that the clinical and nursing care which received during 4 week stay until died on the was excellent. We have already written to thank staff on both wards on which was treated to thank them for the consistent care and attention they provided and the considerable kindness they gave to throughout stay.

We have tried to find out the process for writing to a designated officer at either the hospital or the Trust, but have been unable to locate this on your web site or via your switchboard. Our experience at other hospitals differs considerably from . At these, we have been asked to complete a 'satisfaction survey' and provide feedback, hence this letter.

Our concern is with what we experienced as an apparent lack of process for dealing with bereaved relatives, including inadequate and inaccurate information and poor staff training. The details are as follows:

- We were informed by telephone that if we wished to see body, we should go directly to the ward on which died. This meant yet another long wait at the outer access doors as the entry bell was out of order – and had been for several days. We had already been told that body would be moved from room several hours before we arrived.
- Despite providing the ward with telephone confirmation of the time of our arrival on the ward, there was no one to meet or talk to us. We listened as various support workers called to each other up and down the ward trying to find out where was currently located and what they were supposed to do.
- We were approached by a support worker, who had cared for for several weeks and was visibly upset by death. offered her condolences and proceeded to relate final hours and the circumstances surrounding fall from bed during the night. All of this took place in the corridor in full view of empty room and

stripped bed and this was our only opportunity to talk with someone about [redacted]'s final hours.

- We were eventually shown into the tea room where we could clearly hear various support staff ringing around the hospital seeking telephone numbers and advice on what they were to do.
- On asking support staff if we could collect our [redacted] belongings, we were told that someone from the bereavement service would ring us to make an appointment for us to return to the hospital and collect them. [redacted] bags had already left the ward. After several days, I rang the hospital, was transferred to PALs, who informed me that this was incorrect – no one would ring, we had to call in. When, several days later, we collected [redacted] belongings, [redacted] overnight bag was missing and could not be located.
- The bereavement service only appears to operate between 11 and 3 and with limited staffing. We left a couple of messages on the answer-phone, but no-one responded to these, as we expected. It took several calls before we could find someone and arrange to call in.
- Back on the ward: after 10 minutes, a nurse came in and apologised for the confusion and delay and offered us tea etc. She was obviously very upset that we must wait until someone could be located who knew where [redacted] body had been taken.
- After a further 15 minutes, a support worker indicated that she would take us down to see [redacted] body. She explained that she had not done this before.
- We then arrived at the mortuary door – to find that no one was there to meet us as the support worker had expected. After several attempts to ring someone who could let us in or find alternative numbers for help and as this is opposite your estate department, she knocked on the door and asked an estate worker with access to the mortuary, to enter and try and locate someone. After calling out, he returned and then both tried to ring your switchboard to get telephone numbers. As they got no response, the estates worker then ran off to find the person in charge of the mortuary, who eventually arrived, apologising for getting delayed.
- The support staff had told us that the coroner's certificate would be sent to the hospital for signature by a doctor and that the bereavement service would telephone us, again to make an appointment to collect this for the registrar. As we live in [redacted] and the rest of the family faced a stressful return to [redacted] by public transport, I rang PALs again to see if we could combine collecting the belongings with collecting the certificate. Again, we found out that this was incorrect and the coroner would inform the registrar directly.
- The coroner's office provided us with all the relevant, correct information on the process and handled this with great sensitivity.
- At no time were we asked to comment on the hospital and its processes. We would have welcomed this – both to praise the staff and to highlight the need to review your bereavement process.

We must stress that all of the staff with whom we were involved were both distressed and apologetic at the confusion and lack of information they had in their possession. They all did their very best to assist us.

L.

Unfortunately, we had a family death earlier in the year, but had been through a very supportive and efficient process at [redacted] The procedure for viewing the body, collecting belongings, discussing 'final hours' and 'next steps' was handled sensitively and with dignity.

We would ask that you reconsider your procedures and protocols, specifically:

- The unnecessary and distressing visit to the ward
- The unavailability of trained and experienced staff to talk with and guide us accurately through the process
- The process for visiting the mortuary
- The process for the safe keeping and collection of belongings
- The availability of the 'bereavement service'
- The inclusion of a service review form for comments and suggestions

We would hope that no other family has our experience at [redacted] and hope that you will find this helpful in reviewing your processes and protocols. We are sure that [redacted] would make theirs available to you on request.

We would be very pleased to know what action you have taken/will take to address the above.

Sincerely

[redacted]

(On behalf of the [redacted])

M.

Chairman

[redacted]

Chairman

Complaints Departm

[redacted] 2013

Confidential

* Official Complaint by [redacted]

To the [redacted]

Ref: [redacted]

Dear Sir

I am writing to you on behalf of [redacted] the [redacted] of the late [redacted] who **died in the** [redacted] **on the** [redacted]

Please see enclosed photocopy of the letter * **OFFICIAL COMPLAINT** dated [redacted]

Please also see enclosed photocopy of the **GMC reply** dated [redacted]

Please also see enclosed photocopy of the **GMC reply** dated [redacted]

Their ref: [redacted] – Investigation Officer – [redacted]

[redacted] family do understand that such matters take time to investigate and that the GMV having carefully considered the concerns raised about [redacted] the [redacted] does not require the GMV to restrict the doctors ability to work.

However the hospital's website states under:-

Respect : *We respect and value our patients, visitors and staff.*

Excellence : *We take every opportunity to enhance our reputation*

Nevertheless [redacted] **feel 'left out in the cold' by not receiving** ***the courtesy of a reply from the*** [redacted] ***itself.***

Is this *policy* **of the** [redacted]

With respect, if this is *'your'* policy, such discourtesy does not enhance its reputation.

A few words of condolence & understanding would mean so much to [redacted]

Yours very sincerely

[redacted]

[redacted]

GMC
350 Euston Road
London
NW1 3JN

[redacted]

M

Tel: [redacted]
e-mail [redacted]

[redacted] 2012

OFFICIAL COMPLAINT

Dear Sir
I am writing to you on behalf of [redacted] the late [redacted] who died in [redacted] on the [redacted] was [redacted] In [redacted] 2009 [redacted] was diagnosed as having an aggressive form of Leukaemia CMML2. [redacted] then underwent a 'private trial' of a fairly new Chemotherapy at the [redacted] which over several months proved reasonably successful followed by regular 'experimental' treatment of platlet transfusions, and bone marrow tests at the [redacted] and regular blood transfusions in [redacted]. [redacted] was much admired by members of staff for [redacted] bravery and cheerful disposition.

In [redacted] and for last 3 to 4 days of [redacted] life, [redacted] was in [redacted] due to developing pneumonia. [redacted] wishes to offer [redacted] gratitude to the staff in the [redacted] for their efficient, kind and gentle manner given to [redacted] throughout those last days – especially by a male member of staff named [redacted]

However [redacted] quite apart from [redacted] mourning, was deeply offended by what the [redacted] said to [redacted] while [redacted] was sitting by [redacted] a few hours before [redacted] died. 4 other doctors were present.

"I'm sorry to tell you that [redacted] is going to die. Both of [redacted] lungs are now infected."
At that moment [redacted] was observed by [redacted] as having fear in [redacted] eyes.

[redacted] was coughing blood. [redacted] then said "We will water you, feed you (this sounded like talking to a dog) "and give you a blood transfusion" [redacted] then spoke in a manner that was described as a 'condescending and in an almost angry manner'. He said "Do you understand!?" both said "Yes" followed by "Have you any questions!?" both said "no". Morphine wasn't offered. And that was it [redacted] died at [redacted] would have complained sooner but only now feels strong enough to do so.

