

Moderate harm

An elderly patient in hospital became dehydrated because nursing staff failed to monitor her fluid intake. As a result, she became confused and disorientated.

An elderly patient was admitted to a medical ward after being diagnosed with heart failure. A fluid balance chart was set up to monitor fluid intake and the nursing staff recorded each time the patient was given a drink. The ward became very busy and over the next few days the fluid chart was not kept up to date. The patient was not given enough drinks to maintain her hydration. She gradually became more confused and disorientated. Concerned relatives asked the nurse in charge why their mother was confused when she was perfectly lucid before admission to hospital.

The nurse acted immediately by investigating why the patient had become confused. She found the fluid balance chart had not been kept up to date and concluded that the patient's dehydration was causing her confused state. An intravenous infusion of normal saline was prescribed for the patient. The nurse in charge of her care made sure she was given regular drinks and that this was recorded on the fluid chart. The patient recovered from the confused state and the intravenous infusion was stopped the following day.

As soon as the dehydration and its cause were identified, the nurse in charge of the patient's care spoke to the patient and their relatives to explain what had happened. She apologised and explained how lack of fluid intake can cause confusion in older people quite rapidly. She assured the relatives and their mother that from now on adequate fluids would be given and showed them the fluid balance chart that would be filled in each time a drink was given. She asked them to inform staff so that they could update the chart if they gave their mother a drink during visiting.

The nurse explained that an action plan would be put in place to prevent this happening to other patients. The patient and her relatives accepted the explanation and the verbal apology and declined a written apology. Notes were made of the incident, how it was managed and the content of the discussion with the patient.

The nurse responsible for the patient's care informed the trust manager responsible for duty of candour arrangements, in line with the trust's duty of candour policy. The nurse and manager agreed that this was an adverse incident from which lessons must be learned. In line with the trust's policy, an action plan was drawn up and shared to prevent the incident happening again. The nurse also agreed to discuss the incident at her next appraisal.

Severe harm

The straps of a hoist were not properly secured when a patient was transferred from his bed to his wheelchair at home. He fell and sustained a fracture to his left hip resulting in a long stay in hospital.

The community nurse was visiting a disabled patient in the community to dress his leg ulcers. She found him in bed and he asked if she would help him into his wheelchair using the hoist provided by the local authority. The nurse was unfamiliar with the type of hoist he used but agreed to help him. She followed the patient's instructions on how to secure the straps of the hoist but during the move from bed to chair the patient fell out of the hoist and on to the floor. He was in severe pain and the nurse immediately called for an ambulance. The nurse kept the patient calm and as comfortable as possible until the ambulance arrived and the paramedics took over. During the wait for the ambulance the nurse apologised and continued to reassure and comfort him. The patient was admitted to hospital with a fractured left hip. He endured pain and discomfort and later developed a chest infection due to lack of mobility which led to an extended stay in hospital.

When the patient was safely in the care of others the nurse immediately reported the incident to her line manager in line with the organisation's policy for reporting adverse incidents. She then made notes of the incident and followed the trust's clinical governance policy for reporting patient safety incidents. The trust manager responsible for duty of candour agreed with the community nurse that she should take responsibility for visiting the patient in hospital to apologise, explain what went wrong and offer a written apology.

The nurse visited the patient the following day in a place and at a time when he was best able to understand and retain information. She explained how she must have made a mistake when strapping him into the harness which caused him to fall. She apologised again and offered to provide an explanation and apology in writing. The patient accepted this offer and a letter was sent in line with trust policy. The incident was also reported to the UK-wide Medicines and Healthcare Products Regulatory Agency reporting system for adverse incidents involving medical devices. The manager and community nurse agreed this was a notifiable patient safety incident and that their discussions met the professional duty of candour obligations.

The community nurse's manager reminded her about the duty to preserve patient and public safety and to work within the limits of her competence as stated in The Code: Professional standards of practice and behaviour for nurses and midwives (NMC, 2015).

Severe harm

An inpatient was prescribed digoxin and a nurse did not follow procedure and administered the drug without taking the patient's pulse. The patient went into complete heart block and required emergency intervention.

A 67-year-old patient was admitted to a medical ward with atrial fibrillation and was prescribed digoxin. During a busy medicine round a newly qualified nurse decided he did not have time to take the patient's pulse in line with procedure and administered the medication. The patient had a pulse well below the recommended 60 at the time and complete heart block took place needing emergency intervention. The patient was stabilised and recovered.

