Parliamentary and Health Service Ombudsman

Report on selected summaries of investigations by the Parliamentary and Health Service Ombudsman

October to November 2014

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and Health Service
Ombudsman

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Contents

Introduction

The Parliamentary and Health Service Ombudsman investigates complaints about government departments and other public organisations and the NHS in England. This report is the fourth in a series of regular digests of summaries of our investigations. The short, anonymised stories it contains illustrate the profound impact that failures in public services can have on the lives of individuals and their families. The summaries provide examples of the kind of complaints we handle and we hope they will give users of public services confidence that complaining can make a difference.

Most of the summaries we are publishing are cases we have upheld or partly upheld. These are the cases which provide clear and valuable lessons for public services by showing what needs changing so that similar mistakes can be avoided in future. They include complaints about failures to spot serious illnesses and mistakes by government departments that caused financial hardship.

These case summaries will also be published on our website, where members of the public and service providers will be able to search them by keyword, organisation and location.

We will continue to work with consumer groups, public regulators and Parliament to use learning from cases like these to help others make a real difference in public sector complaint handling and to improve services.

March 2015

Parliamentary cases

Summary 456/October 2014

Poor complaint handling by organisation working for Jobcentre Plus

Mr V complained that A4e, a company which was working for Jobcentre Plus to support people into work, did not fully address his complaints. He considered its payment of £25, which was the result of the Independent Case Examiner's (ICE) investigation of his complaint, did not put things right.

What happened

ICE investigated Mr V's complaint that A4e did not give him tailored support and did not take timely and appropriate action to investigate his complaint about members of staff. ICE upheld Mr V's complaint and recommended that A4e apologise to Mr V and pay him £25. Mr V considered this did not remedy his complaint.

What we found

We partly upheld Mr V's complaint. We did not uphold his complaint about ICE because ICE had conducted a reasonable investigation and had identified A4e's failings in how it handled Mr V's case and his complaints. ICE had correctly noted that A4e did not tell Mr V about the outcome of its investigation into his complaints about members of staff and did not tell him about the next stage of the complaints process.

Although we did not uphold Mr V's complaint about ICE, we recognised that A4e's actions caused Mr V some distress and frustration. While we were not critical of ICE's investigation, because we recognised that two parties may reach different conclusions based on the same facts, we considered the £25 Mr V had received did not recognise the level of injustice he had suffered. We therefore upheld his complaint about A4e.

Putting it right

A4e paid Mr V a further £225 in recognition of the effect of its failings on him.

Organisations we investigated

Jobcentre Plus

Independent Case Examiner (ICE)

Summary 457/October 2014

Asylum seeker waited 15 months for a decision on his application from UK Visas & Immigration

Mr K complained about UK Visas & Immigration's (UKVI) delay in deciding his application. He said that the delay caused him frustration, stress and anxiety.

What happened

Mr K came to the UK in 2005 and claimed asylum. The immigration organisation at the time rejected his claim and he subsequently absconded and did not report to an immigration office.

Mr K came to the attention of UKVI in 2010 when he presented a counterfeit passport to his employer. He then absconded again. UKVI subsequently contacted Mr K, but instead of working on his case, it put his file in storage, contrary to guidance. It also wrongly told his MP that he had made a further application. Mr K applied to stay in the UK again in summer 2012. About seven months later, he started receiving asylum support, which should have led to UKVI prioritising his case. But UKVI again put his case into storage and did not look at it for another seven months. It refused his further request in winter 2013. Mr K has since applied again to stay in the UK.

What we found

We partly upheld this complaint. When Mr K came to the attention of UKVI in 2010, he had not made any application to stay in the UK. Under its policy, UKVI should have decided whether to remove Mr K from the UK or grant him leave to stay by summer 2011. Instead, it put his file into storage and did not retrieve it until spring 2012 when Mr K's MP got in touch. And it was not until summer 2012 that it found that it had given the MP wrong information. However, we found it likely that if UKVI had reached a decision in 2011, it would have decided that it was appropriate to remove Mr K from the UK.

As Mr K was receiving asylum support from spring 2013, after applying to stay in the UK, UKVI should have prioritised his case. However, it did not give it priority, and extended his asylum support instead of reaching a decision on his case. Mr K had to wait longer than he should have for a decision. However, UKVI refused his application in winter 2013 and there is no reason to think that Mr K would have had a different outcome if UKVI had decided earlier. Mr K therefore benefited from the delay by being able to remain in the UK during this time, and so he did not suffer an injustice.