The GMC state in the their Good Medical Practice Guide for Doctors
End of life care: Guidance (for people close to the patient and the patient eg:
1)18 ..make sure, as far as is possible, that **their needs for support are met and their feelings respected**
Patients who are approaching end of life need high-quality treatment and care that support them live as well as possible until they die, and **to die with dignity**
4) 20...you **must do your best to explain** clinical issues in a way the person can understand and approach difficult or potentially distressing issues about the patient's prognosis and **care with tact and sensitivity.**
Communicate effectively eg:
SEE 31 and 2. 32 and 3. 33 and 4. 34 Other GMC documentation is to hand.
With respect, [redacted] clearly falls short of what the GMC states in your Good Medical Practice Guide

[redacted]

[redacted] 2013

In reply please quote: [redacted]

General Medical Council

3 Hardman Street
Manchester M3 3AW

Telephone: 0161 923 6200
Facsimile: 0161 923 6201
Email: gmc@gmc-uk.org
www.gmc-uk.org

Private: Addressee only

[redacted]

Dear [redacted]

Thank you for your letter of [redacted] 2013 about [redacted]

I am sorry to hear of the circumstances which have caused you to write to us. I appreciate that this has been a very difficult time for [redacted] and I extend my sincere condolences.

I will be responsible for your complaint and will be your main point of contact. If you have any questions, please contact me and I will do my best to help. My direct contact details are at the end of this letter.

Our role is to ensure that doctors on the UK register are fit to practise. We can restrict a doctor's ability to work, if there are concerns about patient safety or where there are issues that affect the overall reputation of the medical profession.

An assistant registrar (an experienced member of staff) has carefully considered the concerns which you have raised about [redacted] They are of the view that the concerns you have raised, on their own, do not require us to restrict the doctor's ability to work.

This is because whilst we understand your reasons for writing to us, from the information provided we do not consider that this is a matter that would enable us take action on the doctor's registration in order to stop the doctor from working or to limit the type of work that he does. This does not fall into a category of impaired Fitness to Practise as outlined in Section 35C(2) of the Medical Act and does not meet the threshold for opening a full GMC investigation. However to ensure that there is no pattern of this type of behaviour or that there are no underlying Fitness to practise issues of concern for us to consider further, we will contact the doctor's employers.

I enclose a factsheet, which explains how we investigate complaints in more detail and the kind of action we can take.

GMC
350 Euston Road
London
NW1 3JN

[redacted]

M.

OFFICIAL COMPLAINT

Dear Sir

I am writing to you on behalf of [redacted] the [redacted] of the late [redacted] who died in [redacted] on the [redacted] was [redacted] In [redacted] 2009 [redacted] was diagnosed as having an aggressive form of Leukaemia CMML2. [redacted] then underwent a 'private trial' of a fairly new Chemotherapy at the [redacted] which over several months proved reasonably successful followed by regular 'experimental' treatment of platlet transfusions, and bone marrow tests at the [redacted] and regular blood transfusions in [redacted] was much admired by members of staff for [redacted] bravery and cheerful disposition.

In [redacted] and for last 3 to 4 days of [redacted] life, [redacted] was in [redacted] due to developing pneumonia. [redacted] wishes to offer [redacted] gratitude to all of the staff in the [redacted] for their efficient, kind and gentle manner towards [redacted] throughout those last few days; especially by a male member of staff [redacted]

However [redacted] was deeply offended by what [redacted] the consultant said to [redacted], while [redacted] was sitting by [redacted] a few hours before [redacted] died. 4 other doctors were present. Although [redacted] had been coughing up blood * [redacted] was still very lucid. [redacted] said "I'm sorry to tell you this but both of [redacted] lungs are now infected and [redacted] is **going to die.**" At that moment [redacted] was observed by [redacted] as having **fear in** [redacted] **eyes**.

[redacted] was shocked & felt that [redacted] should have been taken to another room and the prognosis quietly explained to [redacted]. Also there was no need to have told [redacted] that [redacted] was going to die because * [redacted] was still very lucid. [redacted] then said "We will water you, feed you (this sounded like talking to a dog) "and give you a blood transfusion". [redacted] then spoke in a manner that was described as a 'condescending' and in an almost angry manner'. [redacted] said "Do you understand!?" both said "Yes" followed by "Have you any questions!?" both said "no". Morphine wasn't offered. And that was it [redacted] died at 6.30am the next day. Frankly that scenario was outrageous and lacking in sensitivity, tact, respect and dignity. [redacted] **would have complained sooner but only now feels strong enough to do so.**

The GMC state in the their Good Medical Practice Guide for Doctors
End of life care: Guidance (for people close to the patient and the patient eg:
1)18 ..make sure, as far as is possible, that **their needs for support are met and their feelings respected**
Patients who are approaching end of life need high-quality treatment and care that support them live as well as possible until they die, and to **die with dignity**
4) 20...you **must do your best to explain** clinical issues in a way the person can understand and approach difficult or potentially distressing issues about the patient's prognosis and **care with tact and sensitivity.**
Communicate effectively eg:
SEE 31 and **2.32** and **3.33** and **4.34** Other GMC documentation is to hand.

With respect, [redacted] clearly falls far short of what the GMC states & advises in your Good Medical Practice Guide

Yours sincerely

[redacted]

Hello [redacted]
Further to your enquiry, I have been asked to forward the information below from the Medical Director.
I hope this answers your query however please do not hesitate to contact Trust Headquarters [redacted] *if you have any further queries.*
Kind regards

[redacted]

The GMC state in their Good Medical Practice Guide for Doctors the following:

End of life care: Role of relatives, partners and others close to the patient

1. 17. The people close to a patient can play a significant role in ensuring that the patient receives high-quality care as they near the end of life, in both community and hospital settings. Many parents, other close relatives and partners, as well as paid and unpaid carers, will be involved in discussing issues with a patient, enabling them to make choices, supporting them to communicate their wishes, or participating directly in their treatment and care. In some cases, they may have been granted legal power by the patient, or the court, to make healthcare decisions when the patient lacks capacity to make their own choices.

2. 18. It is important that you and other members of the healthcare team acknowledge the role and responsibilities of people close to the patient. You should make sure, as far as possible, that their needs for support are met and their feelings respected, although the focus of care must remain on the patient.

3. 19. Those close to a patient may want or need information about the patient's diagnosis and about the likely progression of the condition or disease, in order to help them provide care and recognise and respond to changes in the patient's condition. If a patient has capacity to make decisions, you should check that they agree to you sharing this information. If a patient lacks capacity to make a decision about sharing information, it is reasonable to assume that, unless they indicate otherwise, they would want those closest to them to be kept informed of relevant information about their general condition and prognosis. (There is more guidance in our booklet on *Confidentiality*.) You should check whether a patient has nominated someone close to them to be kept informed and consulted about their treatment.

4. 20. When providing information, you must do your best to explain clinical issues in a way the person can understand, and approach difficult or potentially distressing issues about the patient's prognosis and care with tact and sensitivity. (See paragraphs 33-36 on addressing emotional difficulties and possible sources of support.)

5. 21. When discussing the issues with people who do not have legal authority to make decisions on behalf of a patient who lacks capacity, you should make it clear that their role is to advise the healthcare team about the patient's known or likely wishes, preferences, feelings, beliefs and values. You must not give them the impression they are being asked to make the decision.

http://www.gmc-org/guidance/good_medical_practice.asp

M

What happens next?

In order to ensure that the concerns you have raised are not part of a wider pattern, we are going to write to the doctor's employer(s)/contracting body(ies). Please note that the employer that the doctor was working for at the time of the complaint will be sent a copy of your complaint, as will all other current employer(s)/contracting body(ies) the doctor may have. We will take further action if the doctor's employers tell us of any serious concerns either in relation to your complaint or more generally. We will also write to [redacted]

What we need you to do now

As you are complaining on behalf of [redacted] I require [redacted] consent in order for me to able to progress with the complaint.

