

The Mid Staffordshire NHS Foundation Trust Inquiry

Independent Inquiry into care provided by
Mid Staffordshire NHS Foundation Trust:
January 2005 - March 2009
Chaired by Robert Francis QC

SUMMARY OF ORAL EVIDENCE WEEK 3

This week the Inquiry has heard evidence from 12 patients and or their families about their experiences of care at Mid Staffordshire NHS Foundation Trust.

This is a summary of the third week's transcripts provided by the Inquiry Secretariat. It does not reflect the views or opinion of either Counsel to the Inquiry or the Chairman of the Inquiry who will rely on the full transcripts.

All names and personal details have been removed to protect Patient confidentiality.

Monday

Case 1

On the Monday Mrs A11 told the Inquiry about the treatment her husband (Patient A11) received at Stafford Hospital in July 2007. She was joined by her daughter (Mrs B11) at the hearing.

Patient A11 was admitted to the Accident and Emergency (A&E) at Stafford Hospital by ambulance. When he arrived, he was in considerable pain and had a fit whilst a doctor was examining him. Whilst waiting for a scan he had another fit. A nurse put him on his side before leaving to find another member of staff. No staff returned and his daughter was left holding her father alone until the fit had subsided.

Patient A11 was transferred to the Emergency Assessment Unit (EAU). Whilst he required extra pillows to be propped up none were available and Mrs A11 had to go and buy some. The pillows kept been given to other people and were eventually lost when the patient was transferred.

The patient was moved to Ward 7. Mrs A11 told the Inquiry that the staff and care received were excellent and that her husband was treated with dignity. Following Patient A11's brain scan, the family were informed that the prognosis was not good and he was moved to Ward 10.

Mrs A11 described Ward 10 as a 'hellhole' where there was no dignity or care. She said that she had to ask for everything - drips, mouthwash, painkillers. Patients were left to call out for bedpans and help. Moreover, the response by nursing staff was always the same 'in a minute'.

On one occasion, when Mrs B11 went to visit her father she found the rails at the sides of his bed were down and his leg and arm were hanging over the side of a soaking wet bed. She told the Inquiry if she had not visited, her father would have been left and probably have fallen out of the bed completely. There were no staff to assist so Ms B11 helped her father and changed his bed herself. Mrs A11 also told the Inquiry that she had to beg the staff to provide her husband his pain relief.

During his time on the ward, Patient A11 was attacked in the middle of the night by another patient who tried to strangle him. Mrs A11 believes that she should have been told about this incident immediately and not informed in the morning when she visited. The family raised concerns that a known aggressive patient was placed on a ward without extra care or security.

Following this incident, Patient A11's daughter stayed with her father at the hospital the following night. During the night, she had to ask a number of times for her father to be given his regular medication.

Monday

Case 1 contd

That morning, Patient A11 passed away and the staff had to ask his daughter what time her father had died. The family were shown to a dirty room and his daughter told the Inquiry that a nurse came in and literally threw documents at her that she said she would need for the funeral.

The family complained to the hospital. An investigations report was carried out. The family believe the response and report were a 'whitewash. A complaint was also made to the Healthcare Commission (HCC).

Monday

Case 2

On Monday the Inquiry also heard evidence from Mrs C11 whose late husband (Patient C11) received treatment at Stafford Hospital in September 2006 and again in May 2007.

Patient C11 was initially admitted to Stafford Hospital in September 2006 through the Accident and Emergency (A&E) department as he was experiencing chest and back pain. He was subsequently transferred to Ward 12 where he remained until he was later discharged. Mrs C11 does not recall having any concern in the way in which her husband was treated during this initial episode in Stafford Hospital.

In May 2007 Patient C11 experienced a minor transient ischaemic attack (TIA) and was admitted to Stafford Hospital. Mrs C11 recalls that once admitted to Stafford Hospital her husband was transferred to Ward 10 from the Emergency Assessment Unit (EAU). She recalls that whilst on Ward 10 her husband did not receive any of the blood pressure tablets that he was prescribed to take on a daily basis prior to his admission. She recalls that he went without these tablets for a 48-hour period before a nurse was able to locate the necessary medication.

Mrs C11's husband was on a ward with three male patients who had experienced severe strokes and the room was extremely odorous. As such Patient C11 found it difficult to spend any time in his room and felt unable to eat his meals in there given the odour. Her husband reported to her that the other patients in his ward were often left in soiled clothes and bed linen which resulted in the odour. Mrs C11 also reports that her husband informed her of an incident whereby two nurses were talking and laughing about the patients, she reports that her husband actually confronted the nurses about their lack of respect for the patients on this occasion.

Mrs C11 informed the Inquiry that due to problems with her husband's bowels since 1999 he was monitored via regular colonoscopies. Despite annual investigations, in 2002 the patient was informed that his next follow-up would not be for three years and that they would be contacted by the hospital when he was due to attend for the follow-up appointment. When Mrs C11 thought mistakenly that three years had passed she attempted to make contact with the hospital and was informed that they were moving departments and would be in touch when her husband needed to attend. The procedure was undertaken in June 2007, five years after his last examination. Following the procedure a nurse informed him that he had in fact been "lost in the system".

Monday

Case 2 contd

During his stay in hospital following his TIA in May 2007, his results from the colonoscopy indicated that Patient C11 had cancer. The Macmillan nurse subsequently wrote in his notes that the patient was unaware of the diagnosis. Patient C11 was subsequently discharged without being aware of the diagnosis. It was a month before Patient C11 was told of the diagnosis. It was subsequently agreed that Patient C11 would undergo surgery and he was admitted onto Ward 6 in July 2008.