Organisation we investigated

UK Visas & Immigration (UKVI)

Summary 458/October 2014

Legal Aid Agency failed to handle solicitor's submissions appropriately

Mr A complained about the Legal Aid Agency's handling of claim forms needed for payment of Legal Aid services that he submitted in 2006 and 2010, and the Legal Aid Agency's complaint handling. As a result, he said, he had not been paid money he was owed, and this affected him personally.

What happened

Mr A owned a solicitors' partnership at which he employed a number of solicitors. Four solicitors left the partnership, taking their files with them. Mr A entered into a long correspondence with the solicitors to reclaim the files. He told the Legal Aid Agency about the difficulties and explained why his submission of claim forms would be delayed. There was then a fire at the partnership's premises and some files were destroyed. Mr A also told the Legal Aid Agency about this.

When Mr A submitted the forms, the Legal Aid Agency took a long time to assess them. Communication between the Legal Aid Agency and Mr A became difficult. Mr A complained to an independent complaints assessor, who agreed with the Legal Aid Agency's stance. Mr A came to us.

What we found

We partly upheld this complaint. We found that the Legal Aid Agency had failed Mr A in several areas.

The length of time the Legal Aid Agency took to handle Mr A's submission was so protracted that it was a failing. Its communication with Mr A was not always appropriate or fair, and it did not treat him with respect. Its actions were not free from personal bias.

However, we also found that the Legal Aid Agency's complaints procedure in terms of Legal Aid practitioners was reasonable and in line with what we would expect.

Putting it right

We made three recommendations to remedy the injustice to Mr A. We said that within, 28 days of the date of our final report, the chief executive of the Legal Aid Agency should write to Mr A to apologise for the injustice we found, the Legal Aid Agency should pay Mr A £5,000 to recognise the injustice, and within six weeks, it should arrange for another independent complaints assessor to examine whether Mr A had a good case for not submitting his claim forms within the set period.

The Legal Aid Agency agreed to our recommendations.

Organisation we investigated

Legal Aid Agency

Summary 459/October 2014

Not enough adjustments for a man to use work programme

Mr P complained to the Independent Case Examiner (ICE) when Maximus, a work programme provider, delayed making adjustments to help him use its service.

What happened

Mr P had a place on a work programme run by Maximus, a company contracted by Jobcentre Plus. As he had dyslexia and a visual impairment, Maximus needed to make adjustments, including printing letters and documents on different coloured paper. There was a delay in it making these adjustments.

ICE found that Mr P's complaint was justified, but that Maximus had already adequately resolved the problem by apologising and putting adjustments in place. ICE did not uphold the other complaints Mr P had made about Maximus's service.

Mr P was unhappy and came to us.

What we found

We partly upheld the complaint. ICE had carried out an adequate investigation of Mr P's complaint and had reached a fair decision.

However, there was one issue that ICE had not considered. This was that Maximus did not always follow one of the adjustments it had agreed. This was a serious failing that caused Mr P inconvenience and frustration.

Putting it right

Maximus apologised to Mr P for not always carrying out its agreed adjustment.

Organisations we investigated

Jobcentre Plus

Independent Case Examiner (ICE)

Summary 460/October 2014

Prison staff lost man's legal papers

The prison lost Mr L's personal legal papers. It then did not search for the papers properly, so Mr L's complaint could not be resolved.

What happened

In summer 2011, prison staff took legal papers from Mr L's cell because they thought the amount of paper he had was a fire risk. A prison officer told Mr L that a bag with some of his papers had split, so staff had put some papers in a new bag, which was given a new seal number. The officer gave Mr L the new number on a post-it note. When Mr L tried to get the papers, the prison could not find the bag.

Mr L mentioned the lost documents to the Prisons and Probation Ombudsman (PPO) when he complained to it about another issue concerning his legal papers. The PPO did not uphold that complaint.

When Mr L complained to the prison, it suggested he speak to the officer who had told him the bag had split and who had given him the details of the new seal number for the bag the documents had been transferred to. Mr L spoke to the officer, but the bag with the documents could not be found.

Mr L then wrote to the PPO about its decision on his other complaint and said that officers at the prison had deliberately lost some of his legal documents.

What we found

We partly upheld this complaint. Mr L did not expressly put his complaint about the bags containing his legal documents going missing to the PPO. We have therefore found no failings in how the PPO looked at this matter.