Therefore, if [redacted] is happy to give me permission to send a copy of the complaint to [redacted] and [redacted] employer, please could [redacted] fill in the enclosed disclosure consent form and return it to me by [redacted] **2013**. I have enclosed a prepaid envelope with my letter.

I should let you know that without your consent it will be difficult for us to take any further action on your complaint.

I look forward to receiving your completed consent form and in the meantime, I would be happy to answer any queries you might have, if you wish to contact me on my direct dial number.

Yours sincerely

[redacted]

Direct Dial: [redacted]
Fax No: [redacted]
Email: [redacted]

Enc: [redacted]

RECEIVED 7/9/13

M.

[redacted] 2013

In reply please quote: [redacted]

General Medical Council

3 Hardman Street
Manchester M3 3AW

Telephone: 0161 923 6200
Facsimile: 0161 923 6201
Email: gmc@gmc-uk.org
www.gmc-uk.org

Private: Addressee Only

[redacted]

Dear [redacted]

We have received the completed consent form from [redacted] please could you convey our thanks for completing and returning this.

As I explained in my initial letter, I will now write to [redacted] and [redacted] employer(s)/contracting body(ies). I will ask the doctor's employer(s)/contracting body(ies) to confirm whether or not there are any immediate concerns about the doctor that might require investigation by us.

We will take further action if the doctor's employers/contracting body(ies) tell us of any serious concerns either in relation to your complaint, or more generally. Please note that I will not contact you again unless the doctor's employer(s) inform us of concerns that may require us to take further action.

I would like to take this opportunity to thank you for taking the time to write to us and for the information that you have provided. I would be happy to answer any queries you might have, if you wish to contact me on my direct dial number.

Yours sincerely

[redacted]

[redacted]
Direct Dial: [redacted]
Fax No: [redacted]
Email: [redacted]

15534
N

To,
[redacted]

[redacted]2013

Dear Sir,

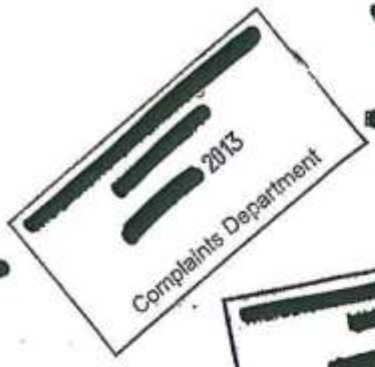
My name is [redacted]r and [redacted], I had been sent a letter that my operation would be on 4th nov so accordingly I prepared the whole week before for the operation, so from 3rd nov night till 4th nov morning I was fasting and [redacted]took taxi in the morning to keep my appointment for 7:30am for my operation. When I reached [redacted] they told me I am not on their list for the appointment then instantly I showed them my appointment letter confirmation then made me wait for 1 hour after that they told me its not today its tomorrow 5th nov. I was very shocked and frustrated seeing this situation how can such a big mistake happens with a patient. [redacted]whole 2 days got wasted and we did lots of hassle for this mistake and took mental stress and physically it was a big torture for me as I had to fast almost for 2 days consecutively which I should not be according to law , I was only to be fasted one day from 3rd-nov night to 4th nov which my letter says. So for this negligence with me I want to apply for a compensation payout because this types of negligence is totally unprofessional and unacceptable.

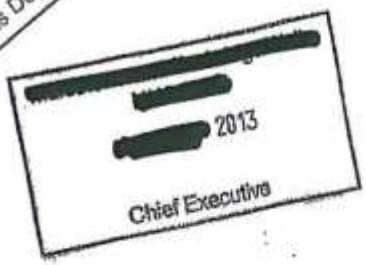
I hope you would solve my complaint as soon as possible please do not hesitate to contact me if you need more information. My address is [redacted] and phone number is [redacted]

Waiting to hear from you soon.
Regards
[redacted]

[redacted]

[redacted]
2013





Dear Sir

Complaint regarding care, treatment and follow up services – [redacted]

[redacted] **NHS Number** [redacted] **D.O.B:** [redacted] **Hospital Number:** [redacted]

I am writing to you to request an investigation into the following complaint/concern.

I was admitted to [redacted] on [redacted] September 2013 as a day case for a bilateral Zadek procedure (removal of ingrowing toe nails). I had been referred to [redacted] by my [redacted] as I have a recent history of collapse following local anaesthetic injections at my dentist. The local GP, minor treatment services and podiatrist did not wish to attempt this minor surgery in the community knowing my history.

At both the pre op assessment and in the history taken by the surgical team on my admission to the day case ward, I again advised of my local anaesthetic reaction history. I was assured this was noted.

I understand from both my [redacted] and the medical team, that following my short day case surgery, the air way was removed and I was recovering satisfactorily as expected. However during recovery one of my toe nail beds began to bleed heavily. To control the bleeding I am advised that the surgical team re administered some general anaesthetic, inserted an air way and then gave local anaesthetic to my toe to enable the surgeon to ? cauterise the wound further and control the bleed.

Following this incident the anaesthetist then attempted to bring me round and remove the airway, at which point it became apparent that my airways had swollen and I was having severe difficulty breathing. This situation could not be rectified, I was unable to breathe unaided so I was intubated, sedated, placed on a ventilator, sent for a CT Scan and admitted to ITU.

[redacted] who was expecting a telephone call to come and collect me on the same day, received a call to advise that I was seriously unwell and the team could not understand what had actually happened. As you can imagine the shock and distress this caused [redacted], but unfortunately this was further compounded when [redacted] who repeatedly requested information to try and understand what had happened, clearly wishing to know why I was given local anaesthetic with my history, was told by the anaesthetist that he was aware of this history, but felt my symptoms in the dentist was not typical of such a reaction and therefore he felt it was clinically "not significant". It certainly appeared significant to my family to result in this serious situation and was not the most sensitive thing he could have said.

[redacted] was advised that blood had been taken and sent for investigation to establish if I had had a true anaphylaxis reaction and that these tests were highly specialised, sent to [redacted] and would take 6 to 8 weeks for the results to come back. [redacted] repeatedly advised the team that adrenaline seemed to be a trigger, even noted when in ITU, when I was administered an adrenaline inhaler to help reduce the swelling it appeared to result in blood pressure collapse, no one appeared willing to listen and investigate. Eventually one of the consultants did take this seriously, trying to see if this was related to cardiac issues, but due to my swelling they were unable to establish this via x-ray/cardiogram.

I remained sedated and ventilated for 5 days, being slowly woken and weaned off the ventilator following insertion of a tracheostomy some 6 to 7 days later. In total I remained in ITU for 11 days before being transferred to [redacted] late on [redacted] September.

On this ward I understand that I was under the care of a ortho geriatrician (I am aged 49) and indeed this ward could only be described as being for the care of elderly, mentally infirm patients. I had no sleep and was becoming increasing muddled and confused due to a lack of basic rest and chronic sleep deprivation. I self-discharged, with [redacted] support less than 24 hours after transfer from ITU, as we all agreed, (including the FI doctor who completed the discharge paperwork) that I would be more likely to recover in the peace and quiet of my own home. It is my good fortune that [redacted] is a registered nurse and was able to care for me and dress my wounds as no follow up community nursing was arranged and I certainly at that point was in no fit state to go to my GP surgery.

To aid your investigation, the following bullet points are the issues that I wish to have addressed and full responses provided:

- Why did my toe bleed so profusely that I required further anaesthetic?
- Was the surgery and cauterisation inadequate in the first instance?
- Why did the team inject local anaesthetic, being fully aware of my history?
- Why was this incident NOT raised as a SUI by the Trust?
- Why have I not received any follow up out patient's appointments? Neither the surgical team, the consultants in ITU or the medical team appears to have taken responsibility for my on-going care and follow up to ensure that we discover the cause of this incident and mitigate the chances of it happening again.
- What are the results of the blood tests and who will advise me of them?

