The Response to my complaint From Health Care (NHS Tayside)

Anonymised to protect individuals' identities

"The fact of the matter is that health care and social care services failed to provide safe care and treatment, exacerbated by staff incompetence. Services were repeatedly warned of dangers lurking. There is no incident in my view that couldn't have been prevented. It is reprehensible that HSC continually put her at significant risk of avoidable harm. We can only hope that this report falls into the correct hands and provides a much needed jolt to prioritise patient safety across both departments resulting in meaningful change.

To my mind, systemic failings caused or more than minimally contributed to these incidents and her injuries. Her situation and her suffering were contributed to by neglect and a gross failure to provide adequate basic care".

Item 1

Question: Can you provide a copy of the completed Falls Risk Assessment and Falls Prevention Action Plan, which was a statutory requirement upon each admission?

HSC Response: "This information can be requested from Health Records Department - tay.accessmrninewells@nhs.scot"

Comments:

This assessment is a statutory requirement and all elderly patients must be assessed for their risk of falls within 24 hours of admission. Why did I ask this question? I asked this question because the night before discharge, she fell from an upright position while motioning to sit. Two workers were accompanying her. The chair behind her moved as she lowered. She broke her femur in two places and her hip, also causing swelling and bruising to the head. She underwent two operations and had a metal plate inserted in her leg. A second operation followed due to the wound becoming infected (very likely as a consequence of a subsequent incident). A short stay extended to additional months spent in hospital including a period of painful physiotherapy and rehabilitation: an avoidable injury from which she never fully recovered.

I'm not convinced evidence of these records shouldn't have been produced by the Investigating Officers. This surely fell within their sphere of influence when responding to this complaint. Certainly this shouldn't have prevented HSC from providing answers.

In the circumstances of an injury acquired in hospital what I am interested in establishing is whether statutory records were completed and procedures followed which would have significantly mitigated the risk of falls.

I have copied the following from the NHS Tayside Management of Adverse Events Policy which states that incidents involving a patient "*should be noted in the patient's case record*". The policy also states:

"*A full, frank and factual explanation must be shared with the patient at the time of the incident. This should be done by a team of at least 2 staff members including a clinician who has a pre-established relationship with them with a clear team leader identified. State what happened, why it happened and what is being done to prevent it from happening again (IHI, 2010). Address any concerns the patient and/or family have as soon as possible. This team should inform the patient and family as soon as the organisation has any new information pertaining to the event*."

I can't recall a single event when this happened according to this policy. When our solicitor read her medical file and asked the health board for the statutory documentation and witness statements, he received no response.

I note that these were not all fully completed.

Item 2

Additional questions about hospital acquired injuries:

- **What are the circumstances of this leg and hip fracture?**
- **Where is the incident report relating to those injuries?**
- **Where are the records of statements taken which would appear to be missing from her medical records?**
- **Assuming one existed, was the Falls Prevention Action Plan shared with and read by the temporary carers prior to moving and handling her?**
- **Following this particular leg fracture incident, what statutory guidelines were followed?**
- **What actions were identified as a result of that incident"? "How were they implemented?**

HSC Response: "unfortunately this part of your complaint is out of time".

Comments:

A Falls Prevention Action Plan wasn't completed meaning workers did not have the necessary guidance and information available to them.

This is a salient point because two random bank staff arrived to provide cover for vulnerable patients, with whom they were unacquainted. This is precisely why this statutory policy exists. I consider the failure to implement this policy properly to be negligent.

Two random workers were engaged in a specialised task for which they were given inadequate supervision, training and guidance. This significantly increased the risk of a significant incident.

Worth noting is the fact that my request for a copy of the incident report and statements is referred to the Health Records Department. Soon after the incident however, I recall asking to see these and being advised weeks after the injury that the report still hadn't been completed because they had been unable to interview one of the bank staff transferring her.

As stated, a further request by our solicitor received no response.

Item 3

Introduction: Section 4 of the report explains that following an operation to repair the leg fracture, late in the evening she returned to the ward. She had received no food or fluids for 24 hours. She was dehydrated and unnourished. When I asked for fluids to serve her, this was denied. I was advised that the nurses were too busy. I visited the concourse to buy fluids instead. In a civilised health care system, one would think that disabled and post-surgery patients would receive more specialist care.

Question: Why was post-operative care ignored?

Question: Why were fluids refused and why did I have to provide this care?

HSC Response: "unfortunately this part of your complaint is out of time".

Comments:

To my mind, these out of time messages represent avoidance. The problem is, is this avoidance a permanent state?

So, whilst in the care of NHS workers, a vulnerable elderly patient sustains a significant injury. She broke her femur while they failed to stabilise a chair and support her properly whilst sitting (wooden chair on tiled floor). She underwent two operations involving the insertion of a metal plate. She endured excruciating pain and trauma and months of physiotherapy. She returned from theatre and received no post-operative care. Timescales are presented as a reason for remaining silent on the subject although, in principle, this information could easily have been carried from records.

These leaders in our HSC service, including when the matter was originally reported, all seek to avoid any acceptance of responsibility or responding to questions about this matter? Is it possibly because they all care about their jobs and reputations far more than vulnerable patients?