The nurse acted in line with his duty of candour and admitted that he had not taken the patient's pulse due to time pressures and workload. He reported the incident to his manager. The manager was supportive towards the nurse, indirectly encouraging others to be honest when mistakes are made and fostering a culture of learning and improvement. Together they wrote a report and the incident was reported in line with the local clinical governance policy.

The nurse felt unable to face the patient to apologise for his mistake and the harm caused so the nurse in charge of the ward agreed to make the apology and explain to the patient what had happened. The newly qualified nurse was sent on the next available duty of candour study day to learn and develop the skills required. He also agreed to reflect on his learning and include the incident for discussion at his next appraisal.

When the patient had recovered the nurse in charge explained to her what had happened and why. She apologised verbally and asked if the patient would like an apology and explanation in writing. The patient declined the offer. The nurse in charge explained that there would be an investigation and the nurse would have further training to make sure he did not omit taking a pulse before giving digoxin in the future. The content of the discussion with the patient, the acceptance of the verbal apology and the patient's decline at the offer of a written apology were all added to the incident report. An action plan was put together to prevent the circumstances which led to the newly qualified nurse feeling under pressure when administering a drug arising again. The plan was shared in line with trust policy.

The newly qualified nurse, the nurse in charge and the trust manager responsible for duty of candour arrangements agreed that it was a notifiable patient safety incident and that their discussions and actions met the professional duty of candour obligations.

Moderate harm

A young adult with a learning disability became distressed when she was not informed that her usual nurse would be replaced by someone she had not met before. This resulted in her self-harming and being treated in hospital for superficial cuts to her forearms.

A young adult with a learning disability who lives in supported accommodation was expecting a visit from her usual key worker. The key worker, who was a learning disabilities nurse, had forgotten to inform his client that he would be on annual leave and someone different would visit instead. In addition, due to an overlap of annual leave he did not have time to explain the nature of the client's behaviour to the replacement nurse and had not recorded in the notes that certain rituals needed to be observed to prevent the client from becoming anxious and leading to possible self-harm. As a result the client became very distressed when the replacement nurse visited and the nurse had difficulty in calming her down. Eventually the client appeared calm and the nurse left. Later on, the client could not cope with the distress caused and cut her forearms with a razor. She called her parents and they took her to hospital where she was treated for superficial cuts to her forearms and sent home in the care of her parents.

When the usual key worker returned from annual leave, he visited the client at her parents' home and apologised for not making proper provision for her in his absence. He explained that he should have given the replacement nurse a full report about the client and that her needs should have been more clearly written in her clinical notes kept at the supported accommodation. He apologised again and asked if they would like a written apology and the parents said that they would. He promised to arrange this as soon as possible. He explained that there would be an investigation and an action plan would be developed to prevent anything like this happening again.

The replacement nurse wrote a report documenting the details of his visit. The usual key worker added an account of his meeting with the parents and the client. This included details of his apology and explanation and that he had agreed to send a written apology and explanation.

The incident was reported in line with the organisation's policy for reporting adverse incidents. The nurse manager and the trust manager responsible for duty of candour arrangements agreed that it was a notifiable patient safety incident and that their discussions and actions met the professional duty of candour obligations.

Near miss

A child admitted to hospital for a routine operation was known to suffer from attention deficit hyperactivity disorder (ADHD). He was put in a four-bedded ward next to a young girl who had had an operation earlier that day. A nurse entered the ward just as he was about to pull out the young girl's nasogastric tube.

A child known to have been diagnosed with ADHD was admitted to a paediatric ward for routine surgery. He was put in a four-bedded ward next to a child who had surgery earlier that day. The nurse who admitted the child left the ward mistakenly believing the parents would stay with their son. The parents, believing their child to be in the care of the nurses, decided to go and have a cup of tea in the canteen but did not tell anyone they were leaving.

The child began to play in the ward, jumping on and off the bed. He suddenly spotted the nasogastric tube in the nose of the post-operative child next to him and in an impulse leapt towards her to pull it out. The nurse entered the ward just in time to stop him and an adverse incident was narrowly avoided. The nurse returned the child to his bed and asked a healthcare support worker to sit with him until his parents returned. The post-operative child was unaffected by the incident.