- Have the results indicated anaphylaxis?
- Should someone be investigating the cardiac concerns?
- What are the management plans to ensure that I do not have a reaction such as this again – I was under the impression that I was to be referred for full allergy testing?
- [redacted] urges a review of my potential reaction to adrenaline or its additives. Is this now to be left to my GP to arrange? If that is the case when, and who, will be responsible for advising my GP of the results of the blood test and on-going care required?

[redacted] would also like me to draw to your attention [redacted] comments on the care I received in ITU. [redacted] view is that the nursing care and support was excellent, however the continually changing daily consultant cover resulted in differing medical opinion on a 24 hour basis, lack of continuity of care and poor communication in [redacted] opinion. This lack of medical responsibility appears to have continued post discharge.

I look forward to your full response within 28 days.

Yours faithfully

[redacted]

cc [redacted]

P

[redacted]

[redacted] 2013

[redacted] 2013

Chief Executive

[redacted] 2013

Complaints D[redacted]nt

Dear Sir/Madam,

I am writing to you with regard to my recent admissions to [redacted] I was contacted on [redacted] by a research company on behalf of [redacted] and was asked to participate in a survey regarding my most recent hospital admission. I agreed to participate but subsequently after 4 questions was told my opinion was not needed as enough people fulfilling the criteria had been selected already. I therefore was not able to give feedback to a company asking for it. The researcher suggested I talked to my GP with my concerns. She did not suggest PALS. I contacted PALS at [redacted] on [redacted] and still have not had a phone call This made me even more frustrated than I already feel and spurred me to write this letter.

I was admitted to [redacted], on [redacted] by ambulance from my GP surgery. I stayed in for 12 days and would like to draw your attention to the following concerns and issues.

I must first praise some of the care I was given and especially thank [redacted] on [redacted] for [redacted] thoughtfulness and attention during my stay. I am afraid there were other nurses and members of staff that I would like to thank but do not have their names.

Consultant [redacted] came to see me on [redacted] and I was upset by the way in which [redacted] spoke to me. [redacted] was abrupt and rude and I did not feel that [redacted] was listening to me nor was sympathetic to my situation. [redacted] had a few other members of staff with [redacted] and I felt [redacted] was showing off to them. [redacted] told me [redacted] wouldn't take my gall bladder out. [redacted] said I would be put on a waiting list and I asked [redacted] how long this list would be. [redacted] answered abruptly and I was made to feel put in my place. No sympathy was shown by [redacted] regarding the pain I had been in, which I have to say had been unbearable and excruciating. I felt my opinion was brushed off and how dare I question [redacted].

I did talk to members of the nursing staff afterwards and was in tears. I did ask to see the ward manager on more than one occasion during my stay to discuss [redacted] attitude but [redacted] did not come. I saw a ward manager with a different consultant on another day but [redacted] came and went with [redacted]. [redacted] did not make any effort to see me afterwards to discuss my condition. I talked to a senior nurse on the day of discharge and [redacted]

reassured me I was fit for discharge but only after I asked for a doctor to explain what had happened.

I was informed by nursing staff on the ward that [redacted] has a reputation for being arrogant and rude. This may be but [redacted] obviously is carrying on in that manner. I am afraid and angry about this as vulnerable patients should not be made to feel like this. Nurses have told me they do not like doing ward rounds with [redacted] Surely senior nurses should be doing the rounds with [redacted] in the best interests of the patients. The nurses may not be very professional in telling me how they feel, however it reflects their frustration about the situation which has obviously been allowed to carry on. I do not blame them at all and by writing to you to inform you of the situation hope it might help them in their work.

I had an ercp on [redacted] and afterwards the nursing staff had to call the surgeon to see me as nurses had concerns regarding my condition. I was told I would then need an operation to remove my gall bladder the following day. I was prepped for theatre on the following 2 days and was then sent home on the [redacted] not having had my operation. I was told it would be on the [redacted] then [redacted] and then again on the [redacted] and then changed again to the [redacted]. [redacted] was contacted at home on [redacted] by the hospital to tell me it was on the [redacted] even though I was still an inpatient.

During my stay in [redacted] I was nil by mouth on intravenous fluids but they were slow to be put up and I had to ask for them. I had pancreatitis but fluid charts were started 2 days afterwards when a nurse highlighted the problem. I had to keep reminding staff not to use my right arm to have my blood pressure and bloods taken despite it being written on the entrance to my room. I was told that I should have oramorph to reduce the pain despite me saying I would be sick. I did take it as the nurse insisted and was sick . She did apologise afterwards. I had loose stools and 2 specimens were taken. I never heard if the samples were positive for clostridium. I have had contradictory advice with regards diet and am still unsure as to what I should be eating. Nurses advised a low fat diet but the menu was very restrictive and not inspiring and not informative with this in mind. I was overlooked on occasions with meals as the board outside the room had not been updated. My family brought food in for me in the end.

In my opinion I was very lucky. My family brought me food and drink to supplement the food I was offered in hospital. I do have a good idea of a low fat diet. All patients would not be this fortunate.

The room in which I stayed in my opinion was not built for purpose. I was not visible to nursing staff when I vomited. I again was lucky that I could use a call bell but others may not be so lucky. My shower was lovely but the fact that water crept up to the sink and toilet was dangerous leaving the floor wet and slippy. I reported this but it was not fixed during my 12 day stay. Again I was sensible and put a towel on the floor to absorb excess water. The window in my room was held open with a chair. A small breeze blew the whole thing open. No thought has been put into the design of this. I asked for another pillow and was told one was not available. My family had to bring a pillow in for me. The TV and radio were excellent. The room was cleaned but no one cleaned the right side of my bed. The over the bed table could not be raised or lowered

so I had to sit on a pillow to eat my meals.

I had a number of cannulas during my stay but one nurse answered her mobile and took the call in my bathroom whilst the tourniquet was still tight around my arm. Unbelievable!!

One of the nurses told me a doctor would not sign a sick note whilst I was in hospital and would only do so on discharge. However I needed one as I had been in for so long and so I asked and was given one without question from one of the doctors.

When I was discharged from hospital I was able to get free parking for that day but the ward staff did not give me the correct information and so [redacted] missed out for 2 days prior to that.

I came home for 4 days and then was due to go to [redacted] hospital for my operation. I was contacted and asked to go to [redacted] for preassessment. Luckily I was able to change this to [redacted] as someone used their initiative and was able to rearrange my appointment. A less forceful person would not have been able to do this.

On the [redacted] I was told to be nil by mouth from 6.30am. This then changed to 11 am when I telephoned for bed availability. I was told to come in at 11.30 then rung to say come in at 10 as the list was being brought forward. I was then kept waiting until gone 2pm.I was told I may go home after the operation but ended up staying in overnight in a ward where there were few patients and the nurses were not familiar with surroundings. I was discharged by a doctor who informed me I could eat a normal diet contradicting advice I had been given already. If the nurse in charge hadn't insisted on the doctor coming I don't know if I would have been seen that day.

I do not feel that I was prepared for the amount of discomfort I would feel following the operation and I was one of at least 3 people who had it done that afternoon and kept in overnight.

Before going into hospital I was given 6 leaflets on what to expect. I was not given one explaining what my procedure was and have still not had anything to clarify what I should do about diet. This I feel needs to be addressed for future patients.

I unfortunately am still recovering from my operation. I am still in pain and off work. I have been in hospital before but never have I had such a horrible experience.

I summary I have concerns about staff attitude and bedside manner, patient information, communication between staff within the hospitals, respect for patient integrity, safety issues and professional nursing issues.

I hope my letter will be looked at by relevant people and would like a senior member of the trust to give me assurances that my concerns will be addressed for the good and wellbeing of future patients. As a registered nurse I have been disappointed and angry about my experience and will not allow the opportunity to inform you of them to pass.