Following the operation Mrs C11 went to visit her husband. She recalls that he was complaining of pain despite having been administered an epidural. She reports that the nurse was dismissive of her husband's pain and disputed that he was suffering. Sometime later the nurse agreed to give her husband some liquid paracetamol, however, this did not reduced the pain. Mrs C11 recalls the nurses having a poor attitude and when her husband informed them that his pain had not improved they ignored him and walked away. She also recalls that he did not receive morphine or artificial tears, despite it being stated in his notes that he required them.

In terms of personal hygiene Mrs C11 recalls that her husband was infrequently washed and given clean clothes despite frequently soiling himself. She recalls that her husband had sores on his bottom and on his heels. She states that her husband rang the bell for toileting assistance but by the time the nurses arrived it was too late. She reports that she used to ring the bell for 20 minutes before it was responded to.

Mrs C11 states that the bed linen was not changed as frequently as it should and when it had been changed her husband was afraid to go to bed in case he soiled it as he feared the reaction from the nurses. Mrs C11 was informed by her husband that nurses had been angry at having to change his soiled bed linen. Subsequently on one occasion he sat in his chair from 5am until 8pm.

When her husband was allowed to resume eating following the operation, Mrs C11 feels that little consideration was given to his nutritional needs. She also considers that he was given inappropriate food given that he had been nil by mouth for nine days. She recalls that after eating he was violently sick.

Monday

Case 2 contd

Mrs C11 states that she never met with the consultant who operated on her husband and she did not feel that his junior fully understood her husband's condition. Furthermore, she recalls finding it difficult getting access to a doctor in order to discuss her husband's condition or care pathway.

Despite continuing to experience diarrhoea and vomiting and being unable to eat Patient C11 was informed that he could be discharged home. Being concerned by this Mrs C11 contacted the Macmillan nurse who reported that he should not go home until he was fully functional.

Later that day Mrs C11 went to visit her husband who was rolling around on the bed in pain. When a doctor examined him Mrs C11 was unable to comprehend how much weight he had lost during his time in hospital. She reports that he had not been given any build-up drinks or vitamins during his time in hospital. Mrs C11 recalls that on completing the examination the doctor left without saying anything to the patient or his wife.

Patient X's condition deteriorated further over the next couple of days and Mrs C11 received a call in the early hours of the morning to inform her that her husband was extremely poorly. Despite only taking 20 minutes to get to the hospital she was informed on arrival that her husband had passed away.

Monday

Case 3

On Monday the Inquiry heard evidence from Mrs D11 about the treatment her father (Patient D11) received at Stafford Hospital in the summer of 2007. Her daughter (Ms E11) joined her at the hearing.

In July 2007 Patient D11 fell at home and fractured his femur and was taken to Stafford Hospital Accident and Emergency (A&E) department in the early hours of the morning. The family report that they were satisfied with the treatment that their father/grandfather received in A&E and the communication that took place between staff and the family. After about four hours Patient D11 was admitted to the Emergency Assessment Unit (EAU), The family settled him for the night and left at approximately 4am. At this point they were informed that Patient D11 would undergo an operation the following day. When the family then called the hospital to ascertain whether Patient D11 had undergone the planned surgery they were informed that he had not and to call again later. Later that day the family received a call from the hospital to inform them that the patient was agitated, which concerned them as this was not his usual character. The following day their father finally underwent surgery. Due to the delay in the procedure Patient D11 had remained nil by mouth for an extended period of time. Given that the patient was diabetic, the family feel that this could have been the cause of his agitated state on the Saturday.

Mrs D11 states that staff on Ward 7 were informed not to change Patient D11's insulin as he was allergic to other forms. Despite this, his insulin was changed and he came out in a rash. The family requested that he be prescribed cream to sooth the itchy rash but they were not provided with any. The family subsequently had to arrange to get the cream from their GP.

Mrs D11 reported that her father disclosed that the nurses failed to answer call bells. This resulted in him and another patient soiling themselves. After a couple of days Mrs D11 visited the Patient Advice and Liaison Service (PALs) office as she felt she was not getting sufficient information regarding her father's care. She states that the PALS representative phoned Ward 7 and arranged for Mrs D11 to meet with the ward sister. Mrs D11 was left alone with the ward sister to discuss her concerns. The ward sister initially denied that Patient D11's insulin had been changed and then when Mrs D11 went to get her mother to confirm her story the sister confirmed that it had been changed. No apology was offered.

On one occasion Patient D11 informed his wife that he had been shaved with the same razor that had been used to shave other patients on the ward.

Monday

Case 3 contd

With regards to meal times, Mrs D11 said that her mother used to fill in the menu card for her father. She said that patients who did not have regular visitors would not get assistance. Furthermore, these patients were not provided with assistance when eating. She recalls that food was often placed out of the reach of patients and then taken away untouched.

Despite initially being under the impression that he could be discharged, Patient D11 was informed that staff wanted him to remain in hospital for a further 24 hours in order to monitor his potassium levels, to which he agreed. He was subsequently transferred to Ward 11.

The following day Mrs D11's mother visited to find Patient D11 slumped in a chair, unconscious with blood coming out of his mouth. She ran out into the ward to get assistance but there did not appear to be any staff around. Eventually staff appeared and activated the panic button and a crash team arrived and he was stabilised. The staff did not know how long Patient D11 had been in this hypoglycaemic state.

The family feel that Patient D11's blood sugar levels were not monitored closely enough, that staff did not act swiftly enough when a deterioration was recognised and that too great a time elapsed before they took a further sugar test. Furthermore, the fact that Patient D11's low blood sugar levels continued for a sustained period of time did not appear to raise concern.