It's a simple question to answer based on the evidence: post-operative care was disregarded and fluids and pain relief was refused due to the dire quality of healthcare workers on shift that day. Although alerted they remained unyielding. This doesn't represent a compassionate response within a care environment. There are many examples of this level of neglect across the health and social care spectrum – all of which contravene policy guidelines.

What are the implications for other vulnerable patients without someone to highlight these perceived failings?

Item 4

Introduction: Section 4 of the report explains that when she returned to the Royal Victoria Hospital for physiotherapy on her damaged leg, there was another incident. By her own lucid account, her vulnerable leg was hurt whilst using stand-aid equipment resulting in swelling and bruising. She said they apologised to her. I consulted the nursing team who denied any knowledge of this incident.

Question: Is there an incident report for this injury?

Question: If not, why did staff fail to investigate this new incident?

HSC Response: "unfortunately this part of your complaint is out of time".

Comments:

As evidenced through the absence of a completed Falls Prevention Action Plan we have already established that statutory procedure does not always seem to be readily followed. This provides further example of a failure to follow the Incident Management and Recording Policy.

There is no record of this injury. Staff failed to investigate this incident. An opportunity for learning was lost: learning which might have prevented future incidents.

Why was recording this particular incident important? Because shortly afterwards the leg became infected and she returned to theatre to have a second operation to treat the healing wound for infection.

Item 5

Introduction: Section 5 of the report explains that, in Sept 2020, at the point of admission she was capable of standing and walking. She was perfectly lucid and in reasonable spirits. She was admitted for a short course of intravenous antibiotics. The course ended. But the stay continued. To my mind; upon admission, she was unnecessarily confined to bed daily and she was unnecessarily catheterised. Instead of being nourished and hydrated she was permitted to dehydrate over a few days and then given a saline drip. This cycle was repeated. Contrary to promises to take her out of bed daily, she remained confined to bed. This summary neglect resulted in avoidable decline in mobility. This resulted in an otherwise avoidable transfer to the Royal Victoria Hospital for physiotherapy to restore the level of mobility with which she had entered. Admission had been an option not a necessity.

The premise of the following questions refers to the stay from day one thereby managing her relatively minor treatment during an elected short stay, while preventing the creation of circumstances for deterioration.

Question: Why was my mother unnecessarily confined to bed for the duration of her stay at Ninewells from day one?

Question: Why did she suffer summary neglect resulting in an otherwise avoidable transfer to RVH?

Specific details have been withheld for purposes of confidentiality.

The HSC response lists a cluster of medical details which are not listed chronologically resulting in a skewered impression of the facts.

Comments:

I was present during admission, the following morning and during subsequent days. The pertinent question the Investigating Officers omit to answer explicitly is; prior to developments far later into this particular stay, why wasn't she taken out of bed, dressed and mobilised the next morning? At this initial stage she was certainly very capable. Leaving her to languish in bed from day one set a precedent.

What also contradicts the explanation offered is an evident lack of awareness that, the following week, once the course of medicine was complete there was agreement to discharge, pending re-establishment of home care arrangements. It was agreed that the hospital would dispense with the customary practice of automatically transferring her to RVH for a course of physiotherapy to recover the mobility with which she entered. As stated in the report, one nurse clapped her hands

and said to mum "right then, if you're going home soon we need to start getting you out of bed tomorrow". What are the implications of this remark? But of course, this failed to happen.

If her medical condition had been as HSC now presents, discharge would not have been considered let alone agreed. There are other contradictions:

Although she had been left languishing in bed for more than a week, she remained strong enough to walk. Following **assessment by OT** they agreed she could be discharged. The Investigating Officers seem to be unaware of this fact.

A rationale is presented about why she was **supported with fluids via a drip**. I distinctly recall a conversation agreeing that she would be encouraged to increase her fluid intake by drinking more, since she was clearly capable.

An explanation is offered for **catheterisation** that presents no new information to similar circumstances faced at home. The Investigating Officers also seem unaware of my conversation with a clinician who said it provided an opportunity for rest. My question is, for whom exactly? It was agreed the catheter would be removed only to discover days later that she had been catheterised again. This was another lost opportunity to keep her active.

Regarding **mobilisation**, the Investigating Officers refer to an assessment by occupational therapy, during week two. It is claimed the team were unable to engage her, partly due to 'fatigue'. It is claimed that she was unable to ***sit out of bed in a chair***, due to exhaustion.

The response claims that due to '**acute illness on top of her pre-existing frailty'**, her mobility worsened and she was transferred to RVH to support her rehabilitation before discharge. Staying with the comment "acute illness on top of her pre-existing frailty" some contradictory and revealing scenarios exist:

- They Investigating Officers don't appear to have read my report in which I stated (during a joint meeting) "I offered to demonstrate her **mobility**. I encouraged her out of bed and asked her to stand. She walked around the ward and back towards the bed. Significantly, this was following nearly two weeks of confinement. The response from OT was "but she does it for you". I replied, "She's doing it because I'm encouraging her". The **physiotherapists** conceded there was adequate mobility. It was agreed she would be discharged the following Monday".

- ***Prior to transfer to RVH***: the Investigating Officers seem unaware of the agreement to discharge and the nurse's intention to "**get her out of bed then**" in preparation. At that stage she was seemingly devoid of 'acute illness'. It was the failure to follow through on this commitment that caused deterioration in her mobility.