We upheld the complaint about the National Offender Management Service, which oversees the prison.

The prison did not handle Mr L's case in line with the relevant Prison Service Instruction on how prisons should deal with complaints from prisoners. Although Mr L provided all necessary information for a thorough search for the missing bag, the prison failed to search properly. If the prison had made appropriate enquiries in summer 2011, even if staff could not find the bag and the prison could not find out what had happened, Mr L would not have felt that his complaint had been ignored. Instead, the prison's handling of Mr L's complaint was so poor that he may have lost the opportunity to have his complaint resolved appropriately. This caused Mr L unnecessary distress, as well as inconveniencing him when he had to bring his complaint to his MP and to us.

Putting it right

Mr L wanted his documents back. Because of the time that had passed since the documents went missing, and because the prison had undertaken searches for the documents, we accepted that they had been lost and the prison could not return them.

The prison apologised to Mr L for the loss of the documents and for failing to investigate the complaint thoroughly. It also paid Mr L £200 in recognition of the frustration, distress, inconvenience and lost opportunity to have his complaint resolved appropriately.

Organisations we investigated

National Offender Management Service (NOMS)

Prisons and Probation Ombudsman (PPO)

Summary 461/October 2014

Man compensated for long delay in reinstating his driving licence

Mr A complained to us that the Driver & Vehicle Licensing Agency (DVLA) had wrongly taken away his driving licence on medical grounds and had taken far too long to reinstate it.

What happened

DVLA took away Mr A's licence when it received medical information about his fitness to drive after he was diagnosed with early-onset dementia. DVLA did this under an urgent, 24-hour process rather than its standard medical investigation procedures. This meant DVLA made the decision based on incomplete information.

After this, Mr A's consultant sent DVLA more information indicating that he was fit to drive, and further investigations showed that this was the case. However, DVLA took nine months to reinstate Mr A's licence. During this period, DVLA's explanations about what had happened and what Mr A needed to do were unclear and confusing.

What we found

We partly upheld this complaint. DVLA's initial decision to take away, or revoke, Mr A's licence was reasonable. Although it did not have all the information about Mr A's condition when it revoked the licence, it had received medical information regarding his fitness to drive from a doctor. Under its procedures, it has to consider such information within 24 hours, in case there are urgent concerns about a person's fitness to drive. Therefore, DVLA made a decision based on the information it had to hand. However, it did not record this decision properly or explain it to Mr A.

DVLA received more information about Mr A's medical condition some weeks after the decision. This indicated that Mr A may well have been fit to drive when DVLA revoked his licence. However, if DVLA had acted appropriately, Mr A would not have avoided the entire nine-month period that he was without his licence because DVLA needed time to consider the information. Nevertheless, it still took seven months longer than it should have to reinstate the licence. We considered that, if DVLA is to operate a policy in which there is an understanding that a decision can be made based on incomplete information, this should be balanced by similarly urgent consideration of follow-up information that could challenge the revocation decision. DVLA should have prioritised Mr A's case on this basis.

The explanations and advice DVLA gave Mr A about the revocation were very poor and made it difficult for him and his doctor to follow it up. This contributed to the delay in reinstating Mr A's licence.

Putting it right

DVLA apologised to Mr A, and paid him compensation of £1,000 to recognise that its failures had caused him to be without a driving licence for much longer than should have been the case, and to acknowledge the distress and frustration it caused throughout the process.

We also recommended significant changes to DVLA's procedures. We said that DVLA should make sure that it explains and records these types of revocation decision clearly. It should also put in place a robust procedure for the subsequent consideration of further information after a driving licence is revoked under this 24-hour process.

Organisation we investigated

Driver and Vehicle Licensing Agency (DVLA)

Summary 462/October 2014

UK Visas & Immigration took too long to process a student visa application

Ms H complained about UK Visas & Immigration's (UKVI) handling of her request to extend her student visa, and particularly that it retained her passport and took ten years to make a decision. She said that this caused her severe personal, financial and career problems, and her family suffered stress and financial hardship.

What happened

Ms H came to the UK in 1996 on a student visa, which was extended while she completed a degree. In 2001 she started an accountancy course and applied for her visa to be extended three months after the previous visa expired. The organisation that handled immigration cases at the time sent her case to the wrong team, and it was put into storage and stayed there for nearly ten years. In 2011 UKVI turned down her application. By that time, Ms H had stopped her studies and had a partner and child. UKVI asked Ms H to arrange to leave the UK. She appealed against the decision, and it was overturned by a tribunal in early 2012. There was then a delay of nearly 14 months before UKVI granted her three years' leave to remain.