The nurse immediately reported the incident to the ward manager. They discussed the circumstances and agreed it was a near miss incident that could have led to harm. They reported it in line with their organisation's policy for reporting near misses. They then decided that both children's parents should be informed of the incident and should receive an apology and explanation of what happened. The nurse who prevented the harm wrote a report and an action plan was drawn up to prevent a similar incident happening again. As no harm came to either child both sets of parents were satisfied with the explanation and apology and did not wish to receive anything further in writing.

The nurse manager and the trust manager responsible for duty of candour arrangements agreed that their discussions and actions met the professional duty of candour obligations.

Prolonged psychological harm

A 75-year-old resident in a nursing home complained to a nurse on night duty that she had been assaulted by one of the male staff during the day. The nurse judged the accusation to be a symptom of the resident's dementia and did not report it.

A 75-year-old woman with a diagnosis of dementia is cared for in a nursing home. She complained to a nurse on night duty that a male member of staff had assaulted her during the day. The nurse judged the accusation to be a symptom of her confusion and told her she would make sure it didn't happen again. The nurse did not mention the accusation or report it to anyone. Over the next few days the woman was assaulted on three more occasions by the same member of staff. In a very distressed state she eventually told a second nurse that she thought the first nurse would make sure that it didn't happen again.

The second nurse reassured the woman and apologised to her. She said she would report it immediately and it would be investigated promptly and fully. She reported it to the home manager immediately and the appropriate authorities were informed. The woman remained agitated and the home manager contacted her relatives to ask them to come to a meeting at the home. She met with the woman and her relatives. She apologised that the complaint had not been dealt with immediately and that the woman had endured further distress. She explained the investigation and how it would proceed. She asked if they would like a written apology and the relatives said they would so she promised to provide this as soon as possible. The meeting with the resident and her relatives was documented immediately, with a full account of the discussions, the verbal apology and the promised written apology.

The nurse who had decided not to report the initial complaint apologised to the woman in line with her duty of candour. She recognised that she was in breach of her professional code and had failed to preserve the patient's safety. She agreed to reflect on the incident and discuss it at her next appraisal. She understood that during the investigation she would have to account for her failure to exercise her professional duty to protect the patient's safety.

The nurses and the home manager all agreed that their discussions met the professional duty of candour obligations.

Moderate harm

A seven-year-old boy developed an infection whilst in hospital for a routine operation.

While the child was being prepared for the operation, the nurse realised that he was becoming increasingly agitated and restless. She checked his vital signs and noted that his temperature was slightly raised so continued to monitor him closely. Over the next two hours he became more restless and agitated. His temperature continued to rise and he developed a chesty cough.

The nurse called for the duty doctor to check on the child for a second opinion. The doctor confirmed that the child was suffering from a chest infection and would not be fit to have surgery. The doctor prescribed penicillin to be given immediately. The anaesthetist asked for the child to be sent home and readmitted once the infection had cleared.

The nurse administered the first dose of penicillin and the child quickly developed a rash and felt unwell. The parents then told the nurse that their child had an allergic reaction to penicillin when he was younger and this should have been recorded in his medical notes. The nurse checked the notes and found out that an allergy had been recorded. She immediately told the prescribing doctor. The penicillin was stopped and a different treatment was prescribed. The child recovered and went home the following day.

The nurse explained to the parents that she and the doctor had not read the notes fully and were unaware that their son was allergic to penicillin. She apologised to the parents and said it should not have happened. She explained that the child had fully recovered and would not suffer any long-term harm. She apologised again for the error and said the prescribing doctor would discuss it with them later.

The doctor apologised to the parents and said that he should have read the notes fully before prescribing the penicillin to their son. He reassured them that there would be no long-term effects and that the rash would soon clear up. He explained that the incident would be reported in line with trust policy and that steps would be taken to prevent it happening again. He offered a written apology but the parents declined this and accepted a verbal apology. Notes were made of the incident, how it was managed and the discussion with the parents, including that they had declined a written apology.

The duty doctor reported the incident to the consultant who would be carrying out the child's operation. The consultant discussed the incident with the trust manager responsible for duty of candour. All nurses and doctors in the trust were reminded to read a patient's notes before prescribing medication and to ask if the patient is allergic to any medicine during the admission procedure. They both agreed to discuss the incident at their next appraisal meeting.

