

## Case Summary

Complaint against the Hospital Authority (HA) for failure to attend to a patient promptly and for mishandling a complaint.

### The Complaint

The complainant's father (patient) was admitted into a HA hospital on 27 December 1996 for a minor stroke. Patient was later found to have vomited blood and an urgent upper endoscopy (OGD) was performed him on 7 January 1997 followed by a second OGD in the evening due to signs of rebleeding. On 10 January 1997, another OGD was conducted. At around midnight on 11 January 1997, the patient's condition became unstable and he died later in that morning.

2. The complainant was dissatisfied that the duty doctor had not promptly responded to urgent paging and showed up on two occasions despite the poor conditions of patient. He also felt aggrieved that his complaint against another doctor lodged with the hospital's Patient Relations Officer was mishandled.

### Findings and Conclusion

3. Upon investigation, this Office notes that, on 7 January 1997, the duty doctor for that evening was paged by the telephone operator in the ward on the instruction of the day duty doctor at around 6 p.m. so as to brief him on patient's condition on his taking over. Despite the repeated paging, the evening duty doctor did not show up until at about 8:30 p.m. Although the duty doctor claimed that he only received the call through another doctor at 7 p.m. and that he was busily attending to other patients in another ward, the hospital confirmed that the paging system was functioning properly at the same. All points considered, this Office considers that the response time by the duty doctor to the urgent calls was unreasonably long, particularly having regard to the patient's condition after receiving an urgent OGD and the result of which showed large duodenal ulcer and bleeding.

4. As mentioned in para. 1 above, at around midnight on 11 January 1997, the patient's condition became unstable. At this time, the same duty doctor was urgently paged by the nurse in the ward. He ordered

over the telephone for transfusion of Haemocel and continued blood transfusion as well as hourly observations. He did the same when he was urgently paged again at around 4 a.m. as the patient's condition deteriorated. Complainant, however, took over the phone and requested the duty doctor to see his very sick father immediately in person. The duty doctor did not turn up until 4:30 a.m. Despite subsequent cardiopulmonary resuscitation, the patient died at 6:10 a.m.

5. This Office is disappointed to note that the duty doctor did not see the patient until four and a half hours after the first calling and after much persuasion and appeal by the patient's family. Although this Office is not in a position to comment whether the duty doctor's failure in providing prompt attendance to the patient was attributable to his death, he should make himself available to respond to urgent calls from hospital staff and any enquiries from the patient's family in these critical hours as far as possible.

6. All points considered, The Ombudsman concludes that the complaint against the duty doctor's failure to respond to the urgent calls and attend to the very sick patient promptly is substantiated.

7. As regards the complainant's verbal complaint lodged against another doctor to the hospital's Patient Relations Officer (PRO) on 28 December 1996, this Office notes that the PRO had told the complainant that she would follow up on his complaint and would inform him of the investigation results. However, nothing followed in the ensuing weeks. The complainant then made an enquiry to the PRO on 27 January 1997 but the PRO claimed that he had not indicated clearly a reply was indeed required. As the complainant pressed on the matter, the PRO promised to give him a written reply. However, despite repeated attempts to chase about the matter, there had been no further response from the PRO.

8. In this connection, the PRO had indeed failed to follow the HA's established public complaints procedures in providing complainants with an interim reply or a substantive reply within a reasonable period of time. On this basis, The Ombudsman concludes that the complaint against the PRO in handling the complaint is substantiated.

## Recommendations

9. The Ombudsman recommends that the Chief Executive (CE) of HA should -

- (a) consider formulating definitive guidelines for responding to urgent calls by duty medical staff;
- (b) review its monitoring mechanism with a view to improving its supervision on the daily work and performance of the medical staff and staff handling complaints; and
- (c) give a substantive response to the queries raised by the complainant together with an apology.

## Response from the HA

10. The CE of HA accepted The Ombudsman's conclusion of his investigation and recommendations.

## Final Remarks

11. The Ombudsman is of the view that it is important that all urgent paging must be acted upon expeditiously and promptly by medical staff. This Office notes that the HA has initiated reviews to improve clinical supervision, performance by medical staff and quality of patient care as well as complaint management. This Office would monitor the progress of these reviews.

12. Finally, this Office notes that the Secretary of Public Complaints Committee (PCC) of HA had informed the complainant in June 1997 that his case would be considered by the PCC as complainant had lodged his complaint with the HA. However, the HA has advised this Office that since The Ombudsman had intended to start an investigation into this complaint, the PCC would not make an investigation into this matter. In response, the Ombudsman has reminded the CE of HA that his investigation should not constitute a delaying factor. In fact, Section 19 of The Ombudsman Ordinance provides that an investigation conducted by The Ombudsman shall not affect any action taken by the head of the

organisation affected, or his power or duty to take further action with respect to any decision which is subject to the investigation.

Office of The Ombudsman

Ref.: OMB 1997/0826

January 1998