What we found

UKVI's delays in processing Ms H's visa application were excessive, and its reasons for rejecting it were wrong. However, as Ms H was no longer a student by the time UKVI made its decision, it was correct to refuse her application. When UKVI later decided that she should leave the UK, it did not clearly record its reasons, although we did not find that the decision itself was wrong. Once the tribunal had overturned the decision to remove Ms H, there were unnecessary delays in UKVI granting her leave to stay in the UK, and it did not prioritise her case as it should have done. It was not wrong for it to keep her passport until it had made a decision.

UKVI's delays caused uncertainty and anxiety to Ms H. But, as she had only applied to stay as a student for a few months, she should have known that after that time she needed to take action to prevent UKVI treating her as an overstayer. Although the initial uncertainty and anxiety Ms H and her family suffered were caused by the organisations that handled immigration in the UK, their subsequent problems were not caused by UKVI's failings. The delay in UKVI granting her leave after the appeal hearing overturned the UKVI decision caused her stress, anxiety and inconvenience.

Putting it right

UKVI apologised to Ms H and paid her compensation of £500.

Organisation we investigated

UK Visas & Immigration (UKVI)

Summary 463/October 2014

Mishandled application for court hearing fee refund

Although Mr T sent in a correct application for a fee remission, a county court did not handle it properly. When Mr T complained to HM Courts & Tribunals Service, (HMCTS), which is responsible for the running of the courts, he did not feel that it properly considered his concerns about how the court had handled his application.

What happened

Mr T was the claimant in a case about a car accident. In summer 2013 he applied to the court for a refund of the fee he had paid (£135) to issue the claim on the basis that he was getting income-based jobseekers allowance.

At first, the court correctly refused Mr T's application because he had not given it proof that the fee had been paid. He returned his completed application, which was stamped as received by the court, later that month.

Over the next two months, the court refused Mr T's application for different reasons and with little explanation. When Mr T questioned the court's refusals, it did not address his concerns. The court maintained that Mr T had not provided a valid fee remission application and it refused to refund the court fee. Mr T complained about the court to HMCTS, which issued its final response in spring 2014. HMCTS did not uphold the complaint and felt that the court had acted reasonably.

What we found

The court should have accepted Mr T's application as valid in summer 2013. Instead, it sent him misleading correspondence that gave contradictory reasons for refusing his application. HMCTS failed to properly consider Mr T's complaint or respond to the various points he had made.

Putting it right

HMCTS accepted our findings and recommendations in full. It refunded the court fee of £135 and paid Mr T £200 for the distress and inconvenience its poor handling had caused. It also apologised to Mr T.

Organisation we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 464/October 2014

Failure to tell man about benefit rules led him into debt

A man moved house unnecessarily and incurred debt when Jobcentre Plus failed to tell him his benefit would be stopped if he moved house.

What happened

Mr A wanted to separate from his wife and move into a council property. He told Jobcentre Plus that this was what he was doing, but it failed to tell him that unless he sold his previous property, he would lose entitlement to income support when it was reviewed after 26 weeks. When the error was discovered some months later, Mr A's income support was stopped and he had to move back to his marital home. He could not afford to rent the council property without his benefit payments, and he was unable to force his wife to sell the marital home. In the process, Mr A incurred council tax arrears and suffered significant stress and inconvenience.

Mr A complained to the Independent Case Examiner (ICE) but it found no evidence of what advice, if any, Mr A had asked for, or what Jobcentre Plus had told him. It decided that Mr A's financial loss could not be said to have been caused by any misdirection by Jobcentre Plus.

What we found

We upheld the complaint about Jobcentre Plus. Jobcentre Plus should have told Mr A that his benefit entitlement would be reviewed after 26 weeks, and warned him about the potential impact on his entitlement if he failed to sell his property. Because it did not do this, Mr A did not have all the information he needed. If he had had the information, he would not have acted to his own financial and domestic detriment.

We did not uphold the complaint about ICE, which had considered all the evidence available to it at the time.

Putting it right

Following our investigation, Jobcentre Plus paid Mr A more than £1,500. This was enough to repay his council tax arrears, but minus the first month's rent to which he had committed himself before he spoke to Jobcentre Plus. It paid Mr A an additional £500 compensation for the significant stress and inconvenience he had suffered as a result of its failure.