- ***Following discharge to RVH***: the Investigating Officers seem unaware of the fact that, once she was transferred to RVH, on day two she was injured during transfer. As the new injury rendered her confined, and physiotherapy was no longer of any use, from day two she was immediately **medically fit for discharge**; seemingly and suddenly devoid of fatigue and 'acute illness on top of her pre-existing frailty'.

In the name of convenience it is all too easy to turn perfectly capable independent elderly patients into dependent patients. All these nursing practices that appear to suit staff convenience rather than patient need are a constant narrative in the NHS.

Why have these particular matters become a source of focus? Because they all contribute to a level of confinement that caused a reduction in independence. If her mobility and independence had been maintained she would have received the pre-planned short course of antibiotics and been swiftly discharged. She would not have been transferred to RVH where she sustained another life-changing injury.

Item 6

Section 5 of the report explains that two days following transfer to the RVH, I received a call advising me about another incident while using a stand-aid. Her shoulder had been dislocated. As a consequence of this injury, she could no longer walk without the support of a gutter frame. She was now medically fit for discharge – and in need of hoist equipment for transfers. This short stay in hospital for a course of antibiotics served only to hasten her decline.

Question: What are the circumstances of this shoulder dislocation?

HSC's central response: "Unfortunately on this occasion her leg gave way and her weight would have been taken by the stand aid sling, potentially causing the shoulder dislocation".

Comments:

Not once is any reference made to the incompetent workers mobilising her using equipment.

"Her leg gave way". I have witnessed many incidents across a number of years while she was at the mercy of dubious HSC staff. I have never once heard anything remotely like an acknowledgement of any kind of responsibility. Not once. Each and every time, even when there were incidents while she was stationery in bed, she, the patient was the immediate culprit.

"Would have?" So if strapped in properly why wasn't it?

"Potentially" So what are the range of factors causing that injury?

The answer doesn't explain why, a sling that is an integral component of mobility equipment used to provide secure support, on this occasion failed to work as it should. Could it be perhaps that she wasn't mobilised properly by incompetent staff lacking commitment and the sling wasn't attached correctly? After all, this is what I have regularly witnessed. There were numerous previous incidents reported from which intelligence could have been derived.

A stand aid sling, if applied correctly prevents a patient falling – even if both legs are not supporting the body. That's precisely why it exists. The simple fact is she couldn't have been strapped in correctly otherwise she wouldn't have fallen from the device, while qualified workers stood around her.

Also note the contradictory answer prior that claims the previous week, at Ninewells, she was too weak and exhausted to sit in a chair, to walk or get out of bed. It is claimed that this is why she remained confined to bed and had to be transferred to RVH for rehabilitation.

But upon admission to RVH for rehabilitation, she was immediately assessed by OT as having sufficient strength to walk and get out of bed. She was clearly not too weak and exhausted to walk or get out of bed. If her legs couldn't support her own bodyweight then the OT team wouldn't have recommended transfer using a stand aid – they would have insisted on a hoist.

This stand-aid incident happened with the same nursing team that, a few days later, needed to be alerted while four nurses stood oblivious to a fall in motion because the sling wasn't correctly attached to the hoist equipment. Was that also her fault?

Similarly, a few days later, the same nursing team attempted to transfer her between bed and chair using a hoist and struggled to land her safely, until I offered assistance.

Similarly, the same nursing team continued to provide personal care in bed while rolling her body weight onto her vulnerable shoulder, in a sling and still healing.

This particular nursing team were quite evidently in serious need of re-training. Did I warn senior staff? Yes, more than once. Did I receive feedback? Never, not once. Is it astonishing that these workers are qualified? It most certainly is.

If workers don't take note or reflect properly on these situations, how can learning be identified and shared as HSC claims?

Item 7

Question: Where is the incident report?"

HSC response: "This is reported and reviewed on NHS Tayside's DATIX system".

But not apparently accessed by the Investigating Officers during the course of a serious investigation?

Why aren't redacted copies included in the medical file?

Item 8

Question: Where are the records of statements taken which would appear to be missing from her medical records?

HSC response: "DATIX reports do not form part of a patient's health record. The record of the incident and management plan is within our DATIX system. We can assure you that they are not "missing".

Comments:

So why didn't the service provide them?

While we have no way of knowing the quality and accuracy of reporting, we have seen enough to know what we need to know.

Again, I have copied the following from the NHS Tayside Management of Adverse Events Policy: NHS Tayside's policy states that "incidents involving a patient should be noted in the patient's case record".

It also states:

"A full, frank and factual explanation must be shared with the patient at the time of the incident. This should be done by a team of at least 2 staff members including a clinician who has a pre-established relationship with them with a clear team leader identified. State what happened, why it happened and what is being done to prevent it from happening again (IHI, 2010). Address any concerns the patient and/or family have as soon as possible. This team should inform the patient and family as soon as the organisation has any new information pertaining to the event."

I can't recall a single instance when this happened according to this policy guidance.

Again, when our solicitor read her medical records and discovered gaps, he asked the health board for this absent statutory documentation and witness statements taken. He received no response. Managing these types of matters in accordance with medical records is his area of expertise. Why would he be searching in a medical file for information that isn't generally kept there and which he has found in other medical records?