Overall the family did not have any concerns regarding the actual nursing care that Patient D11 received on Ward 11, however they recall there being very few staff. The family described that on one occasion there appeared to be just two nurses to care for over 40 patients.

On one occasion the family report that Patient D11's catheter bag was full and on the verge of overflowing. An auxiliary nurse was informed that it needed changing. Mrs D11 ended up changing the catheter herself.

The family also recall that staff did not communicate the severity of Patient D11's condition to them and it took considerable probing for staff to release information regarding his prognosis.

Patient D11's condition deteriorated and he was moved to Ward 1. He was initially placed on a ward but as he deteriorated further he was given his own room.

Monday

Case 3 contd

Overall, the family were satisfied with the nursing care afforded to Patient D11 on Ward 1. They emphasised that they were primarily dissatisfied in the period following his operation when he was a patient on ward 7. They had a positive experience of the Sister on Ward 11 and felt that she was very “hands on”. In contrast, they recall the Sister on Ward 7 being less visible and less of a team player.

Following further deterioration Patient D11 passed away in September 2007. The family made a complaint to the trust, initially when Patient D11 was still alive and the complaint continued after his death. The family do not feel that their complaints have been dealt with in a timely or satisfactory manner.

Tuesday

Case 1

On Tuesday, Mrs F11 told the Inquiry about the treatment that her 96-year-old mother (Patient F11) received at Stafford Hospital. Her husband (Mr F11) joined her at the hearing. Patient F11 was admitted to Accident and Emergency (A&E) in June 2006 before being transferred first to the Emergency Assessment Unit (EAU) and then to Ward 11.

Patient F11 was referred to A&E by her nursing home as she was screaming and had a water infection. When she arrived in A&E she was very distressed and in tears. She was also dehydrated. A fluid drip to help with the dehydration was brought to her, but it was not connected despite a number of requests by the family. No staff spoke to Patient F11 or her family about why she was being transferred to EAU.

On arrival to EAU, no staff introduced themselves to Patient F11 or her family. Whilst Patient F11's fluid drip was connected in EAU, Mrs F11 said that they would often find the fluid bag empty and she could not recall a nurse ever coming to check on her mother whilst she was there.

Mrs F11 told the Inquiry that on one occasion when she and her husband visited her mother, she had no clothes on and her door was open which meant that anyone walking through the ward would have been able to see her. Her mother was covered in faeces, it was in her hair, nails and bedclothes. Mrs F11 said that the faeces had dried, indicating it had been there for hours. Mrs F11's husband had to go and find staff to ask them to clean his mother in law. No one apologised for the condition in which Mrs F11 was found.

Patient F11 was then transferred to Ward 11 where she was given a side room. Her family were not informed about the move.

Whilst on Ward 11 Patient F11's drip bag was often empty. Mrs F11 said that on one occasion, a nurse tried to fix the drip, but left before it was done because she said her husband was waiting for her as her shift had finished. Mr X was left to try to fix his mother-in-laws drip alone.

Mrs F11 said a male patient in the adjacent room on the ward told her that nobody ever came to attend to her mother. She also said it was extremely difficult to find a member of staff on the ward and that she never witnessed a nurse checking on her mother. Mrs F11 also reports that a doctor did not review her mother when she was on the ward.

When Patient F11 was ready to be discharged, she had to wait without anything to eat or drink for several hours for an ambulance to arrive. Patient F11 was diabetic and Mrs F11 asked for something for her mother to eat. She was brought a trifle by a member of staff and told 'this is all I can find'.

Tuesday

Case 1 contd

Patient F11 returned to her nursing home where she passed away six weeks later.

Mrs F11 made a formal complaint to the Chief Executive but was dissatisfied with the response that she received, describing it as very curt.

Tuesday

Case 2

On Tuesday the Inquiry heard evidence from Mrs G11 whose late mother (Patient G11) was at Stafford Hospital between July 2006 and December 2006. Mrs G11 was accompanied by her husband (Mr G11) at the hearing.

Patient G11 had been diagnosed with bone cancer in March 2006 and subsequently underwent chemotherapy, which was perceived to be going well. Patient G11 had began experiencing difficulties with mobility and experienced a couple of falls at home. Patient G11 was subsequently admitted to Stafford Hospital having experienced a particular fall in July 2006. She was referred to hospital by her GP and was admitted to the Emergency Assessment Unit (EAU) until she was transferred, the following day, to Ward 2.

When Patient G11 was admitted to Ward 2 her family raised concerns about her suppressed immune system as a result of her chemotherapy. They requested that she be placed in an isolation bay. Mrs G11 was informed by nurses that this was not necessary and there was not the capacity even if required. Within a few days of being on Ward 2 Patient G11 was diagnosed with *Clostridium difficile* (C. difficile). Mrs G11 recalls her mother experiencing severe diarrhoea on one occasion and being unable to find a nurse to clean her mother. She therefore cleaned her mother herself and was then informed by a nurse that she should not be doing this given her mother's contagious condition. Mrs G11 pointed out that Patient G11 was afforded little dignity and respect being left to sit in her own faeces in front of other patient's visitors within the ward.

Mrs G11 reports that she was never informed that her mother was suffering with C. difficile and she only became aware of this through reading her mother's medical notes that were kept at the end of her bed. She recalls that it was extremely difficult gaining information on her mother's condition during her time on Ward 2 from both doctors and nurses. On one occasion she recalls raising her concerns with a nurse on a Monday morning and being told that if she came back at 9am on the Thursday morning then she would be able to speak with a doctor. However, on doing this the same nurse informed her that she had not informed them to return that day. Despite this a junior doctor agreed to speak with them and discuss their concerns.