Organisations we investigated

Jobcentre Plus

Independent Case Examiner (ICE)

Summary 465/October 2014

Tax credits award was not updated

Mr A twice gave HM Revenue & Customs (HMRC) correct information but it did not act on it, and then overpaid him.

What happened

Mr A claimed tax credits with his wife in early 2010. He incorrectly stated that he received income-based Jobseeker's Allowance, when he was in fact receiving contribution-based Jobseeker's Allowance. This had the effect of giving him a higher entitlement to tax credits than he should have had.

HMRC wrote to Mr A the next month. It said that it had received information from the Department for Work and Pensions that he got contribution-based Jobseeker's Allowance, and asked him to confirm this. It said that if he did not do so, it would correct his record the next month.

Mr A called HMRC soon after and then wrote. Each time he got in touch, Mr A confirmed that he got contribution-based Jobseeker's Allowance, not income-based Jobseeker's Allowance. However, HMRC did not adjust its records to show this. As a result, Mr and Mrs A were overpaid tax credits between winter 2009 and summer 2010, when another system check by HMRC suggested that Mr A still got contributions based Jobseeker's Allowance. HMRC acted on this, and sent award notices to Mr A and his wife that indicated that they had been overpaid nearly £1,800 in 2009-10 and nearly £1,500 in 2010-11.

Mr A complained about HMRC's actions and the overpayments, ending with an investigation by the Adjudicator's Office. The Adjudicator's Office did not uphold the complaint. It accepted that HMRC had failed to properly react to Mr A's confirmation that he was receiving contribution-based Jobseeker's Allowance, but considered that his failure to contact HMRC after receiving still incorrect award notices in spring 2010 meant that Mr and Mrs A had not fulfilled their responsibilities.

Mr A also complained about the Adjudicator's Office.

What we found

We partly upheld this case. Whilst we understood the Adjudicator's conclusion that Mr and Mrs A had not fulfilled their responsibilities under HMRC's Code of Practice 26, we considered that they had taken reasonable and appropriate steps to notify HMRC of the inaccuracy in the records when they telephoned and wrote to it.

We did not uphold the complaint about the Adjudicator's Office because this was largely a matter of judgment and we saw no grounds for saying that its approach to the complaint was at fault.

We upheld the complaint about HMRC. Its letter saying that it would correct its records in spring 2010 if it did not hear from Mr A, created a reasonable expectation that this would happen. It was reasonable for Mr and Mrs A not to take further action after they had contacted HMRC with the correct information twice.

Although we understood why the Adjudicator had decided that Mr and Mrs A's case did not meet the criteria for the overpayments to be written off under Code of Practice 26, we took the view that Mr and Mrs A had taken reasonable steps to avoid being overpaid, and that it was HMRC that had failed in its responsibility to record accurate and up to date information.

Putting it right

HMRC wrote off the overpayments totalling nearly £3,200 on Mr and Mrs A's tax credits award, and paid them compensation of £200 instead of the £50 recommended by the Adjudicator.

Organisations we investigated

HM Revenue & Customs (HMRC)

Adjudicator's Office

Summary 466/October 2014

Cafcass officer made speculative comments in report written for court

Mr N complained that a report written by the Cafcass officer assigned to his case was inaccurate and misleading and contained inappropriate comments about him. He complained that the officer had called him a liar in the report and also complained about Cafcass's handling of his complaint about these matters.

What happened

In spring 2013, a Cafcass officer filed a report with the court that wrongly suggested the possibility that Mr N was preying on children, possibly for sexual purposes. This report also gave the officer's view that Mr N had lied to her.

We interviewed the officer to establish on what basis she had included that statement in the report.

When Cafcass looked at the complaint again, it said that the officer had expressed her regret at suggesting Mr N had lied to her. Cafcass apologised at that time for any distress this had caused him.

What we found

There was no evidence to back up the officer's statement that Mr N had preyed on children. We considered it was purely speculative and we took the view that the officer no longer had a balanced view of the case. Cafcass confirmed that its officer should also not have implied that Mr N had lied to her.

Cafcass did not investigate Mr N's complaint fairly. We considered it was wrong for Cafcass to rely on its belief that what the officer had said in her report was her professional judgment, and it failed to identify that the statement about Mr N preying on children and lying to the officer was not based on any evidence.

When it first considered the complaint, Cafcass did not look robustly at Mr N's complaint that the officer had called him a liar. We considered Cafcass acted defensively when looking at Mr N's complaints and was not impartial.