I asked to read this report a few weeks after the incident. I was told that it hadn't been completed because they were still waiting to speak to one of the workers involved. Since there remains no reference in her medical records it would indeed be interesting to know if this report was completed in the way that it should have been completed.

Item 9

Question: Upon admission, was a Falls Risk Assessment and Falls Prevention Action Plan completed? Can you provide a copy please?

Salient points from HSC's response: "A falls risk assessment and prevention action plan were initiated upon admission to RVH...but not completed...not been possible to find any record of notes audits completed around this timeframe"... "A copy of the falls risk assessment and prevention action plan can be requested from Health Records Department via tay.accessmrninewells@nhs.scot."... "The team would have been advised by the Senior Charge Nurse to ensure that documentation is completed fully and regular notes audits are complete".

Comments:

"***Initiated***". What does this comment mean exactly? They wrote her name on the top of the form?

"The team '***would have been'*** advised by the Senior Charge Nurse to ensure that documentation is completed fully and regular notes audits are complete". On what basis are the Investigating Officers so sure? Evidently there was a serious failing. Did the SCN fail to advise the team or did the team fail to listen? Have the investigating officers even bothered to find out?

So, completing these statutory reports isn't common practice then? When and how did the Senior Charge Nurse ensure documentation was completed? Why didn't she audit records and performance? Is this failure common practice across HSC?

She suffered the injury on day two. Wasn't this a strong indicator that it was vital to complete the plan immediately? Apparently this didn't occur to our nursing professionals. These adverse events continued daily until she was rescued from that ward for her own safety.

These questions relate to a serious injury which had a life-changing impact ultimately confining her to bed. Only two weeks earlier she had been mobile and active supported by a zimmer frame. She required a single carer for personal home care.

Following this short stay, as a direct result of this idiocy, she returned home confined to bed, mobilised through the use of a hoist, in terminal decline and with a need for round-the-clock-care. Our world class NHS.

That opaque response answers in the singular to this particular admission to RVH. Imperceptible is the fact that there is no evidence to suggest these plans were completed during any admission to Ninewells or RVH. Nothing in the medical records would suggest that they were. Neither does that answer reveal whether they are routinely completed for other vulnerable patients.

Another point worth noting is that, recall the Investigating Officers stated her mobility was deemed weak and she was allegedly exhausted, which is why they didn't get her out of bed and why it was necessary to transfer her to RVH for rehabilitation. Yet, no falls ***prevention*** plan was completed. Ultimately was there an incident? Predictably, she suffered a life changing injury involving the use of equipment. This was ***followed*** by a series of adverse events in which I regularly intervened to prevent a new injury.

I am now curious what else might have been uncovered if all my questions had been answered rather than uniformly citing the complaint was out of timescales. I am also deeply curious about what else might have been uncovered if Investigating Officers had answered my complaint put to social care about matters relating to home care and social work.

Item 10

Question: Was this action plan read by the nurses prior to moving and handling her? How do you know?

HSC response: "We are unable to ascertain if the plan was read by staff prior to delivery of care for which we offer our sincere apologies".

Comments:

The answer to that question should be quite simple to ascertain shouldn't it? If the falls prevention plan wasn't completed then clearly it wasn't possible for staff to read it. Logically, this would suggest not having a Falls Prevention Action Plan in place is only one factor contributing to the falls incident and the subsequent series of adverse events. And given my observations and intervention, it seems self-evident to anyone bothering to look that re-training was required for many nursing and care staff.

Item 11

Question: Following this [arm dislocation] incident, what statutory guidelines were followed?

HSC response: "Following the fall, local guidelines were followed to assist her onto her bed and initiate a medical review and x-rays as appropriate".

Comments:

Incredibly, there is no reference to what was done about the cause: staff malpractice.

For instance, are the investigators aware that, whilst awaiting paramedics, her leg actually fractured while she was being transferred from the floor to the bed? Should they not have made her comfortable until the paramedics arrived and evaluated the extent of her injuries?

Item 12

Question: What actions were identified as a result of that incident? Were they implemented?

HSC response: "Unfortunately following her return to RVH and requirement for a full body hoist, there was some difficulty in sourcing a suitable sling. Once this had been sourced, we sought support from both physiotherapy and practice development to ensure correct use".

Comments:

Then workers don't appear to have had enough "support from both physiotherapy and practice development to ensure correct use" because there were 3 further near-misses. All incidents were reported, never apparently recorded and I was never approached to provide a statement. Neither did I receive feedback.

Would common sense not dictate that a patient, damaged by the service should not have been transferred into the environment that caused the damage, before ensuring the correct equipment was in place?

Item 13

Section 5 of the report explains that following the latest shoulder injury in hospital, she was unable to walk unsupported and it was necessary to transfer her using equipment. However, the safety incidents continued unabated. These included near-misses using a hoist; rolling her in bed during bathing and placing weight onto her vulnerable shoulder; inserting the hoist sling incorrectly causing skin abrasions, placing weight onto her vulnerable shoulder while inserting the sling. Although unnecessary, and contrary to our request, she remained confined to bed since admission.

Question: I reported all of these near-miss incidents, as should have the nurses involved. Where are the incident reports"? "Can you provide copies please?

HSC response: "These are also reported and reviewed on NHS Tayside's DATIX system. As stated above, DATIX reports do not form part of the patient's health record. DATIX reports are not routinely shared with families".