In terms of the nursing staff on Ward 2, Mrs G11 described them as being extremely busy and constantly running around. She stated that some of the nurses were very kind, however there were others who were not.

In relation to Mrs G11's general observations of Ward 2, she recalls that patients were not given bedpans in a timely fashion or drinks regularly. Furthermore, she observed patients being left to sit in their own faeces and urine, unable to reach their buzzers and generally being left in an extremely

Tuesday

Case 2 contd

distressed state. Her view was that there was not enough staff to cope with even the basics of nursing care.

Mrs G11 was extremely positive in relation to the physiotherapist who worked with her mother. She recalls that he was extremely overstretched and was required to provide a service to a significant number of wards across the hospital. However, she felt that he always ensured he spent as much time with Patient G11 as possible.

In relation to the cleanliness of the ward, Mrs G11 recalls that her mother's blood stained swabs were often left on the cabinet beside her bed or were dropped onto the floor. On one occasion she decided to leave a blood stained swab on the floor to see how long it remained there. Three days later it was still there and Mrs G11 threw it away.

Patient G11 was moved into an isolation room which her family considered to be filthy. Mrs G11 reports that she and her family cleaned the room daily but it was extremely dusty. Additionally, she recalls a basket at the end of the bed where her mother's soiled linen was placed, which she considered to be an infection control issue. Her concerns were ignored by nurses. Furthermore, she recalls that the hand gel dispensers on the ward were often empty.

Mrs G11 recalls that on one occasion she went into the room to find her mother on her bed on a bedpan which she was falling off. She was clearly in agony. Patient G11 informed her daughter that she had been left on the bedpan for over an hour and that the call bell was out of her reach.

Mrs G11 was keen for her mother's weight to be monitored as she was concerned that she was losing a considerable amount of weight. She was informed that it was not possible to weigh her due to her immobility. Mrs G11 disputed this as there was a hoist available, but again this was dismissed.

Mrs G11 was informed by her mother's consultant that her mother had gone into remission from the bone cancer and that nutrition was important to improve her strength to improve and that in particular she should consume red meat. Mrs G11 ensured she ordered cottage pie for her mother's lunch the following day. However, when lunch arrived it consisted of a cheese salad. The auxiliary nurse was adamant that this had been ordered and her meal was not changed. As a consequence, Mrs G11 went into town to purchase a more appropriate meal for her mother.

On one occasion Patient G11's foot became tangled in the sheets at the bottom of the bed. Unable to get the attention of the nurses and having been stuck in that position all night she contacted her daughter using her mobile phone. When Mrs G11 arrived she was still in this position and in a considerable amount of pain.

Tuesday

Case 2 contd

Furthermore, Mrs G11 reports that she has recently learnt that her mother suffered fractured ribs whilst in hospital. This information was never shared with her or her family. She recalls her mother complaining of pain in that region and it was suggested that her mother's pain was psychological.

Mrs G11 recalls hearing a very loud alarm ring for a considerable amount of time on one occasion. After some time a number of staff came running onto the ward and she recalls one member of staff saying to another "how long has that emergency button been going?" Mrs G11 feels that this incident typified the situation on the ward. Furthermore, at night Mrs G11 recalls staffing levels being particularly low.

In relation to eating, Mrs G11 recalls having to assist other patients with removing the packaging from their meals. She recalls that patients who did not have relatives to assist them with eating were often left unfed. She recalls that meals were placed out of reach and then they were taken away untouched.

Mrs G11 recalls reading in her mother's file that she had contracted Methicillin-resistant Staphylococcus aureus (MRSA). She found a nurse with whom to discuss this with and the nurse explained to her exactly how her mother had contracted MRSA. However, there is no record of this on Patient G11's medical notes.

The night before Patient G11 passed away she was described as unresponsive and the family were informed that it may take several days before she passed away. As such, the family went home at about 10pm but received a call at 2.30am to say that Patient G11 was very poorly. Mrs G11 recalls being back at the hospital within 20 minutes of the phone call, but Patient G11 had already passed away.

Despite nurses informing the family that they were with Patient G11, holding her hand when she passed away, they were unable to document the time of her death. As such, Mrs G11 fears that her mother died alone and was found by nurses after she had passed away. Mrs G11 sat with her mother for sometime after her death and wanted to remain with her mother. However, she was keen to get her out of the hospital and it was agreed that she would leave her now and spend more time with her when she was moved to the chapel of rest. However, after Patient G11 was moved to the undertakers her family were informed that they would not be able to see her body as the hospital had advised that she was highly infectious. The undertakers reported that they had been advised by the hospital that Patient G11 had to be buried in a sealed body bag. The family were extremely distressed to learn this and made attempts to contact the hospital. The Bereavement Officer informed

Tuesday

Case 2 contd

Mrs G11 that the paperwork had been completed incorrectly and that her mother could in fact be embalmed. However, as this information had not come from a clinician it was not deemed sufficient to override the information previously received by the undertaker. The family were very upset as the only viewing of the patient's body was of her head sticking out of a body bag.

Mrs G11 subsequently made a complaint to the trust, primarily regarding the nursing care received by her mother and the situation which occurred following her death. Mrs G11 was unhappy with the way in which her complaint was dealt with. She recalls that letters were not received and investigations were not undertaken in a timely manner.

Tuesday

Case 3

On Tuesday the Inquiry heard evidence from Mrs H11 whose late mother (Patient H11) was at Stafford Hospital in October 2007. Mrs H11 was accompanied by her daughter (Ms J11).