P.

Yours faithfully

[redacted]

[redacted]

Date of birth [redacted]

[redacted]

From: [redacted]
Sent: [redacted] 2013 09:31
To: [redacted]
Subject: [redacted]
Attachments: [redacted]

Categories: Green Category

Hi, please can you confirm that you will take forward.

I am unsure why the letter was not received in August.

Kind regards

[redacted]

From: [redacted]
Sent: [redacted] 2013 14:46
To: [redacted]
Subject: complaint

Good afternoon,
I sent a letter of complaint to the hospital in august and as of today have not received either an acknowledgemnet nor reply.
I am attaching a copy of this letter and also one from the consulant .
I have today been in contact with my solicitor who is now on this case and has asked me to resend this to you which I am cordially completeing
Yours

[redacted]

Sent.
1st NOV.

TO WHOM IT MAY CONCERN

RECENTLY ON THE [redacted] 2013. [redacted] WAS ADMITTED TO HOSPITAL I PREVIOUSLY HAD BEEN TO SEE 4 DOCTORS WHO MISSED DIAGNOSED [redacted].

1. [redacted] FELL ILL OVER [redacted] JULY. DURING THE DAY [redacted] WAS NOT HERSELF
2. THEN [redacted] DID NOT SLEEP ALL MONDAY NIGHT AND BY TUESDAY MORNING AT ABOUT 6AM [redacted] WAS BLING SICK
3. I RANG 111 WHO TOLD ME TO CALL MY DOCTOR AND BOOK APPOINTMENT WHICH I DID [redacted] IN [redacted]
4. I WENT TO SEE THE DOCTOR AND EXPLAINED THAT [redacted] WASN'T WELL AND REALLY NOT [redacted] WITH HIGH TEMPERATURE AND BEING SICK AND CRYING.
5. [redacted] AT [redacted] TOLD ME THAT MY [redacted] HAD A VIRAL INFECTION. I ASKED IF THERE WAS ANYTHING I COULD DO BUT WAS TOLD TO GIVE [redacted] CALPOL AND NUROFEN
6. WHEN I TOOK [redacted] BACK HOME ,I GAVE [redacted] CALPOL .AFTER 1 HOUR [redacted] TEMPERATURE STARTING TO GO UP. AND WAS HITTING 39 DEGREES. [redacted] WAS CRYING MOST OF THE DAY AND VERY UPSET WOULD NOT EAT AT ALL AND NOT REALLY DRINKING. I GAVE [redacted] THE CALPOL AND NUROFEN LIKE I WAS TOLD BUT THROUGH THE NIGHT [redacted] WAS GETTING WORSE TEMPERATURE GOING UP TO 39.6 AND BEING SICK ALL NIGHT.

THE NEXT DAY WEDNESDAY I DECIDED TO RING 111 AGAIN TO SEE IF I COULD GET SOME MORE HELP AS TO WHY [redacted] WAS SO ILL AND SEE IF I COULD GET MORE ANSWERS AS I WAS SO CONCERNED.

1. I THEN TOOK [redacted] TO THE [redacted] I WENT INTO A+E AND THE TRIAGE NURSE WHO SAW [redacted] AND TOOK HER TEMPERATURE WHICH WAS ABOUT 39.5 SO [redacted] GAVE HER CALPOL I HAD TO SIT IN THE WAITING ROOM WITH [redacted] FOR ABOUT 1 HOUR 30 MINS WHICH WAS AIR CONDITIONED
2. THEN I GOT CALLED THROUGH TO SEE THE DOCTOR THEY RETOOK [redacted] TEMPERATURE AND IT WAS 38 THE DOCTOR THEN ASKED ME WHAT MY DOCTOR SAID TO ME YESTERDAY AND I TOLD HIM HE SAID IT WAS A VIRAL INFECTION.
3. THE DOCTOR IN A + E SAID TO ME MY DOCTOR WAS RIGHT AND SENT US HOME.
4. WITHIN A HOUR AGAIN OF US BEING HOME. [redacted] TEMPERATURE HAD RISEN [redacted] WAS VERY DISTRESSED [redacted] HAD NUROFEN BUT IT DIDN'T SEEM TO BE WORKING [redacted] WAS

(2)

5. I DECIDED TO STAY AT MY MUMS HOUSE WITH [redacted] BECAUSE I WAS SCARED OF [redacted] FITTING BECAUSE THAT IS WHAT THE TRIAGE NURSE SAID COULD HAPPEN WITH A TEMP THAT HIGH.
6. ALL THROUGH THE NIGHT OF WEDNESDAY, [redacted] WAS UP BEING SICK AND [redacted] TEMPERATURE WAS GOING UP AND DOWN. [redacted] WAS COLD. HAD GOOSEBUMPS, AND WAS SHAKING. [redacted] TEMPERATURE WAS HITTING 39.9 SO I DECIDED TO RING 111 AGAIN, AND THEY TOLD ME TO GO SEE MY GP IN THE MORNING.

THURSDAY MORNING I MADE AN APPOINTMENT WITH [redacted] BEFORE I LEFT HOME [redacted] 'S [redacted] AT [redacted] TEMP WAS HIGH SO I GAVE HER CALPOL.

1. WHEN I WENT TO THE DOCTORS SURGERY I SAW [redacted] [redacted] WHO GAVE [redacted] AN EXAMINATION .THE DOCTOR ALSO GAVE ME A URINE SAMPLE TEST TO TAKE HOME TO GET A SAMPLE FROM [redacted] BUT DID SAY IF I COULDN'T GET THE SAMPLE BACK BY FRIDAY AM DON'T BE WORRIED! BUT I WAS TOLD THIS WAS A VIRAL INFECTION AGAIN . DOCTOR [redacted] [redacted] SAID [redacted] WAS DRINKING BECAUSE [redacted] SAW [redacted] HAVING A SIP OF [redacted] JUICE BOTTLE IN THE WAITING ROOM..
2. BUT [redacted] HAD NOT REALLY BEEN DRINKING SINCE MONDAY AND STILL HAD NOTHING TO EAT [redacted] WAS NOT REALLY EVEN GOING TO THE TOILET VERY OFTEN.
3. I GOT SENT HOME AGAIN AND AGAIN WITHIN 1 HOUR OF BEING BACK FROM THE DOCTORS [redacted] TEMPERATURE WAS HITTING 39.9 AGAIN AND I FELT THAT NO ONE WANTED TO HELP MY [redacted] WAS IN PAIN AND NO ONE WANTED TO HELP.

I MANAGED TO GET A URINE SAMPLE FROM [redacted] WHICH MY NAN DROPPED DOWN TO THE SURGERY FOR ME THAT AFTERNOON. [redacted] WAS STILL VERY UNHAPPY OFF [redacted] FOOD NOT DRINKING AND CRYING IN PAIN .THIS CARRIED ON ALL DAY THEN WHEN NIGHT CAME [redacted] WENT TO SLEEP AT ABOUT 7PM.

1. [redacted] THEN WOKE UP ABOUT 9PM AND WAS SHAKING WITH TEMPERATURE OF 40 DEGREES.
2. WE THEN RANG 111 LINE AGAIN. THEY TOLD US THEY WOULD GET A DOCTOR TO RING US [redacted] THEN WENT BACK TO SLEEP. SO I TOOK [redacted] TO BED AND MY NAN WAITED UP UNTIL 11OCLOCK FOR A CALL BACK WHICH NEVER CAME UNTIL ABOUT MIDNIGHT WHICH WAS 3 HOURS AFTER MY CALL AND BY THEN WE WERE ALL ASLEEP .
3. [redacted] THEN WOKE BACK UP ABOUT 4OCLOCK IN THE MORNING SWEATING WITH HIGH TEMPERATURE AND BEING SICK SO I DECIDED TO RING 111 AGAIN AND THE TOLD ME TO TAKE [redacted] TO A+E.