Severe harm leading to death

An 86-year-old woman was discharged home from a rehabilitation unit having been diagnosed as suffering from a chest infection. She was found dead at home three days later. After an autopsy the cause of death was confirmed as a pulmonary embolism (PE).

An 86 year-old-woman was coming to the end of her stay in a rehabilitation ward. The nurse responsible for the patient's discharge planning noticed that one of her legs looked more red and swollen than usual and that she had developed a chesty cough and appeared slightly breathless. He called the duty doctor who examined the woman and diagnosed a chest infection. The doctor prescribed an antibiotic and asked that the community nurses visit the patient within a couple of days of discharge to check on her condition. The patient was discharged home the following day, and it was agreed that a community nurse would visit her within the next couple of days to see how she was getting on.

Unfortunately, due to a high workload, the community nurse was unable to visit her until three days after discharge. When she visited she found the woman dead in her armchair. She called the GP who certified the cause of death as having been brought on by a severe chest infection. However, a later autopsy found the actual cause of death was a PE caused by undiagnosed deep vein thrombosis (DVT). The autopsy found that the woman had been dead for around 24 hours.

In line with policy, the GP notified the person responsible for clinical risk in the clinical commissioning group. The clinical risk manager contacted the hospital. The hospital manager organised a meeting with the woman's daughters to explain how their mother died. The consultant in charge of the woman's care, the ward nurse manager and the managers for duty of candour and clinical risk in both organisations met with the relatives. They explained the cause of death and how the nurse and duty doctor had missed the presence of a DVT. They said that their mother's condition was stable when she was discharged and that the community nurse had planned to visit the following day but was delayed due to workload.

The consultant, nurse and community manager apologised to the relatives. They explained that the hospital would carry out a full clinical review to learn lessons from the incident. They said that they will inform the relatives about the review's outcome and whether the cause of death was due to the missed DVT diagnosis or their mother's underlying condition.

The consultant apologised again for the apparent lack of a full diagnosis of the mother's underlying condition, the nurse manager apologised for the nurse not assessing the swollen and sore legs as a possible sign of DVT and the community manager apologised for the delay in visiting their mother. The relatives requested these apologies in writing and the hospital manager agreed to arrange this quickly. The hospital manager then made notes recording the meeting with the relatives, including the verbal apologies given and that these would be followed up in writing. Despite the apologies and explanations they had received, the relatives decided to make a formal complaint to the trust. The complaint was investigated and the trust issued another formal apology to the relatives, with steps it would take to prevent a similar situation from arising again.

Moderate harm

A mother had a successful home birth but required a hospital transfer due to a retained placenta and a near miss postpartum haemorrhage.

A 26-year-old, low-risk, first-time mother delivered a healthy son at her planned home birth, with two midwives in attendance. The client preferred to deliver the placenta without outside assistance or drugs (a physiological third stage). The midwives followed correct procedure but there were no signs of separation of the placenta from the uterus. The midwives recognised this as a case of a possible retained placenta.

The midwives discussed the situation with the mother, explaining that one of the dangers of a retained placenta is postpartum haemorrhage (PPH). To avoid this, they explained, the mother would need to be transferred to the local hospital to receive the necessary medical assistance. The mother was upset that her home birth had not gone to plan, but understood the reasons as she remembered that the risk of a retained placenta was mentioned in her antenatal appointments. The mother consented to the planned action, as she felt that it had been explained clearly and was for the best if the risk of a PPH was to be avoided.

The midwives followed the protocol for commencing an 'active third stage approach' to remove the placenta. However, they did not call to arrange a transfer to the hospital, as they were busy focusing on the clinical procedures. The second midwife noticed the mother's blood loss was increasing slowly and she explained to the mother that the risk of a PPH was now high. The midwives arranged a transfer to the hospital and apologised that they did not do this earlier.

Fortunately the mother was transferred to the hospital in time and major PPH was avoided. However, the mother still had to undergo a manual removal of placenta in theatre, which in itself prolonged her stay in hospital. As the midwives identified this as a near miss situation, which had the potential to cause harm, they shared information with their supervisor of midwives (SOM) and their team manager. They also kept to the trust's guidelines on reporting concerns by completing an incident form.

A subsequent meeting was arranged with the mother and her partner to offer a formal apology and allow the mother to ask questions. The mother was content with a verbal apology. The apology was documented in the mother's clinical notes. The team agreed that the discussion with the mother and her partner met the trust's duty of candour policy.