Patient H11 experienced a fall at home approximately one week prior to being admitted to Stafford Hospital. Despite the efforts of ambulance staff at the time of the fall, Patient H11 refused to go to hospital for treatment. Approximately one week after the fall, suffering from a urine infection and injuries to her arm, Patient H11 was admitted to Stafford Hospital.

Patient H11 was diagnosed as having a mid-shaft fracture of the humerus. From A&E Patient H11 was transferred to the Emergency Assessment Unit and the following day was moved to the Trauma and Orthopaedic Ward. Mrs H11 recalls being concerned about this ward from the first night her mother was moved there. She states that she was concerned about how high her mother's bed was from the ground and that the bed did not have sides to it. She reports that her mother fell out of bed on the first night but staff did not call Mrs H11 or her family to notify them of this incident.

Patient H11 then underwent an operation on her injured arm. The family raise concerns that they were not asked to consent to such a procedure. They feel that given the confused state that Patient H11 was experiencing that the family should have been asked to consent to the operation.

The family raised concerns relating to their mother's dietary intake. The family recall that Patient H11 was eating and drinking very little, on some occasions just half a cup of tea. Patient H11's lack of food intake was attributed to dementia. However, Mrs H11 feels that staff did not do enough to try to encourage her mother to eat.

Mrs H11 recalls noticing an strange smell in the ward which went on for several days before asking a nursing friend of hers to visit her mother to see whether she could determine what the smell was. She recalls that as soon as her friend entered the ward she could tell that her mother was uraemic. Her friend informed her that this is a condition where extreme dehydration causes urine to come out through your skin. She recalls that her friend informed her that this condition occurs as a result of poor nursing care.

Mrs H11 reported that nursing records were chaotic and that they have received different versions of the same forms that have subsequently been completed in a different manner.

Tuesday

Case 3 contd

Mrs H11 states that the family were made to feel as though they were “irrelevant” in the care of their mother/grandmother. They recall that they were not informed when Patient H11 had fallen out of her chair and they often learnt information like this from other patients’ relatives who witnessed such falls.

The hospital informed the family that Patient H11’s dementia meant that it was unlikely that she would ever be able to walk again. However, within a month of being discharged into a care home she was able to move with the use of a frame. By the time she was discharged to the care home she had lost a considerable amount of weight, however whilst at the care home her food and fluid intake improved significantly. Her fluid intake was initially increased by placing Patient H11 on a drip, however the family feel that the damage caused by her being left dehydrated in hospital for too long had already been done.

Patient H11 would regularly attend Queen’s Hospital in Burton for assistance with fluid levels and then be discharged back to the care home after a couple of days. The family recall that the level of care Patient H11 received at Queen’s Hospital contrasted significantly with the care afforded at Stafford Hospital. Mrs H11 reports that the levels of cleanliness at Queen’s Hospital were far greater and that patients were treated with a greater level of dignity and respect.. Furthermore, they were able to speak with doctors or nurses as and when they required.

Ms J11 states that the main thing that was lacking in her grandmothers case was basic nursing care, including effective feeding and hydration. .

Wednesday

Case 1

Mr and Ms K11 described the care that their parents received at Stafford hospital.

Mr and Ms K11's mother was admitted to the Accident and Emergency department (A&E) in December 2007 following an incident at her care home. Patient K11's leg was bent at a right angle, which indicated to Mr K11 that she had broken her hip. Patient K11 waited for three hours before pain relief or assistance was given. This was traumatic and stressful for the patient and her family.

An X- ray confirmed that Patient K11 did have a broken hip and she was subsequently transferred to Ward 7. Mr K11 recalled that surgery for the broken hip was delayed. This meant that his mother had significant periods without food and drink and became very dehydrated.

Mr K11 felt that the physiotherapy given to his mother was insufficient and that this was partly because his mother was not on the appropriate specialised ward for her condition.

Mr K11 also told the Inquiry that his mother's medication was not properly administered whilst on the ward. His mother had dementia but staff did not give her the necessary support to swallow tablets. He also observed that call buttons were left out of reach of patients. Patient K11 also developed bedsores during her stay

Patient K11 was subsequently transferred to Cannock Hospital . The transfer was delayed for a number of hours, as she had to wait for transport. Patient K11 was in considerable pain, as a consequence of waiting on a very hard bed in the discharge area and was very distressed and confused.

In April 2008 Patient K11 was again admitted to Stafford Hospital. She was admitted to Ward 11, via A&E and the EAU. Whilst in the EAU Mr K11 recalled finding his mother in a soaking bed.

On Ward 11, Patient K11 had some assistance with food and drink but there were too few staff to cope with all the elderly patients in the ward who needed help.

The nurses station was very rarely manned and if the family wanted to speak to a sister they could not do so immediately and in some cases had to wait two or three hours. Mr K11 felt it was very difficult finding out who was in charge of the ward or information about the current situation. This was worse during the change over from one shift to another.

Wednesday

Case 1 contd

Mr and Ms K11 also suspect that the documentation of their parent's care was inaccurate. Ms K11 gave an example of when food had been reported as eaten when it had not been. She also reported an occasion when her father specifically asked for breakfast but an entry for that day reported that it had been refused.

Mr and Ms K11'S father (Patient L) was cared for in Wards 1 and 2 in Stafford Hospital in early 2008. Mr and Ms K11 had no particular concerns with the care their father received during this period. .

Patient L was then admitted again in April 2008. He was admitted to Ward 7 and later to Ward 10. On admission to Ward 7, Mr K11 had to ask for the bed to be cleaned because there were faeces on the sides of the bed. When in the isolation ward, on one occasion, Patient L could not access the call button and was left without help all night. He was very distressed by this experience. There were also times, after he had contracted C. difficile when he was left for periods of time in a soiled bed.