WE RUSHED [redacted] TO A+E AND GOT THERE ABOUT SIX AFTER GETTING UP AND TALKING TO 111 ON THE PHONE.
WE GOT TO A+E AND WE SAW THE TRIAGE NURSE WHO TOLD US TO WAIT .WE WAITED 1 HOUR AND HALF AND GOT SEEN BY A DOCTOR WHOSE NAME I DO NOT KNOW HE GAVE [redacted] AN EXAMINATION AND LOOKED DOWN [redacted] THROAT WHICH NO OTHER DOCTOR HAD DONE.

(3)
Q

[redacted] THEN ASKED MY MUM AND ME "HOW WOULD YOU WANT TO BE TREATED TODAY?" SO MY MUM SAID WE JUST WANT TO KNOW WHAT IS WRONG WITH [redacted] SO HE TOLD US [redacted] HAD TONSILLITIS AND WE HAD TO KEEP GIVING CALPOL AND NUROFEN .THEN SENT US HOME.

1. WE THEN WENT HOME. [redacted] STAYED ASLEEP FOR A COUPLE OF HOURS [redacted] WAS GETTING REALLY LOPPY AND NONE RESPONSIVE WITH A HIGH TEMPERATURE
2. THIS CARRIED ON THROUGHOUT THE DAY [redacted] FELL ASLEEP AT 5.30 PM. THAT NIGHT [redacted] WAS UP AGAIN MOST OF THE NIGHT BEING SICK WITH HIGH TEMPERATURE NOT CRYING JUST LOPPY AND SHAKING IT CAME TO THE MORNING AND MY MUM SAID WE HAVE TO TAKE HER BACK TO THE HOSPITAL
3. THEREFORE. WE DECIDED TO RING 111 AGAIN.

THEY MANAGED TO GET US AN APPOINTMENT AT THE [redacted] WHICH WAS AT 12.30. [redacted] WAS STILL REALLY LOPPY AND NONE RESPONSIVE WITH A VERY HIGH TEMPERATURE. WE SAT IN THE WAITING ROOM AND WAITED UNTIL 1 O'CLOCK AND HER TEMPERATURE WAS REALLY GETTING HIGH.

1. WE WENT THROUGH TO SEE THE NURSE AND [redacted] TOOK [redacted] TEMPERATURE WHICH WAS 39.9 AND CALLED THROUGH THE DOCTOR AND THE DOCTOR SENT US OVER TO THE [redacted] WITH [redacted] .ME AND MY MUM FELT RELIVED THAT SOMEONE WAS FINALLY HELPING [redacted] WE TOOK [redacted] STRAIGHT OVER THERE AND THEY TOOK BLOODS WHEN WE GOT THERE [redacted] TEMP HAD GONE WAY PAST 40 DEGREES
2. THEY ADMITTED [redacted] STRAIGHT AWAY. AND HAD X RAYS TAKEN AND AN ULTRA SOUND ON [redacted] KIDNEYS.

THE DOCTOR CAME ROUND THE NEXT MORNING AND TOLD ME [redacted] HAD A URINARY TRACT INFECTION AND [redacted] KIDNEYS WERE ENLARGED. THEY WENT ON TO TAKE FURTHER TESTS AND PUT [redacted] ON HIGH ANTIBIOTICS.

1. [redacted] WAS IN THE WOODLANDS WARD FOR 6 DAYS AND I CANNOT FAULT THE STAFF IN THERE [redacted] WAS MISDIAGNOSED 4 TIMES FROM PREVIOUS DOCTORS IN A +E AND THE DOCTORS SURGERY [redacted]

I AM DISGUSTED THAT [redacted] SUFFERED FOR 5 DAYS BEFORE ANYONE WOULD HELP [redacted] AND NONE OF THESE SO CALLED DOCTORS [redacted] SAW HELPED [redacted] AT ALL.
JUST MISDIAGNOSED [redacted] AND SENT [redacted] ON [redacted] WAY AS QUICK AS THEY COULD BECAUSE THEY WANTED TO GET US OUT THE WAY LETS BE HONEST THEY ONLY SAID VIRAL INFECTION BECAUSE THEY ACTUALLY DIDN'T NOW WHAT WAS WRONG WITH [redacted] AND DIDN'T WANT TO SPEND MONEY ON TESTING [redacted]

2. [redacted] NOW IS AWAITING AN APPOINTMENT TO SEE THE [redacted]

12

[redacted]

[redacted] 2013

Dear Sir,

My name is [redacted]. I am writing to you with regards to my [redacted] who I brought into your hospital at around 5.00pm on [redacted] October 2013, after [redacted] had a fall at home and cut [redacted] head. The treatment that [redacted] received in both the Minor and Major Injury Units I cannot fault.

[redacted] was kept in overnight in [redacted] of the [redacted] where [redacted] said [redacted] was treated very well and where a [redacted] called [redacted] kept my [redacted] up to date with all the details that we needed to know on the Thursday morning. We were told that we could pick [redacted] up after 1.30pm from the Discharge Lounge, where again [redacted] was treated very well.

I took [redacted] home and settled [redacted] then returned in the early evening to find the item shown in the enclosed picture lying on the kitchen worktop. I asked [redacted] why [redacted] had it, and [redacted] said that [redacted] had pulled it out of [redacted] arm [redacted] as they had not done so at the Hospital. [redacted] said that it took [redacted] a long time to get it out and hurt. I checked [redacted] arm to see that it was not bleeding, but am angry that this sort of thing is allowed to happen.

Please can you look into this and remind the staff to double check their patients so that this does not happen again.