Moderate harm

A mother's blood loss during birth was underestimated, leading to complications that required a transfer to hospital for a blood transfusion.

A 28-year-old mother had a planned home birth of her second child attended by two midwives. The birth appeared to proceed without any problems. She delivered the placenta naturally. She was told by the midwives that her perineum was intact and that there was no evidence of other tears or lacerations.

The midwives estimated her overall blood loss during birth as 200ml, although they explained this was hard to measure exactly as there was also a considerable amount of liquor. Whilst breastfeeding her baby, the mother got up to use the toilet but felt faint and collapsed. She recovered shortly after and reported that she felt quite dizzy. The midwives correctly made a set of observations and carried out a blood glucose level measurement, which appeared normal. After an hour the mother tried to get up to use the toilet again, but once again felt faint and collapsed. The midwives decided to transfer the mother to the hospital for an obstetric review, which the mother consented to.

In the hospital, the midwives continued their care for the mother and baby and worked with the obstetric team. They took a blood sample in order that a full blood count analysis could be carried out. The mother's post-delivery haemoglobin was found to be 7.2g/dl compared to 12.1g/dl pre-delivery. As a result the mother had three units of blood transfused. The midwives recognised that they were likely to have underestimated the mother's blood loss during birth and immediately informed the registrar on duty.

The registrar and midwives were honest with the mother that something may have gone wrong with her care. They explained to her that her drop in haemoglobin could be due to the amount of blood lost during the delivery which could not be avoided, but that they may have underestimated her blood loss.

They apologised to the woman and her family and explained that a solution was to have blood transfused, which may prolong her stay in hospital. They offered a written apology, as they understood that this episode may have been upsetting for the mother. The mother was happy with their explanation and did not think that a written apology was necessary.

The midwives recorded this discussion in the mother's notes and completed an incident form in line with local guidelines. They also informed their team manager and supervisor of midwives, who decided to hold a team meeting to look at how a similar situation could be avoided in the future. They agreed that the discussion with the woman and her family met their duty of candour.

The team came to the conclusion that further training would be needed in the area for estimating blood loss and this should be included in future staff training days.

Prolonged psychological harm

A mother's history of neonatal death was not taken into account so the symptoms of postnatal depression were missed.

A 34-year-old mother whose baby died two years ago had a spontaneous vaginal delivery of a healthy male infant. The next day she was transferred to the postnatal ward and awaited discharge to return home with her new baby.

The midwives were aware of her history, but felt that despite her previous issues the mother was coping reasonably well. The client, however, felt very anxious about the baby's wellbeing, as she did not want history to repeat itself. Several times she told the midwives her concerns about the baby's feeding patterns. She said that she had not been able to sleep as she was so worried about her baby. The midwives reassured her and advised her to try to sleep when she returned home. The client's partner also raised this as an issue before they went home, but they were asked to update the community midwife on progress when she visited them the next day.

The community midwife visited the family on a number of occasions, but due to her workload she always looked hurried to finish her visit. The midwife saw that the mother looked tired and tearful. She noticed that she regularly voiced concerns about her baby's health. She merely reassured the mother that everything was fine and that such concerns were normal after having a baby. The client was particularly worried about how the breastfeeding was going, but the midwife reassured her that the breastfeeding was going well as her baby was putting on weight. The client also informed the midwife that she had trouble sleeping at night and did not have much of an appetite anymore, making her feel in a very low mood. The midwife passed this off as regular 'baby blues', without questioning the client more closely. The midwife finished her visits to the client and transferred her care to the health visitor.

On the first visit, the health visitor noticed that the client was showing the symptoms of postnatal depression and that delays in her care had made this worse. The health visitor apologised for the care the mother had received so far and made a detailed note of events including her discussion with the mother. She explained to the family that she would arrange for the perinatal mental health nurse to make an emergency visit to them.

The health visitor also told the manager of the clinic. They arranged a second meeting with the family and reiterated their apology that the mother's postnatal depression had not been diagnosed sooner. After a discussion, the client and her partner accepted the verbal apology and felt that a written apology was not necessary.

The health visitor summarised their meeting in a letter explaining what had happened and what would be done to prevent a similar situation happening in the future. She communicated this to the clinic manager and a final note was made in the client's file.

