Order	Time period	Situation	Where	Themes	Themes subgroup 1	Themes subgroup 2
1	GRO-C 1988	In Labour with first child for 36 hours with little care from Midwives on duty.	Bellshill Maternity Hospital	Treatment	Treatment & care of patient	Care of treatment during stay
2	GRO-C 1988	Post emergency C/S - ED taken to a high dependency unit and given three units of blood. No advice given about the potential risks of receiving blood.	Bellshill Maternity Hospital	Treatment	Treatment & care of patient	Did not involve patient in decisions about care
3	GRO-C 1988	ED wakened during the night and told that she was being removed from the hospital because she was a risk to mothers and babies. Transferred from Bellshill maternity to Isolation room in Infectious Diseases Unit in Monklands Hospital. No information provided on why ED was moved to another location or where she was going. Done in middle of night. Husband not told that ED had been moved.	Bellshill Maternity Hospital	Communication	Incomplete information	Lack of communication
4	GRO-C 1988	Given anti-sickness drugs and left in ward. Staff in ward did not explain what was wrong. Doctors and Nurses were deliberately evasive and did not tell ED what infection was - told had an infection and could not be near other mothers or babies.	Infectious Diseases unit - Monklands Hospital	Communication	Inadequate listening & response	Failure to answer questions, unresponsive, would not talk
5	GRO-C 1988	Kept in isolation for first week of motherhood and separated from baby son who was attended to by the Nursing Staff in the Infectious Diseases unit. Nursing staff made comments about “what fun they were having, having a baby to look after”.	Infectious Diseases unit - Monklands Hospital	Quality of interaction	Unprofessional conduct	Insensitivity / no concern for patient as a person
6	GRO-C 1988	A diagnosis was not communicated on discharge from the Infectious Diseases unit. Condescending attitude from clinical staff when ED asked why she had been sick. “Ushered out” of hospital without any explanation.	Infectious Diseases unit - Monklands Hospital	Quality of interaction	Quality of information Disrespect	Inadequate explanation No diagnosis provided Staff spoke in a condescending manner

Order	Time period	Situation	Where	Themes	Themes subgroup 1	Themes subgroup 2
7	From Apr / May 1988	Attended GP with fatigue and pain. No clear diagnosis was determined, GP said possible ME.	Orchard Medical Practice	Treatment	Assessment, tests and diagnosis	Misdiagnosis No tests / improper tests
8	May 1988	Admitted to Hairmyres Hospital as emergency with haemorrhage - retained post-partum after caesarean section causing infection and subsequent haemorrhage. Post-partum removed without a general anaesthetic, 2 more units of blood given. Not given any advice / warned about the potential risks of receiving blood transfusions.	Hairmyres Hospital	Red flags Treatment	 Treatment & care of patient	Medical error / adverse outcome Did not involve patient in decisions about care
9	Feb 1989	Barium meal test at Monklands Hospital as OP. Results identified irregularity in oesophagus requiring further investigation. Asked to return same day for biopsy on hepatic portal vein through endoscope. Hepatic Portal vein punctured (not noticed and sent home) resulting in haemorrhage and emergency admission to Monklands <24h.	Monklands Hospital	Red flags		Medical error / adverse outcome
10	Feb 1989	Emergency surgery on liver and received between 16 & 30 units of blood. Not given any advice / warned about the potential risks of receiving blood transfusions.	Monklands Hospital	Treatment	Treatment & care of patient	Did not involve patient in decisions about care
11	1989	GP giving a mix of morphine and pethidine while at home for severe pain relief	Orchard Medical Practice	Red flag		Medication safety
12	1989 - 1993	Had to attend Monklands, Hairmyres & Bellshill every three months to have blood samples taken and other investigative tests. Monitored by 3 separate hospitals in NHSL, all taking blood samples routinely. ED questioned why this couldn't be done at one place and dismissed "weren't willing". Concerned that tests may have been for research purposes / that doctors were preventing treatment and using ED as a case study.	NHSL	Institutional processes Communication	 Inadequate listening & response	Problems with bureaucracy and accessing care Patient dismissed
13	Feb 1992	GP referred to Gastroenterology Specialist Monklands Hospital for high levels of pain, restricted diet & chronic fatigue. Decision taken by Specialist to remove gallbladder. Emergency readmission post-surgery	Monklands Hospital	Red flags		Medical error / adverse outcome

Order	Time period	Situation	Where	Themes	Themes subgroup 1	Themes subgroup 2
		with acute pancreatitis caused by debris that had not been drained away properly after gallbladder surgery.				
14	Nov 1993-Sept 2000	Under Care of GG&C	GG&C			
15	Sept 2000	Transferred to NHSL care at Strathclyde Hospital for monitoring (bloods every 3 months). Approach by consultant was generally about monitoring the pain and fatigue. Not offered any treatment for Hepatitis C infection	Strathclyde Hospital	Treatment	Treatment & care of patient	Inadequate treatment
16	2005	Advised to apply for Skipton fund as had got Hepatitis C Virus from contaminated blood during blood transfusions. First time a medical member of staff admitted the role of the NHS in relation to infected blood.	Strathclyde Hospital	Communication	Incomplete information	No information / denied information / lack of communication
17	Jan 2007 – Jul 2008	Health deteriorated drastically - prognosis poor. Repeated jaundice / blockages in bile ducts / jaundice / infection. Admitted as an emergency on 5 occasions during January and February 2007. 3 x failed attempts to insert temporary stents in bile duct between August 2007 and July 2008. Each time a blockage occurred ED was placed on a waiting list with no medical supervision.	?Wishaw General	Treatment	Treatment & care of patient	Delay in treatment Unsuccessful treatment
18	Sept 2008	Becoming much more unwell. Concerned that no proactive treatment plan, no management, everything dealt with on an emergency basis. Too often being sent home unable to eat with serious infection and no one monitoring it or looking for danger signs. Not under a Liver Specialist.	? Wishaw General	Treatment	Treatment & care of patient	Lack of ongoing care and support / continuity of care Unable to access specialist care
19	Oct 2008	GP referred to liver unit in Edinburgh Royal Infirmary. Specialist in Edinburgh requested notes from Wishaw General - only able to provide a general summary through telephone conversation. Specialist had no access to previous medical notes.	Wishaw General	Institutional processes	Documentation	Patient notes unavailable

Order	Time period	Situation	Where	Themes	Themes subgroup 1	Themes subgroup 2
20	2018	Admitted to Wishaw General as emergency, no previous medical records available for NHSL. Consultant Surgeons dismissed ED's account of medical history.	Wishaw General	Quality of interaction	Insensitivity, patient not taken seriously	Patient not taken seriously
21	Date unknown	Attended the pain clinic in Wishaw General - situated next to Mortuary which didn't feel appropriate. Did not offer practical solutions or support. Person in charge asked ED to run the meeting.	Wishaw General	Treatment	Treatment & care of patient	Inadequate or incompetent management Lack of ongoing care and support