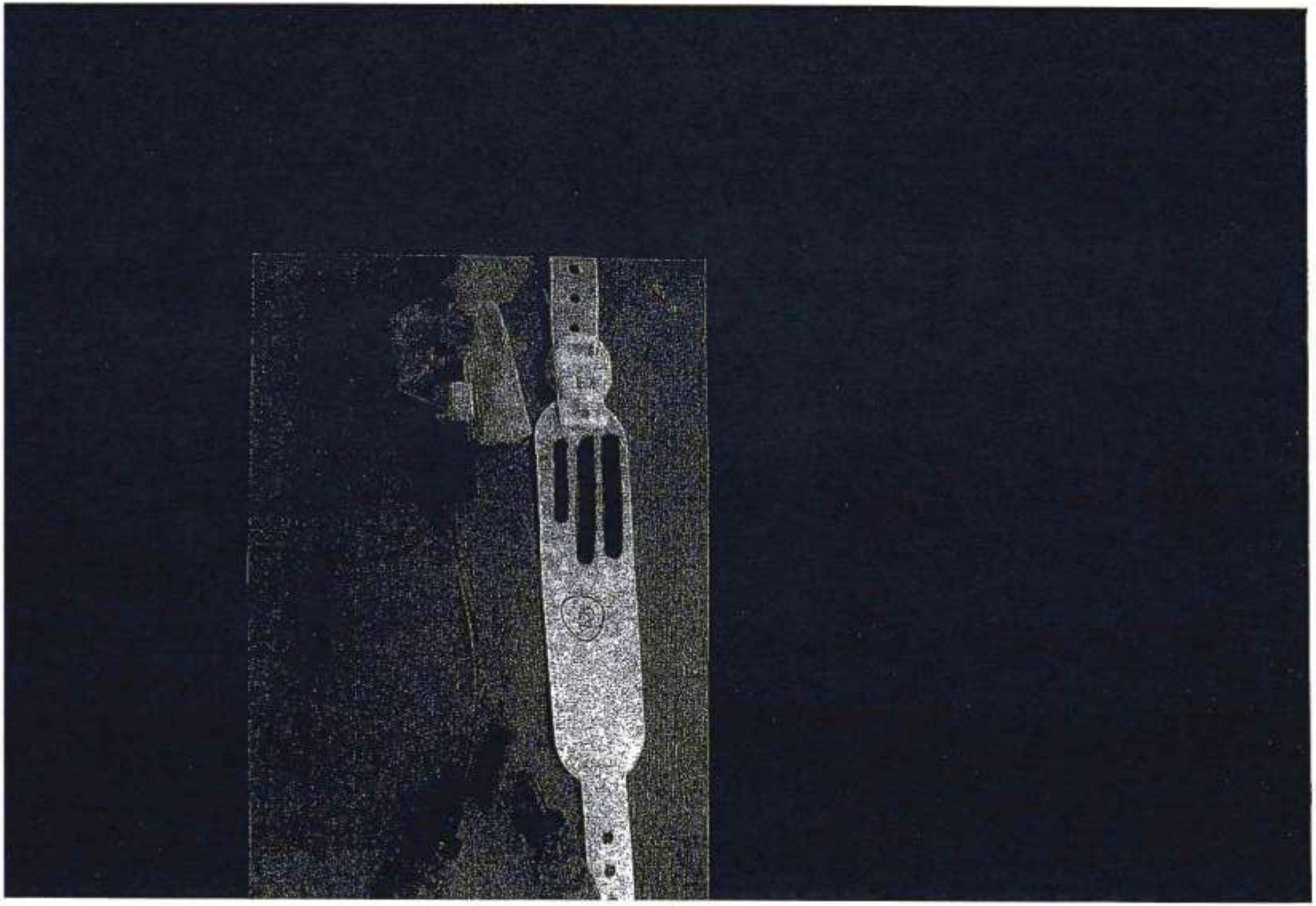
Yours faithfully

[redacted]

[redacted]

21 OCT 2013

Complaints Department



S.

[redacted]

[redacted] 2013

[redacted]

RECEIVED BY
[redacted] 2013
PATIENT COMPLAINTS
[redacted]

[redacted]

SENT BY SPECIAL DELIVERY

Dear Sirs

Re: NHS no. [redacted]

I would like an independent clinical review of the failure to perform a lumbar puncture and any other tests necessary to diagnose and treat me as detailed below.

I am writing this letter from myself, however I was so ill I would not be able to do this without the information and memories of [redacted]. This letter is 2 years down the line because we are all still traumatised by the events.

This was at [redacted] during the period of my stay between [redacted] 2011 and subsequent involvement whilst I was at [redacted] during my various A&E admissions and stay during the period [redacted] 2011 to [redacted] 2011.

1. [redacted] – both failed to provide me with the correct tests and treatment in time to prevent permanent eye damage because of the Hydrocephalus shunt problem. This has also affected my overall wellbeing and recovery. Further tests i.e. a lumbar puncture

should have been undertaken when I started to have visual problems from [redacted] 2011, and further opportunities were missed when I continued declining, and when I could not sit or stand, and when I started having fainting spells, and when I became bedbound, and when you could not control my pain and sickness etc.

2. [redacted] – both hospitals failed to learn the lessons from when this happened before to me in 1997 and details of which were contained in the letter of [redacted] 2005 and was also explained to medical staff by [redacted] on several occasions.

3. [redacted] – stating definitely that it was not a shunt issue after repeated ct scans, despite me being very symptomatic and having a history in 1997 of my scans not picking up a shunt failure. See letter of [redacted] 2005 from [redacted].

4. [redacted] – wasting precious time by subjecting me to repeated scans that are recognised as **not** being a conclusive diagnostic tool and have been proven wrong historically for me. (Please see letter of [redacted] 2005 from [redacted]). See also this open literature information. http://www.spinabifidasupport.com/hydroheadache.htm

5. [redacted] diagnosing it was not a shunt problem just by looking at a scan without even seeing me, on the first day I was admitted to A & E. Also both the Neurology and Endocrinology teams saying that my terrible symptoms were not due to either condition but discharged me anyway.

6. [redacted] – failing to take note of [redacted] request (see letter dated [redacted] 2011) to my GP to arrange for further investigations including a possible inpatient lumbar puncture after seeing me on [redacted] 2010 (in the outpatient clinic). I made this appointment because I had been very unwell for some weeks with enough symptoms to cause concern (see background information below).

7. [redacted] – I would like to know who made the decision not to treat me as urgent and what this was based on, after [redacted] examination of me on the [redacted] January when [redacted] expressed [redacted] concern and I was told I would be going to [redacted].

8. [redacted] – Wasting valuable time over the following 4 days and not communicating to us that [redacted] were treating it as a neurological issue rather than a neurosurgical issue and therefore not treating me as urgently and seriously as the condition required. This gave us a false sense of hope. Communicating this to [redacted] would have allowed them to do more to get me the treatment I desperately needed. They thought someone had finally agreed with their diagnosis.

9. [redacted] – not taking the concerns of my [redacted] seriously when they know me best of all and have been through this misdiagnosis of a shunt blockage before (see letter of [redacted] 2005). You also did not pay attention to the letter of [redacted] 2008 (stating that [redacted] wanted me to be in contact [redacted] as a matter of urgency if I suffer with further headaches, sleepiness, drowsiness (which were only in fact a few of the symptoms I presented with)) and also failing to pay attention to the Hydrocephalus card that I

carry and which lists symptoms and what to do, which were all shown and explained to the medical staff treating me.

10. [redacted] – Failing to reconsider the diagnosis/treatment on several occasions when I worsened in your care, despite what you were being told by [redacted]. Occasions such as becoming bedridden, having hydrocephalic "attacks", my inability to sit or stand up, unmanageable excruciating pain, nausea, vomiting, losing weight and many other symptoms such as:- visual disturbances, photophobia, dizzy, nausea, debilitating headaches, vomiting, neck ache, back ache, numbness in my face, hands and legs, bedridden, "fainting" spells. Please also see letter from [redacted] to [redacted] dated [redacted] 2011.

11. [redacted] – with the symptoms I had I was not capable of being on my own when [redacted] ([redacted] February) asked [redacted] to leave when [redacted] wanted to see me. I should have been given a choice. This has concerned me so much I am now putting a Lasting Power of Attorney in place.

12. [redacted] – I should not have needed help from the GP's at my surgery requesting that you keep me in hospital during the various admissions and discharges. My GP also believed it was my shunt.

13. [redacted] – in view of my visual, physical and mental limitations why were the bed sides not in position to prevent me from falling out of bed, bruising my face, biting my lip and chipping my tooth on [redacted] 2011.

This and many other issues and things happened and because of this I have been left with a total lack of confidence that I will receive the right attention in the future which is causing me continuing stress and worry along with my parents.

Background information

I have had Hydrocephalus since birth with a shunt fitted, I also have Ulcerative Colitis (UC) and Sclerosing Cholangitis (with a recent diagnosis of Hyperthyroidism).

I had a shunt problem before in 1997 when, after being diagnosed with UC I was put on drugs and then had a period of ill health which was all put down to the drugs and the paediatrician said it was not [redacted] shunt because the CT scan was not showing it. This was proved to be wrong and a lumber puncture finally diagnosed it and a shunt replacement resolved my symptoms.

I had a period during [redacted] 2010 of a cold and possible sinus problems and I received some treatment with antibiotics. I was very poorly for some weeks, with enough symptoms (headache, neck ache, dizziness on standing, weak and wobbly, nausea and vomiting) that I arranged an appointment with [redacted] for the [redacted] (a cancellation appointment).