Whilst on Ward 11, Mr K11 recounted being overwhelmed by a stench when visiting his father in the isolation room. His father was suffering from severe diarrhoea. He found the smell was coming from a bin in the room containing soiled bed pads. He went to the desk and requested that the bin be changed and the nurse told him that it was the cleaner's job and that they weren't coming until the evening. Mr K11, unhappy with this, then asked the nurse whether he could take it away but the nurse did not know where to take the full bin liners.

Patient L was often very thirsty during his time on the Ward and was often not left with sufficient water. When he asked for more, he was sometimes ignored. Mr K11 also observed that call buttons were often beyond patient's reach.

Mr and Ms K11 felt their father was incorrectly discharged following the first of the two admissions: a blood test had shown abnormalities in his liver function. They were also confused about whether their father had had a gallbladder procedure during the first admission. They had concerns that case notes had been altered.

Patient L was later admitted to Stoke Hospital where Mr K11 and Ms K11 found the care markedly different. Communication was better and staff were more open and friendly. In contrast to Stafford they felt confident in leaving a relative there.

Wednesday

Case 2

On Wednesday the Inquiry heard evidence from two of Patient M11's sons (Mr N11 / Mr P11) and her daughter (Mrs M11). Patient M11 was at Stafford Hospital in 2005 and again in December 2008 through to January 2009.

In June 2005 Patient M11 went into Stafford Hospital in order to have a nephrostomy tube fitted. Despite feeling unwell, the day after the procedure Patient M11 was discharged home. The following morning her condition deteriorated further. Her GP diagnosed an infection and arranged for an ambulance to take her back to hospital. The family recall that there was a lack of communication between the Accident and Emergency (A&E) staff and the family on this occasion. They state that they were not kept informed about their mother's condition. Mrs M11 also raised concerns regarding the attitude of clinical staff and reception staff within the A&E department. Furthermore, she states that her mother was left in a very cold room without a blanket while her condition continued to deteriorate.

Patient M11 was later transferred to Ward 6 where her family raised concerns in relation to the cleanliness of the ward. They recall observing blood stained tissues on the floor in the ward and bags with blood-stained sheets remaining for days at a time. The family state that the treatment on Ward 6 contrasted greatly with the care received when they moved their mother to a private room within the hospital. They state that on the private ward there were fewer patients and more nursing staff with time to provide a higher level of care to patients.

In May 2008 Patient M11's leg began to swell and her GP indicated that she may have a blood clot and subsequently sent her directly to Stafford Hospital. When examined by a doctor the family feel that the doctor was convinced of a particular diagnosis and subsequently did not pay sufficient attention to Patient M11's swollen leg. Mrs M11 believes that there was a missed diagnosis at this point. Further tests were undertaken and in September 2008 Patient M11 was diagnosed with non-Hodgkin's lymphoma. The family raise concerns that the diagnosis was made without having conclusive evidence. However, a decision was undertaken for her to undergo chemotherapy which initially appeared to be going well.

In August 2008 Patient M11 had a stent inserted. Following this procedure she began experiencing severe pain. The family questioned whether the stent was causing the pain or whether damage had been done when the stent was inserted. However, a decision was taken by the hospital that the stent would remain in situ.

Wednesday

Case 2 contd

In December 2008 Patient M11 was readmitted to Stafford Hospital. The family raised concerns about the level of care received from the time of her admittance until her death in January 2009. They recall that their mother was not treated as an individual. It was their perception that none of the patients they observed were treated as though they were an individual person. They recall that their mother was left constipated for a 16 day period with no attempt made to rectify the situation. They state that they continually attempted to get the nursing staff to address the situation but to no avail.

The family also raised concerns about a lack of information and a lack of compassion being afforded to them. Mrs M11 recalls that in January 2009 her mother had developed a cough and she asked a nurse for a doctor to review her. She states that the nurse responded by informing her that her mother would not get better, that she was going to die and the hospital were just keeping her comfortable until she did. Mrs M11 states that if they were had been made aware of their mother's prognosis then they would have taken her home.

Mrs M11 also raised concerns relating to the pain relief provided to her mother. She states that the predominant reason for her mother going into hospital was to ensure her pain management was brought under control. However, the family state that despite a referral being made to the palliative care team, they did not receive any input from a palliative nurse until two weeks prior to her death. The patient was later placed on a syringe driver in order to manage her pain, however, the family recall that on one occasion she was administered too high a dose of morphine which resulted in her being unresponsive one morning.

Mrs M11 recalls that if her mother needed assistance she would use the call bell, however nobody ever responded to it. In the end a member of the family would go and seek assistance only to find a number of nurses gathered around the nurses station. The family feel that there was a lack of management on Ward 1, which resulted in a lack of direction and control. They recall that during handover time they were unable to have access to any nursing staff for approximately half an hour which they perceived to be unacceptable.

Concerns were raised regarding the lack of staff. They recall that on one occasion their mother pulled her feeding tube out. It subsequently took almost nine hours for it to be reinserted as apparently there was nobody available with the correct level of skills to reinsert the tube. They also raised concerns about equipment not working, particularly the heart rate monitor, and the family recall that the nurse stated that the machine 'never functions properly'.

Wednesday

Case 2 contd

In relation to the administration of medication, the family recall that medication rounds were often delayed which resulted in their mother being woken at midnight in order to take her medication.

In terms of cleanliness the family report that their mother was moved from Ward 1 to a room in Ward 2. However, the room had not been cleaned prior to her moving into it and that debris from the previous patient was still in the room on their mother's arrival.