Comments:

It seems rather convenient that there are gaps in the medical records and that incident reports can't be shared due to patient confidentiality. Similarly that other reports were 'initiated but not completed' and that "DATIX reports are not routinely shared with families".

Given our solicitors challenges in addition to our own, are these barriers to accessing important patient records common practice across Health and Social Care?

I strongly believe that many of these records don't exist for the majority of **near-miss incidents I reported** to both social care and to health care. No-one requested further information, no-one interviewed me and no-one appears to have processed incidents according to procedures outlined in the Management of Adverse Events Policy. Neither did I receive feedback.

If these records do exist then my key evidence remains absent.

None if would inspire confidence that, to quote you: "[HSC] **take all concerns brought to our attention very seriously and thoroughly review the issues raised in an effort to improve the experience of our patients".**

From where I'm standing, the evidence would point in the opposite direction.

Item 14

Question: Contrary to our requests, why was my mother unnecessarily confined to bed for the duration of her stay at the RVH?

HSC Response: "We are sorry that you were under the impression your mother was confined to bed for the duration of her stay in RVH, however it is documented from 16 October 2020 that [she] was assisted out of bed with a full body hoist on all but 3 days".

Comments:

Fact: when an alert, capable patient is left permanently in bed and has stated that she doesn't want to be, that constitutes confinement.

Far from being an ***impression*** it is a fact that she was confined to bed for staff convenience. I witnessed the problem daily from admission to discharge and I recall constant discussions about this subject.

More accurately, following review by the OT team upon admission to RVH, she was assisted out of bed on only 4 days, briefly. The first time was shortly after admission (and OT assessment) when they dislocated her arm. The purpose of removing her from bed on that occasion was to perform personal care. This is an interesting development in the context of your earlier comments that she was too frail and exhausted to get out of bed only days prior. After this incident they continued to bathe and toilet her in bed unnecessarily. This was common practice done for staff convenience rather than patient need. Indeed, there were many similar discussions with social care about carers doing exactly the same thing at home. These questionable practices lead to her shoulder being dislocated again.

Despite a specific request and despite agreements reached, the ward staff continued to leave her in bed all day. She was not assisted out of bed. She was permitted out of bed when I visited and requested this on her behalf because she didn't want to stay in bed all day. It was on the 3 occasions mentioned there was a further 3 adverse events which I reported. I was not interviewed, I received no feedback and there are no records or references in evidence.

Her wish to be out of bed for some of the day was not the only factor to consider. It is widely acknowledged that being confined to bed often leads to other health complications. Following this injury and these 3 subsequent near misses, it was clear that these workers could not mobilise her safely. I was forced to concede that she should remain in bed for her own safety until I could discharge her, which I did at the earliest opportunity.

If records state she was "assisted out of bed with a full body hoist on all but 3 days" then they have no bearing on the reality.

There were particularly serious problems in this specific elderly ward during October 2020. The attitude of some workers was dire. It was this particular ward that previously discharged her with

an untreated skin infection – discovered and noted later that day by carers in the care plan at home.

Item 15

Section 8 of the report explains that upon learning of a new dislocated shoulder injury Kings Cross referred her to A&E at Ninewells where she was examined by a team of clinicians. The doctors were initially pleasant. When I explained how this new injury occurred, the friendly team disappeared, seemingly for advice. As it turns out, they had been speaking to a senior clinician acquainted with her history of injuries. When they returned they were no longer friendly. We were expedited on our way, with festive cheers. We were advised that the surgeon would call us in the New Year to discuss the new injury. A serious injury generally signifies a person is at risk of harm. If a vulnerable child had entered A&E with a dislocated shoulder injury, caused at home through rough treatment, this would have likely initiated a safeguarding investigation. Certainly, serious questions would have been asked. However, the medical team seems to have treated a vulnerable elderly adult differently to what protocols would suggest.

Question: When met with a vulnerable elderly patient, further injured and at risk of further harm, what were the statutory responsibilities of the doctors assessing her at A&E?

HSC response: "The statutory duties are those described by the GMC for all doctors. Upon review, [Consultant], is not aware that the Orthopaedic Team deviated from these".

Comments:

How would the consultant know if the team deviated from these? Did he conduct a comprehensive investigation?

What are "The statutory duties [that] are those described by the GMC for all doctors" to which you refer and can you demonstrate how exactly each of these was followed?

Item 16

Question: Why was a vulnerable, injured patient immediately discharged without proper investigation of the circumstances of this new injury?

HSC response: "There were no indications of abuse or criminality based on [her] presentation to the ED or raised by either [her] or her family who accompanied her".

Comments:

Note: this visit to A&E was in December 2020.

I indicated potential abuse and risk from further harm. That's why they appeared initially concerned. Prior to this visit, I had been indicating potential abuse and risk from further harm regularly.

What further checks for "indications of abuse or criminality" did the team make exactly? Did they look into the history? Did they communicate with social care? Did they check the causes? Did they advise on how her new injury should be managed by the incompetents visiting her daily? Did they make a referral anywhere and did they take any actions to avoid further harm?

No. They didn't follow any of these procedural guidelines. They didn't examine her fully and they certainly didn't make any verbal checks. So how did they assess her for these factors, by osmosis?