By the [redacted] I was so poorly that I visited my GP and expressed my concern over the symptoms and I was referred to [redacted]. After another CT scan we were told there is nothing wrong with my shunt and I could go home despite being so ill. [redacted] insisted that they look further into what was making me so ill as I was too poorly to be taken home. The

following day I was diagnosed with an overactive thyroid gland and immediately told to start treatment. This unfortunately didn't arrive for a further 26 hours which led to incredible stress and worry.

Yours faithfully

[redacted]

T.

[redacted]

[redacted] 2013

Complaints Department

[redacted]

Mobile [redacted]

Email [redacted]

[redacted]

[redacted] 2013

To The complaints office,

It saddens me to write this letter, but following my [redacted] being admitted to [redacted] on [redacted] 2013, we do not feel [redacted] was given the appropriate care.

[redacted], date of birth [redacted] has given [redacted] consent for me to write this complaint on [redacted] behalf and receive correspondence in relation to it (please see the signed document attached) as [redacted] is resting following a heart attack.

On [redacted] at roughly 0430 am, an ambulance took [redacted] to [redacted] with chest pains. Following some tests and based on the symptoms [redacted] was presenting, there was a suggestion by an A&E Doctor that [redacted] may have suffered a heart attack and the doctor requested an urgent Echocardiogram, this is the first event we are concerned about, as this test was never carried out over the two days that [redacted] was at [redacted] I chased the nurses to ask when this was going to be done, only to be told there was a very large demand for such test. However given the circumstances and the urgent requirement, this should have, in our minds, been carried out on the day [redacted] was admitted, as per the initial A&E's doctor's request. We have since received a letter from [redacted] saying this test has been booked for [redacted] 2013 (a copy of which has been included). Is this really an acceptable time frame for such an emergency test? We checked with a consultant at [redacted] and they do not believe this has been booked as a follow up appointment, as [redacted] is remaining under the care of [redacted] as an outpatient, not [redacted] Can this appointment be explained please.

T.

The initial A&E doctor asked for further bloods to be taken at 6 hours after admission, to see what the troponin level was, in comparisons to the morning sample, as this would indicate what had taken place. A blood sample was taken after 6 hours as requested, however we were then told several hours later, that this had been lost and the blood sample had to be retaken, this delay again is unacceptable. The result from the second sample showed the troponin was raised to roughly 600. Earlier on in the day, we were told a reading of 100 would indicate a heart attack, which [redacted] level was already at on the first test, but due to [redacted] kidney transplant the Doctor's said they would have to liaise with [redacted] (whose care [redacted] is under for the kidney transplant), as this reading of 600 might not be a true reading. This communication with [redacted] did not appear to have been made at all whilst [redacted] was in the care of [redacted]. This should have been done ASAP, in order to assess the information to hand, to see if [redacted] had suffered a heart attack, in order for [redacted] to receive the treatment [redacted] required sooner rather than later.

On the late morning of [redacted] September [redacted] was taken for a coronary angiography at [redacted], only to be returned to the ward without it being carried out, as there had been no contact made with [redacted] to confirm it was safe to do so. As mentioned above [redacted] has had a kidney transplant so there was concern about conducting the coronary angiography, in terms of the kidney being able to process the dye. We were advised by the doctors on [redacted] September that they were going to liaise with [redacted], to see if it was safe to do this test. We can still not understand why had this contact had not been made, seeing as [redacted] had been in [redacted] for over 24 hours by now. Along with the contact about the troponin level. Also if there was concern about doing this test, which we do appreciate, then surely the echocardiogram, a non intrusive test, should have been carried out at the very least, in order to explain what the problem was. There seemed to be no urgency in any tests being completed and [redacted] was just left on a side ward, still suffering the chest pains.

Also on [redacted] September, whilst on the side ward of A&E, (that [redacted] had been moved to on the [redacted] after being told by the nurse, that you get moved out of the main A&E bit, to a side ward in order for stat purposes, basically they explained you cannot be in A&E for more than 4 hours otherwise it looks bad on them. Not the most reassuring piece of information to divulge to us.) The nurse paid little attention to [redacted], only conducting some tests prior to [redacted] being moved to the cardio ward in the afternoon. These tests revealed [redacted] had a high temperature, had these tests of been carried out earlier on in the day the raised temperature could have been treated sooner and may have alleviated some of the severe sickness [redacted] was suffering with.

Once in the cardio ward a further blood test revealed the troponin level was now at 9000 and at 2000 hours on the [redacted], [redacted] was transferred by ambulance to [redacted]. On arrival at [redacted] an echocardiogram was carried out immediately, which showed it was more than likely [redacted] had suffered a large heart attack. The doctor explained that the coronary angiography would be carried out in the morning, but if there was a blockage, work had needed to be done within 4 hours of the heart attack, in order for repairs to be made, so realistically it was too late by this stage, due to the delay at [redacted] (around 39 hours), some very sad news to accept, which is what the angiography confirmed the following morning- it was indeed too late to do any repairs (full report from [redacted] included.)

T.

Whilst waiting for this test on the morning of the [redacted] in [redacted], [redacted] could hear the paramedics, radioing in, to say they were on route with a patient suffering a possible heart attack, and they were taking them straight down for these tests, [redacted] was thinking to [redacted] 'why didn't I get such treatment at [redacted]..the outlook may be more positive.'

To summarise main our concerns:

- Why wasn't an urgent echocardiogram carried out
- Why wasn't contact made with [redacted] to see if it was safe to conduct a coronary angiography
- Why wasn't contact made with [redacted] to discuss the troponin level in [redacted] blood
- A blood test was lost
- Why wasn't [redacted] symptoms and troponin levels acted on sooner, did they really need to wait until it got to 9000, such a high a number that shocked the doctors

[redacted] and I feel there was too much reliance on the assumption that [redacted] had not had a heart attack due to [redacted] young age, which was the opinion given to us by various doctors and nurses even though the first doctor had suggested a heart attack on arrival, but had these two tests of been carried out, it may have been possible, that some of [redacted] damaged heart could have been saved. Not only are we suffering the heart ache of [redacted] having suffered a heart attack, we are also left questioning as to whether the outcome may have been different, had [redacted] acted differently. Nearly two days were spent in [redacted] with no resolution/answers and within minutes of [redacted] arriving at [redacted] had had the necessary test to explain what the problem was. Had we of got there sooner there may have been a chance that more could have been done, did it really have to wait for [redacted] troponin level to get to 9000, there was no sense of urgency at [redacted] and no progress was made for the entire time we were there. We were told the cardio ward at [redacted] was full so [redacted] was not able to be taken there until late in the afternoon of [redacted] September, we are also left wondering, had [redacted] of gone onto this ward sooner and had the full attention of the Doctor's the outcome may be different.

We really do have serious concerns and look forward to hearing from you as soon as possible.

Yours sincerely

[redacted]

[redacted] [redacted] 2013

T.

I, [redacted], give permission for [redacted] to raise a complaint regarding the care by [redacted] and to correspond with them on my behalf.

Signed..[redacted].....

Dated..[redacted]2013.....

T.

[redacted] NHS

[redacted]

Telephone: [redacted]

[redacted]

[redacted] 2013

[redacted]

Dear [redacted]

I have been asked to arrange an appointment for you to have an

Echocardiogram.

Please report to the [redacted] on:

Appointment date: [redacted] 2013
Appointment time: [redacted]

The test involves using ultrasound to take pictures of the heart and is similar to a baby scan. Ultrasound is used routinely to image the body, it is completely safe and painless.

You will need to undress to the waist and some gel will be applied to your chest. A gown or towel will be offered should you wish to cover up.
The test will take around 20 to 30 minutes to complete.

If you know you have a prosthetic heart valve, please bring your valve card along with you. Please do not worry if you do not have one or cannot find it. This is not essential to the test.

It is very important that you inform the department if this appointment is not convenient for you as there is a long waiting list for this test.
The office is open Monday to Friday 9am to 5pm.

Yours sincerely,

Office Administrator