Mrs M11 also said that the room on Ward 2 was freezing. She was told that the heating was broken and to use a electrical heater, but she was concerned about the effect of this in her mother's asthma. Mrs M11 had to bring blankets from home to try and keep her mother warm and she told the Inquiry that when she visited she would keep a coat, gloves and scarf on.

Their mother's condition deteriorated and she sadly passed away in January 2009. The family have since made a formal complaint to the trust both in relation to the diagnosis of cancer and the care and treatment received during her time in Stafford Hospital.

Wednesday

Case 3

On Wednesday the Inquiry heard evidence from Mrs R11 about the treatment that her mother (Patient R11) received at Stafford Hospital.

In December 2006, Patient R11 was found by her carer to be unwell and with a high temperature. She was admitted to Stafford Hospital where spent time on the Emergency Assessment Unit (EAU) and Ward 11.

The Inquiry was told by Mrs R11 that they had no issues with the care provided on EAU.

When Mrs R11 visited her mother on Ward 11, she found an uncovered used commode by her mother's bed. She recalls that it was there for six hours. Mrs R11 had to ask staff personally to move it. No apology was given.

Despite Patient R11's family telling staff that their mother could not see her water jug due to poor vision and that she needed to be encouraged to drink no help was provided. Patient R11 was also unable to see her meals as they were left at the bottom of her bed.

Patient R11's son and daughter in law had to tell staff when their mother developed oral thrush, as staff had not detected it. Mrs R11 also reports that her mother was left in dirty nightwear and that dirty laundry was placed near her bed.

Patient R11 was scared of showers. Her family requested that they be allowed to help her into the shower to ease her fears but they were refused on health and safety grounds. Patient R11 did not have a bath for her entire stay on the ward, as staff could not locate a bath for her.

Mrs R11 told the Inquiry that the family asked if they could wash her mother's hair or organise for a hairdresser to visit. She was informed that the hospital would organise it, however this did not happen.

Mrs R11 feels that the staff at the hospital failed to diagnose her mother and treat her correctly.

When Patient R11 deteriorated, her family were informed that it was unlikely that she would regain consciousness. She was placed in a side room. Mrs R11 said the side room smelt and was unclean and that she and her sister along with a healthcare assistant had to clean the room.

Mrs R11 told the Inquiry that one doctor told the family that Patient R11 had suffered a stroke. Yet other members of the family were given different information.

Wednesday

Case 3 contd

Mrs R11 told the Inquiry that she disagrees with information recorded in her mother's medical notes.

Thursday

Case 1

Miss S11 and Miss T11 told the Inquiry about the care and treatment provided to their mother (Patient S11) and father (Patient T11) by Stafford Hospital.

In February 2008, Patient S11 was dehydrated and was admitted to Stafford Hospital Accident and Emergency (A&E) by ambulance. She spent five days at the hospital.

Miss S11 told the Inquiry that her mother was kept waiting for a long period in A&E whilst in considerable pain. No one explained what was happening and Miss S11 told the Inquiry that she felt 'lost'.

Patient S11 was transferred to the Emergency Assessment Unit (EAU). Miss T11 phoned the unit the following day to ask about her mother and was informed she had been sent for cardiac tests. Their mother had not been sent for cardiac tests – the hospital was referring to a different patient. That evening when they visited with their father they were taken to see their mother. Again, it was the wrong patient. Their mother had in fact been transferred to Ward 1.

On Ward 1, they found their mother was extremely cold as she only had one sheet covering her. Despite her high risk of sores, Patient S11 had not been put on an air mattress and her pressure sores returned as a result. They also discovered that their mother had not been given her eye drops. As a result, Patient S11 eyes deteriorated.

Miss S11 and Miss T11 said they had concerns regarding their mother's nutrition and hydration on the ward. She was given inappropriate food that she could not see to eat and water was placed in a glass for her that she was unable to use.

After three days, Miss S11 saw a doctor who said her mother was going to have a chest X-Ray. Neither daughter knows if this ever took place.

Patient S11's daughters asked if an ambulance could bring their mother home; as they were concerned about lifting her. The hospital refused.

Miss S11 and Miss T11 said that their mother left hospital in a worse condition than she entered. Their mother passed away in April.

In January 2009 Miss S11 and Miss's T11's father was admitted to Stafford Hospital's A&E. He had diarrhoea and was vomiting. They reported an improvement in the system. Their father was seen promptly and staff were more helpful. However, he still had to wait several hours to be transferred to EAU.

Thursday

Case 1 contd

Whilst on EAU, their father started to deteriorate and was shaking. They asked for a doctor. A doctor did not arrive until 2 hours later. The doctor said that A&E had not told her about the arrival of their father.

Their father was then transferred to Ward 11. Miss S11 told the Inquiry that there were no staff and patients were shouting for assistance. They learnt from another patient that their father had fallen out of bed. The fall was not recorded in Patients T11's medical records/ No one communicated with them about their father's condition. Their father later died at the hospital

Complaints have been made to David Kidney MP and the hospital. Miss S11 and Miss T11 are not satisfied with the hospital's handling of their complaint.

Thursday

Case 2

Mrs U11 told the Inquiry about the treatment provided to her mother (Patient U11) when she was a patient at Stafford Hospital in March and in June / July 2006. Her husband (Mr U11) joined her at the Inquiry.

Patient U11 had started to lose the use of her right leg and in March 2006 she was suffering constant back pain. The emergency doctor visited her and organised an emergency appointment at Stafford Hospital. When Patient U11 and her family arrived at Accident and Emergency (A&E), she waited for two hours before been seen. Mrs U11 said there were no staff available and that there was blood, used plasters and bandages on the floor.