As for **"her family who accompanied her":** I indicated that the team were no longer interested in what I had to say and following telephone discussion with the consultant they stone walled me. I attempted to emphasise that there was a serious problem and that she remained at serious risk.

Note: In November 2020, this is why I had previously made social care and NHS Tayside aware of the risk of further harm. This is why I earlier requested an ASP/safeguarding investigation. This is why I had *formally put the entire service on notice*. Those efforts attracted the same apathetic level of interest as this particular visit to A&E.

It was after my ASP report, that her shoulder was dislocated again. When these injuries and incidents escalated out of control the matter had previously been reported to the police who listed her on The *Vulnerable Persons Registry* and notified social care. All these actions happened *before* this visit to A&E.

If people across the service fail to recognise an existing basic lack of competence in their qualified colleagues, how are they going to recognise potential cases of abuse or criminality? What further illustrations do you need to suggest that all is not well? Do you consider swiftly discharging her without adequate checks or guidance, and sending her back into the risk environment while telling her to have a lovely Christmas was appropriate in the circumstances? That was your highly respected highly qualified consultant's recommendation wasn't it.

Item 17

Question: Can you provide a copy of the medical report and records for that particular visit to A&E?

HSC response: "A copy of this information should be requested from Health Records Department via tay.accessmrninewells@nhs.scot".

Comments:

I await response from the records department.

My MP awaits response from the records department.

Item 18

Question: Following a call to a consultant familiar with mum's medical history, what suddenly spooked the doctors at A&E?

HSC response: "I am sorry if you felt the communication with healthcare professionals changed during your mother's consultation. The information shared supported clear care planning to enable your mother's care and treatment to progress timeously".

Comments:

I didn't ***feel*** "the communication with healthcare professionals changed" I objectively observed by their sudden inexplicable hostility and unwillingness to engage with me that something in the dynamic had changed. In my view, the team were initially very concerned. Following a private phone call, they turned away and refused to engage in eye contact.

"The information shared supported clear care planning to enable your mother's care and treatment to progress timeously?"

The information shared during the fleeting visit was 'go home, have a happy Christmas and the consultant will call you in the New Year'. Where is there evidence of "clear care planning?" They didn't even make any basic recommendations about how to live with and manage the new serious injury or contact social care to tell them how to manage the new injury. The fact is that the consultant called us in the New Year to advise what had already been predetermined on that day at A&E. Without meeting or examining her, he had already decided against another operation. In my view one of the reasons for this irresponsible evasiveness is that she was an elderly vulnerable adult and the elderly are not valued. Another is that, given the history of injuries she represented a problem they wanted to avoid.

Meantime, we returned home to daily appeals and incidents – and a less than happy Christmas.

Item 19

Question: What problems do you envisage, learning of an existing injury, and sending a vulnerable adult back into the same environment in which she sustained that injury?

Question: Do you consider she might have been at further risk of serious harm?

HSC response: [Consultant] has advised he is unaware of any indications that would have suggested further risk of harm.

Comments:

As already questioned, did [the Consultant] bother to properly check?

The team failed to establish the extent of past harm or how the present injury occurred therefore; on what basis could they make an assessment of <u>further</u> risk of harm?

How did the Consultant arrive at his conclusion? What evaluation did they carry out and what probing questions did they ask before making that determination? What pertinent information do the A&E records note on that day about this particular subject? If the event passed as you suggest and the team followed their responsibilities fully, then the record must surely reflect that. The team were advised she was continually injured by HSC workers and had sustained yet another injury. What indications would have been required in order for the consultant to act on this information and take the matter seriously? The truth of the matter is, there was very little investigation and certainly not enough to make any kind of determination, other than to establish that the shoulder had been dislocated again which was self-evident.

For the greater part of that visit, the team disappeared for private talks with the consultant. This all happened out of earshot but this is clearly what altered their position.

You don't consider that in the circumstances and at the very least, health care should have made contact with social care and documented this? After all, social care and social care response had been warned about this injury and the risk of further injury on the day she was discharged. As I indicated in my original report, all my alerts were ignored.

They discharged her to continue the daily series of incidents at home.

Item 20

Question: Would you consider discharging her from A&E in the circumstances described to be a dereliction of duty?

HSC response: "Upon review by [Consultant], his understanding from the clinical narrative is that [her] discharge from A&E was discussed in detail with her and yourself, with whom she lived.

"There is no documentation to suggest that either of you disagreed with this decision":

Comments:

I know what my clear recollection is and I have already stated this. I would be very interested to read the version of the medical team about how "[her] discharge from A&E was discussed in detail with [her] and yourself". But providing answers and reports doesn't seem to be HSC's specialty.

It is this practised evasion that allows HSC to continually paper over the cracks.

The fact that she lived with me is irrelevant. She couldn't be considered at less risk of harm simply because she lived with me. The recurring history of incidents both in hospital and at home evidences that despite my best efforts I was unable to keep her safe. Our living arrangements provided no protection whatsoever. When she lived in hospital, with a retinue of qualified nursing staff, did that keep her safe? At home, carers operated in a room behind closed doors, unless I was called to assist, perform a task or to respond to a cry for help. As the documented evidence provides, all injuries and incidents were sustained whilst under the care of health and social care professionals attending her in hospital and at home.