Putting it right

Cafcass wrote to the court before the final hearing, asking it to disregard the speculative statement in its officer's report. Cafcass's chief executive apologised to Mr N for the inconvenience, distress and damage caused by the speculative information and for Cafcass's poor complaint handling. Cafcass reimbursed Mr N's legal fees of just under £3,000 and paid him £1,500 to compensate him for the distress, inconvenience and damage caused by its errors. It reminded all managers to make it clear to staff that, when quality assuring reports, they must make sure that they include evidence-based information, not speculative statements.

Organisation we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 467/October 2014

DVLA refused to replace full driving licence because original was provisional

Mr H said he had a full driving licence but the Driver & Vehicle Licensing Agency's (DVLA) records showed otherwise.

What happened

In spring 2012, Mr H applied to DVLA for a replacement driving licence because he had misplaced the original. DVLA refused the application for a full licence because the driver record showed that Mr H had not claimed his full licence within two years of passing his test, as required by law. Instead, DVLA issued a replacement provisional licence.

Mr H complained to DVLA. He said that DVLA had made a mistake and had not properly recorded when it issued his licence. He gave DVLA a copy of a police officer's witness statement, relating to an incident in autumn 2007, that showed that the police officer had confirmed with DVLA that Mr H held a full licence. DVLA would not comment on the police statement and said that a check of the driver record would have showed that Mr H's licence status was provisional.

What we found

DVLA's records contradicted Mr H's claim that he held a full licence. We contacted the police and Mr H's former employer to try to get impartial evidence to reconcile the conflicting information.

While the police officer's statement supported Mr H's version of events, it was not confirmed by any of the other evidence we saw. We examined DVLA's records and we were satisfied that any enquiries made about Mr H's driver record at the time would have shown that Mr H's licence status was provisional.

Mr H told us that he had previously worked in car sales and had needed a full driving licence as a condition of his employment. Mr H's former employer gave us a copy of the driving licence that Mr H had shown when he took the job. There were several discrepancies between the copied licence and Mr H's personal details and the information in DVLA's records. We were not satisfied that the copied licence was a genuine copy of a licence issued by DVLA to Mr H.

Taking all the evidence into account, we were not persuaded that DVLA had issued a full driving licence to Mr H and we did not uphold his complaint.

Organisation we investigated

Driver & Vehicle Licensing Agency (DVLA)

Summary 468/October 2014

Asylum seeker waited more than four years for a decision on his application

UK Visas & Immigration (UKVI) delayed making a decision on an asylum seeker's application to remain in the UK.

What happened

Mr T applied for asylum in the UK in 2006. The organisation responsible for handling immigration and asylum cases at that time refused his application and considered compulsorily returning him to his home country. In 2009 Mr T made further representations to be allowed to stay in the UK and he was given public financial support. He and his representatives continued to ask UKVI for a decision throughout 2010 but received very few responses. UKVI put Mr T's case into an already large backlog of old asylum cases, and did not decide what to do until the end of 2013, when it rejected his further submissions.

What we found

Mr T's case should have been prioritised because he was getting public financial support. But UKVI put his case into the backlog of old asylum applications for four and a half years. Mr T suffered an unnecessary delay in receiving a decision. However, as his applications had all been rejected, there is no reason to think that, had his most recent application been dealt with earlier, there would have been a positive outcome. We considered that Mr T had benefitted from the delay by being able to remain in the UK during this time, and so did not suffer an injustice.

Putting it right

We did not make any recommendations because we did not find any injustice.

Organisation we investigated

UK Visas & Immigration (UKVI)

Summary 469/October 2014

Grandparents frustrated by court case delays

Children and Family Court Advisory and Support Service (Cafcass) failed to follow its procedures when it handled Mr and Mrs B's case. The delay and the ineffective management of their case caused Mr and Mrs B anxiety and frustration.

What happened

A case involving Mr and Mrs B's grandchild was referred to Cafcass in 2011. The case involved a dispute between Mr and Mrs B and their adult child over the residence of their grandchild. The court ordered a wishes and feeling report (a report to find out a young person's wishes and feelings). A family court adviser prepared this but it was strongly contested by Mr and Mrs B. The court then ordered a family assistance order (an order made by a court or local authority that a Cafcass officer assists and advises a family) but Cafcass took no steps to implement this for several months.