Mrs U11 said that her mother was very uncomfortable so she asked if she could wait in a chair as opposed to on the bed. She was told she could not. Mrs U11 then asked if her mother could have a pillow for her back to ease the pain. She was informed that there were no pillows available.

Patient U11 was transferred to Ward 12. Mrs U11 reports that there were insufficient staff and that the information provided by staff was inconsistent. On the ward, her mother was given a commode without a potty in it. Mrs U11 said this made her mother very embarrassed.

Patient U11's medical records at the time of discharge state she had MRSA. Neither Mr U11 nor Mrs U11 was informed of this by the hospital.

In June 2006, Patient U11's leg had deteriorated and she was again admitted to Stafford Hospital.

Mr and Mrs U11 told the Inquiry that the staff on A&E were not polite. When Mr U11 offered to help move his mother in law into a chair, he was ignored. Instead, two members of staff grabbed her immobile leg and swung her into the chair. Mrs U11 said this made her mother cry out in pain.

Patient U11 was then moved to Ward 6. Mrs U11 was contacted by the hospital and asked to bring in her mother's morphine, as they did not have any available in the hospital. Mr and Mrs U11 also state that Patient U11 was not given her medication regularly and that she often had to request it.

On one occasion, Patient U11 rang for assistance, as she required the toilet. A nurse came and placed a Zimmer frame beside the bed and left. However, Patient U11 was immobile and therefore unable to use a frame. She consequently wet the bed, which Mrs U11 said upset her mother greatly and left her feeling dirty and degraded. Mrs U11 also told the Inquiry that the ward was dirty and that she and family members had to clean the sink and commode before her mother used them.

Thursday

Case 2 contd

Patient U11 was sent for an urgent scan on her back. The results took two weeks to arrive. Patient U11 was then informed she had cancer. Mrs U11 said that the hospital should have alerted the family so they could have been with their mother when she was given this news.

Patient U11 was due to be transferred to Stoke Hospital at midday. She was suffering extreme pain. Her family kept asking when the transfer would take place and were continually told they were busy. Patient U11 was finally transferred at 23:45 after waiting for more than ten hours.

Patient U11's son in law told the Inquiry that the longer his mother in law was on Ward 6 the worst she became. This was in stark comparison to the care she received at Stoke Hospital. Mr and Mrs U11 said their mother seemed to be a "different woman" there – sitting up in bed with clean-brushed hair and staff checking she was OK.

A complaint was made to Stafford Hospital. They did not receive a full response to their complaint until seven months later. The family met with the hospital. Mr and Mrs U11 do not feel that the hospital's handling of the complaint was satisfactory.

Thursday

Case 3

Mr V11 told the Inquiry about the treatment that his late wife (Patient V11) received during her stay at Stafford Hospital in January 2008. His son (Mr W11) joined him at the Inquiry.

Patient V11 had Alzheimers disease and developed a water infection. She was taken to Accident and Emergency (A&E) by ambulance (check date). She was left to wait for a considerable period of time at A&E. Mr V11's son, who is a paramedic, told Mr V11 that he should go home, as his mother would be kept in over night. At 3.30 am, the hospital called to say Patient V11 was being discharged and Mr W11 subsequently collected his mother. Mr V11 said that despite it being in the middle of a winter night, Patient V11 was discharged in just a nightdress and shawl. Mr V11 and his son had to carry Patient V11 into the house. They then discovered that she had been discharged with a cannula still in her arm. Mr W11 was able to remove it, as he is a paramedic. He told the Inquiry that if removed incorrectly there would have been a serious risk of infection and bleeding.

Patient V11 was re-admitted to Stafford Hospital in January 2008. She refused to have a scan. No one at the hospital discussed this with her family and Mr V11 told the Inquiry that because of his wife's Alzheimers she would not have known what was happening.

Patient V11 spent a period of time on Ward 7, which Mr V11 described as "horrendous".

Mr V11 told the Inquiry that there was a clear lack of staff and also spoke of his concerns about the nutrition on the ward. He found his wife's Fortisips bottle left out of her reach and said a cold meal was brought on a tray and left at the foot of his wife's bed that, due to her condition, she would not have known was there or have been able to reach.

Patient V11 could not move herself. One day when he visited, Mr X found his wife lying on her side and her arm with a drip in was under her hip. No one had thought to move her arm. Mr V11 said he could not imagine the pain she must have been in. When he asked for assistance, he was told someone would be there in a minute. He cannot recall how long it was before someone eventually came to help.

Mr V11 would also find his wife lying in soiled sheets and her catheter unemptied and overflowing. For two weeks, he took his wife's dirty laundry home to wash as no-one at the hospital had told him that there was a laundry service.

Thursday

Case 3 contd

The medical records state that Patient V11 was given a bed bath and had her hair brushed each day. Mr V11 does not believe this is correct. He told the Inquiry that other visitors had also commented on his wife's appearance and unbrushed hair.

Patient V11 was due to be transferred to Cannock Hospital. Mr V11 went to visit his wife and when he went to her bed he discovered it was occupied by someone else. Mr V11 spoke to a nurse. She wagged her finger at him and told him he knew his wife was being transferred. Mr V11 knew she was due to be transferred but no one had notified him that it had taken place. He then had to catch the bus back to Cannock and was very upset because he was only able to see his wife briefly at Cannock hospital because visiting hours had nearly finished by the time he arrived. After a brief period in Cannock Hospital Patient V11 was transferred to Marquis Court. At Marquis Court, a member of staff noticed that she had faeces left in her fingernails.

Mr V11 made a formal complaint to Stafford Hospital and had a meeting to discuss his concerns. The hospital organised for him to take an unannounced visit to the hospital. Mr V11 believes that the visit was orchestrated.