In fact, due to the frequency of incidents, culminating in an alleged assault, I removed the bedroom door. The care manager at social work, who was sketchy about the absent ASP report and who struggled to process my emails without management intervention, suddenly found the time to take a deep interest in this matter. We hadn't managed to get her commitment to properly investigate the important safety matters but she was suddenly proactive in raising concerns about the bedroom door being removed. Typically however, she wasn't interested in what was going on behind that door.

Apropos HSC comments: "There is no documentation to suggest that either of you disagreed with this decision":

It doesn't surprise me that the documentation is incomplete. That is why these blunders continued happening. It was very clear that the team at A&E weren't interested in our views. As I have highlighted, following their call to the Consultant they turned hostile, they turned their backs and excluded me from dialogue. They swiftly made their determination and following a few cursory remarks towards a patient quite clearly not in a position to fully engage, hurried us on our

way. It was highly embarrassing. The message was abundantly clear. What else were we to do exactly? Conduct a sit in protest and remain seated until forcibly evicted or until our grievances were answered?

If we had resisted being shown the door, how would this have changed the behaviour of the medical team?

In my view, the simple truth of the matter is there had been so many incidents and injuries by that stage that the hospital team wanted to distance themselves. She was not the cause of her injuries and condition. She was a victim who was unjustly perceived to be a problem that people wanted to go away, rather than face up to the fact that there are serious problems across the entire service. Let us make no mistake - if there had not been successive prior adverse events, then I believe she would have been treated very differently.

As I stated in my report: “As the incidents and injuries increased and as we questioned these failings, our profiles were raised. Although my mother was the injured party, we seemed to be perceived to be the problem”.

I consider this section of the NHS response to be one of the most egregious examples of whitewashing.

In my view, HSC culture has a default position of immediately passing responsibility to the patient. When I commented in my report “the Hippocratic Oath has been replaced with a new Health and Social Calamity Oath. It’s no longer first do no harm it’s first blame the patient” I wasn’t being facetious. To my mind, this comment accurately reflects my perception of HSC practice today.

Item 21

Section 10 of the report explains that I submitted an Adult Support and Protection inquiry to NHS Tayside.

Question: When I notified NHS Tayside of the need for an ASP inquiry, what actions followed?

HSC response: "Unfortunately we are unable to identify who you raised the need for an ASP inquiry with. If you can provide further information, this can be addressed separately".

Comments:

I referred to this matter in a spreadsheet sent to you early last year. Did social care read it properly or was the service perhaps more focused on circumventing an investigation?

On 05/11/2020 I sent a letter via email to the Chief Executive of NHS Tayside raising an ASP/safeguarding inquiry. My message stated that I had attempted to raise an ASP with Social Work and it was abundantly clear my message was failing to penetrate. I stated that I was putting the entire service on notice. While this letter was acknowledged I received no further response.

Before and after this date, I continued contacting the social work department and when this department failed to respond I then contacted the social care enablement team who acknowledged my message but who also failed to act my report. In fact I recall that the manager of that team then went on annual leave and left the matter unanswered.

Ultimately, I spoke to the Care Inspectorate who succeeded in opening an investigation on my behalf. The care manager that had failed to manage her care plan and safety properly was the nominated investigating officer for the ASP investigation. What could possibly go wrong? There was a request for a second home visit which failed to materialise. It is unclear how that investigation unfolded because we received no further information. However, I was advised by the investigator that a final report would be drafted and I would receive a copy. Despite numerous requests, I heard nothing more. My information is that, neither did the Care Inspectorate.

All calls to social work were made from our home phone number. From prior dealings, I know that all calls are recorded and copies of those recordings can be accessed by making a subject access request.

This information can be requested from Information Governance, Dundee City Council - infogov@dundeecity.gov.uk

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Item 22

Moving and Handling Training at NHS Tayside

Section 11 of the report suggests that aids and equipment in the wrong hands can be lethal. Proper training is vital including an understanding of the importance of following the rules. Not doing so can result in permanent damage and risk to life. Professionals may be trained "in principle" but many are not properly trained. Whether or not they hold a certificate, some workers are clearly not trained at all.

Question: What are the details of moving and handling training for permanent and temporary staff working at NHS Tayside?

HSC response: NHS Tayside's Manual Handling policy identifies the training requirements for all new and permanent members of staff. All new staff attend foundation level induction manual handling training. This training is 7.5 hours and is a full practical session. The theory underpinning safe manual handling is covered by Module A.

All training is delivered to the Scottish Manual Handling Passport Standards (2014). All wards and departments who are patient facing have access to a local manual handling trainer or competency based assessor who have been supervised and monitored by the core manual handling team. Services also have access to the core manual handling team for advice, support and training. Bank staff are not permitted to undertake a shift until they have completed their manual handling session.

Comments:

I note your comment "wards and departments have access to a local manual handling trainer or competency based assessor [and] Services also have access to the core manual handling team for advice, support and training". This represents yet another pertinent remark due to its passivity.

Having access isn't enough. That is reliant upon workers self-regulating. The services that caused her injuries had access to support. Did they access it? Even after they injured her they still failed to complete the incomplete falls risk assessment.

The service, if it is acting with due diligence has primary responsibility to actively ensure services are first properly trained and assessed to determine if they need to access additional support and training.