In the first six months that Cafcass worked on this case, it allocated several family court advisers to it. Cafcass did not make a case plan and case records were incomplete. When a manager reviewed the case, she decided that the family assistance order was unworkable and returned to court, which ordered a report to evaluate and assess the situation. Cafcass allocated a new family court adviser to the case and she kept the case through to its conclusion ten months later.

Mr and Mrs B complained to Cafcass about the way it had handled the case. Cafcass dealt with the latter part of the case but did not address Mr and Mrs B's concerns about the way it handled the case in the first six months after it was referred.

What we found

We partly upheld this complaint. Cafcass mismanaged the case virtually from the beginning until the allocation of the last family court adviser. It failed to communicate or work with the people concerned as it should have done. As a result of Cafcass's mistakes, there were delays to the case of about four months during a time when there were welfare concerns about Mr and Mrs B's grandchild.

Although Mr and Mrs B were also unhappy about both court reports, and in particular with the comments and recommendations that the Cafcass family court advisers had made, we were not able to look at the contents of the reports themselves as we had found no fault in how they were prepared.

Cafcass should have responded to Mr and Mrs B's complaint about how it had managed the case. As a result of Cafcass's actions, Mr and Mrs B suffered anxiety, frustration and a loss of confidence in Cafcass.

Putting it right

Following our investigation, Cafcass apologised to Mr and Mrs B for the injustice they suffered.

Organisation we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 470/October 2014

Decision on asylum seeker's application to stay in the UK was unnecessarily delayed

After it delayed making a decision on Mr K's application to stay in the UK for three years, UK Visas & Immigration (UKVI) told Mr K to leave the UK even though his period of leave to remain had not expired.

What happened

Mr K applied for asylum in the UK in 2003 and was refused. Mr K made further submissions in 2010 asking to stay in the UK. In 2011 UKVI gave him discretionary leave to remain for three years until summer 2014. Mr K objected and asked for indefinite leave to remain. In 2013 UKVI refused Mr K's further submissions and told him he had to leave the UK. In early 2014 UKVI turned down Mr K's request to have his discretionary leave to remain converted to indefinite leave.

What we found

We partly upheld Mr K's complaint. UKVI's 2011 decision to grant Mr K discretionary leave to remain was flawed because the caseworker made an error in the decision making. But Mr K benefitted from that mistake because he was able to stay in the UK.

UKVI should have made a decision on Mr K's further submissions and request to have his discretionary leave converted to indefinite leave earlier but there was no injustice, because Mr K was able to remain in the UK. UKVI should have apologised for its mistake in telling Mr K he should leave the country, and it has now done so.

Putting it right

We did not make any recommendations because there was no injustice.

Organisation we investigated

UK Visas & Immigration (UKVI)

Summary 471/October 2014

Pension Service gave woman incorrect information about state pension entitlements

When we found that the Pension Service had given Ms B the wrong information, we were critical, but its error did not mean that she lost out.

What happened

The Pension Service sent Ms B a pension forecast that wrongly stated that she would inherit her late husband's additional state pension when she reached state pension age. In fact, she was not entitled to this. Ms B relied on this additional amount when she made decisions about her private pension and future income, only to find out afterwards that she would not receive the money when she reached state pension age.

Ms B complained about this to the Pension Service, saying that she had lost out financially because of its error. The Pension Service did not initially respond to her complaint in line with its complaints process. Eventually it decided that as she was not entitled to her late husband's additional pension, there was nothing further for it to do.

Ms B complained to the Independent Case Examiner (ICE), which criticised the Pension Service for the way it had handled the complaint and for giving Ms B the wrong information. It agreed that Ms B had not lost out financially because she was not entitled to Mr B's additional pension. It said that she should have got more information before making decisions about her future income. It recommended she receive a consolatory payment for poor complaint handling and for the wrong information the Pension Service gave her, but Ms B refused to accept this.

What we found

We partly upheld this complaint. We agreed with ICE about how the complaint was handled and that the Pension Service should not have sent Ms B the wrong information. However, we disagreed with its view that Ms B should have got advice after she had received the pension forecast that included Mr B's additional pension.

We told Ms B that she was entitled to expect that the Pension Service would give her the right information. We added that the information available to Ms B would not have shown that she was not entitled to Mr B's additional state pension.

Putting it right

When we looked at the injustice that Ms B said she had suffered, we saw that by the time she reached state pension age, her state pension entitlement had gone up. She had been expecting a certain amount of money based on the Pension Service's forecast. She received more than this. It was clear throughout the complaint that Ms B had not suffered a financial loss. We concluded that the consolatory payment already offered was fair in the circumstances.