Misdiagnosis

Despite an expectant mother's concerns, her uterine rupture was not identified by the team. This led to an emergency caesarean.

A 35-year-old expectant mother who had delivered a previous child by caesarean section five years before was admitted to the delivery suite. She had been experiencing contraction pains for over two hours and was in established labour. She planned to have a vaginal birth and requested an epidural. The delivery suite was very busy, due to this no one from the obstetrics team was available to review the mother or provide an epidural there and then. The only midwife available to provide one-to-one care had just finished her preceptorship training.

During a routine abdominal palpation, the midwife did not identify that the expectant mother had scar tenderness. The expectant mother explained to the midwife that her lower abdomen was tender to touch and she did not remember this having been the case when she gave birth before. The midwife reassured her that it was normal to feel such intense contractions and that she would feel better after the epidural.

Once the epidural was administered the expectant mother's scar tenderness disappeared. She told the midwife and obstetric team that she had felt scar tenderness earlier, but was again reassured. After a couple of hours the midwife noticed abnormal features on the continuous cardiotocograph trace. She found that the liquor contained fresh blood. The midwife explained to the parents that there appeared to be a complication that needed the obstetric team's urgent attention.

Preparations were made for an emergency caesarean. The outcome of the caesarean for both mother and baby was good in that the mother delivered a healthy baby. Following successful delivery, the root cause of the problem was found to be an undiagnosed uterine rupture, which women having a vaginal birth after caesarean are at a higher risk of. The obstetrician apologised to the expectant mother for not detecting this earlier. The midwife recognised that she had not identified this possible cause of complication earlier and also apologised to the parents.

The parents received a verbal apology from the lead professionals and a meeting was arranged with the parents and the team. The mother expressed frustration that she had not been listened to. However, she was impressed with how the team worked together to correct this. The delivery suite coordinator said it was possible that the midwife had not been given enough support as she had only very recently finished her preceptorship. She explained to the mother that the unit would review its support for new midwives. The obstetricians also apologised that they had not had time to review the mother before the epidural, as this may have made the scar tenderness clearer.

After the meeting, the mother felt that a written apology was not necessary. The outcome of the meeting was documented and a formal letter sent to the parents.

Severe harm

A woman in labour had a pathological cardiotocograph (CTG) which was not escalated and resulted in a stillbirth.

A 32-year-old first-time expectant mother was in labour. She was receiving an intravenous infusion (IVI) of syntocinon. She had also received an epidural and a cardiotocograph (CTG) was in progress. The CTG started to show signs of atypical variable decelerations that the midwife mistook for normal. This lasted for more than 90 minutes and advanced to late decelerations. During this time the midwife increased the syntocinon.

After a shift change, a new midwife immediately identified the abnormal features on the CTG. She explained fully and promptly to the parents that this 'pathological trace' was a cause for concern and that it was necessary to stop the IVI syntocinon. She escalated her concerns to the duty obstetricians and her coordinator.

The team worked together to transfer the expectant mother to theatre for an emergency caesarean. The anaesthetist explained the situation to the parents. The expectant mother initially requested continued epidural analgesia, as she preferred not to be under general anaesthetic (GA). However, after the anaesthetist explained that this may not be possible as potentially a GA is the most appropriate way to offer a rapid caesarean, she consented to a GA.

The emergency caesarean took place and the outcome was a stillbirth. Both midwives and the supervisor of midwives, as well as the obstetric team, approached the parents to offer their condolences and an apology as soon as possible. They explained that a full investigation would take place. The team was open and honest with the parents, informing them that although the facts were not yet established they would answer any questions they had to the best of their knowledge. This was documented in the notes and an incident report was also completed.

The trust manager responsible for duty of candour held a multi-disciplinary team meeting with the parents present. This helped the parents to understand in more detail what went wrong. A bereavement care pathway was set up to help deal with the harm caused. The parents accepted a verbal and formal written apology, including an apology from the first midwife responsible for their care. The team reassured them that steps would be taken to prevent such an incident happening again. This would include intensive CTG training for all staff.

Separately it was also agreed with the midwife that she would discuss her training and supervision needs with her supervisor at her next appraisal meeting.

Although the parents had been considering a litigation claim against the trust at first, they now felt the trust's response was adequate. However, they still wished to make a formal complaint. This discussion was documented and information was provided to the parents to enable them to make a complaint.