In my initial report I referred to this subject. I attended a council approved manual handling training course via an accredited provider. The same course you mention. The service provider claimed that this course was “delivered to the Scottish Manual Handling Passport Standards”. That training was “7.5 hours and [was] a full practical session”. Attendees were mainly workers entering or already working in health and social care. By the end of the “full practical session” the class had not used a single item of equipment. This evidences my point already stated that, just because people have attended a training course and been certified this does not guarantee they are competent in the use of equipment.

Certification and having access to support and training means nothing. It is disappointing that this important message fails to penetrate.

Item 23

Question: What auditing process is used to assess if there are any credibility gaps between moving and handling certification and performance?

HSC response: "As with any clinical skill, performance is monitored by the team leader or Charge Nurse / Senior Charge Nurse. Where performance issues in manual handling are identified then a competency based assessment would be completed. If there are any concerns regarding knowledge and / or skills then further training would be given to address the gaps. All patient facing areas have access to a local manual handling trainer".

Comments:

Then why did I have to continually alert workers to safety breaches? Why did senior staff not detect these deficiencies before I did? There are without doubt performance issues. This is precisely why this journey continued as it did.

I repeat; just because people have attended a training course and been certified this does not guarantee they are competent in the use of equipment. There is an abundance of evidence to support this view.

Item 24

Question: Based on our direct experience, why are many nurses and carers using equipment to move and handle vulnerable adults not properly trained and competent?

HSC response: "In addition to the education and training mentioned in the previous question, NHS Tayside have a suite of generic risk assessments and safe systems of work (pictorial step by step guides) covering all patient handling tasks to ensure staff use the correct technique and this is available to support staff. NHS Tayside also has a manual handling skills video available for staff".

Comments:

The evidence suggests these **generic assessment practices** clearly aren't working.

Item 25

Question: What correlation can you see between incorrectly operating equipment and risk from harm?

HSC response: "The manual handling team regularly interrogate the incident reporting system (DATIX) to identify incidents or events involving the use of equipment and harm. All incidents are investigated and where appropriate adverse event reviews are carried out to identify any learning".

Comments:

The evidence suggests these **adverse event reviews** clearly aren't working.

Item 26

Question: If each incident could have been avoided, please explain how my mother's injuries can be considered accidents rather negligence?

HSC response: "NHS Tayside promotes a learning approach to reported incidents. Each event or incident is reviewed or investigated to determine any underlying causes or contributing factors".

Comments:

The evidence suggests this **learning approach to reported incidents** clearly isn't working.

Item 27

Question: What actions do you intend to take to address the matters raised in this report?"

HSC response: "As noted in Question 35, feedback and learning is constantly shared with relevant teams to improve and increase the safety of our care for everyone".

Comments:

The evidence suggests the **system for feedback and learning** clearly isn't working.

Item 28

Question: "How do you know that these failings are not being repeated among other elderly vulnerable service users?"

HSC response: "There are a number of processes and structures in place to measure, monitor and assess practice and key quality indicators or outcomes, to provide assurance of care delivery and identification of areas of improvement as part of a learning system. These are communicated and reviewed through line management and professional structures. We believe that listening to, understanding and acting upon feedback is essential for patient centred care, and we welcome feedback to enable us to improve the service and provide an opportunity for staff to learn and improve. We would therefore like to thank you for providing us with an account of your experience and acknowledge this was unpleasant for you in your time of grieving. I hope you have been assured that we take all concerns brought to our attention very seriously and thoroughly review the issues raised in an effort to improve the experience of our patients".

Comments:

It seems to me that these "line management and professional structures" have long since demolished and need to be rebuilt.

I haven't been "assured that we take all concerns brought to our attention very seriously and thoroughly review the issues raised in an effort to improve the experience of our patients" for the following reasons:

- Your response is devoid of satisfactory answers or common decency.
- In the absence of any apology for this appalling journey, it is impossible to take those remarks seriously. Apologising would have been the decent and conscionable thing to have done.
- Both complaints have been responded to with characteristic evasion, deflection and denial.
- There is no indication of genuine alarm at this line of events.
- There is no sense of contrition for this appalling patient journey.
- There is a sense of a begrudged obligation to respond as minimally as possible.
- You repeatedly state "unfortunately this part of your complaint is out of time" when answers are immediately accessible to you if, as you claim there are no missing records.
- HSC refused to conduct an investigation at social care.
- HSC disregarded subsequent evidence I submitted to social care.

- Social Care and NHS Tayside continually failed to take heed of my advance warnings. In fact, my important messages were resented, disregarded and unfairly viewed as “interference”.
- There was inexplicable chaos in the processing of my complaint, inordinate delays in obtaining that final response and little sense of urgency all round.
- Failing or refusing to produce records, or carry information from established records, many of which you indicate are not available to me, is highly revealing.
- Waiting more than a year to refer me to the records department, when I should have been alerted immediately and when the investigator must surely have had the necessary authority to obtain this information, is again highly revealing.
- Many assurances offered have been proven to be inaccurate.
- These incidents continued unabated no matter how many times incidents were reported and irrespective of how many advance warnings were given.
- Your response appears to be driven by self-preservation and targeted evasion instead of accepting responsibility, providing proper answers and offering an apology for this appalling patient journey.