Organisations we investigated

Pension, Disability and Carers Service (Pension Service)

Independent Case Examiner (ICE)

Summary 472/November 2014

Border Force did not fully understand its own processes

Ms R complained that Border Force refused to allow her to reclaim her VAT through a particular process. She said that when she complained, Border Force failed to give her appropriate explanations and referred to the wrong guidance. Ms R said she wanted to prevent the problem happening again.

What happened

Ms R intended to take goods overseas for business purposes in her baggage in winter 2012. She wished to use the Merchandise in Baggage process, under which the goods would be zero-rated for VAT. She had completed the necessary documentation, five sets of forms (called C88 forms), as a customs declaration.

Ms R presented the five sets of forms to the Customs Office at Heathrow airport. However, the customs officer cancelled the forms and refused to allow Ms R to carry the goods as Merchandise in Baggage. Ms R complained to Border Force.

During the complaints process, Border Force said that the goods appeared to be for Ms R's own consumption and were mixed in with her other items. Border Force also thought that Ms R's goods were an indirect export and so did not qualify for zero rating. Border Force also suggested that Ms R had a right of appeal. Lastly, it said that Ms R had not completed the correct codes in her C88 forms.

Ms R disputed that the goods were an indirect export, and said that they were a direct export. She also provided advice she had received from HM Revenue & Customs to support this. However, Border Force maintained its previous view.

What we found

We partly upheld this complaint. Border Force was wrong when it said Ms R's goods were an indirect export as it should have considered them as a direct export. Border Force did not fully understand the Merchandise in Baggage process and did not give Ms R accurate information about it. We also noted that Ms R had provided correct codes so it was unfair of Border Force to say she had not included them. Lastly, Border Force was wrong to suggest to Ms R that there was a right of appeal when there was no such mechanism.

However, we noted that Border Force had consistently maintained that Ms R's goods appeared to be packed in a way that suggested they were for personal use and that this presented reasonable grounds for it to refuse the C88 forms. We also accepted Border Force's explanation that Ms R could have used other modes of transport to obtain evidence of export (post and so on) and reclaim her VAT.

Putting it right

After our investigation, Border Force apologised for its handling of the case and the trouble it had put Ms R to. It paid her compensation of £100.

It also reviewed the training and instructions it gives customs officers with regard to the Merchandise in Baggage process.

Organisation we investigated

UK Border Force

Summary 473/November 2014

Confusion over lost documents

Mr K complained that UK Visas & Immigration (UKVI) lost his documents and did not properly compensate him for replacing them. Mr K said that he missed out on a holiday and a job opportunity overseas.

What happened

In spring 2013, Mr K applied for British citizenship for his two children. It was approved in early summer 2013. Later that month, Mr K told UKVI that he wanted it to return his documents via recorded delivery. However, UKVI's database noted that during a telephone call soon after, Mr K agreed that it should send his documents back using second class post. The note also stated that staff had posted each of the documents to Mr K that day.

Mr K did not receive his documents. UKVI undertook a search but was unable to find them, and offered to reimburse Mr K's costs for replacing the documents. When Mr K submitted his compensation claim, UKVI only agreed to reimburse part of the costs. In particular, UKVI did not agree to reimburse Mr K for his holiday costs, his missed job opportunity or his overnight costs in travelling to London with his family (to obtain replacement documents). In addition, in its letter, its calculation of the compensation claim did not include the costs it had agreed to reimburse.

What we found

We partly upheld this complaint. The evidence showed Mr K had agreed that UKVI could send his documents to him using second class post. The evidence also showed that UKVI had returned Mr K's documents to him.

As the evidence showed that UKVI was not responsible for the lost documents, it therefore followed that it was not responsible for Mr K's missed holiday and lost job opportunity.

However, UKVI's handling of the complaint was poor. Only when we spoke to UKVI did it make it clear that it did not accept liability for the lost documents, and that paying for replacements was a goodwill gesture. UKVI had led Mr K to believe that it had lost his documents when it undertook searches and offered to pay reimbursement costs. We said that UKVI should have made it clear to Mr K at the outset that its actions were a gesture of goodwill.

Lastly, we noted that UKVI had calculated the costs it had agreed to pay Mr K incorrectly. However, we were pleased to note that UKVI had now agreed to pay the correct (higher) amount.

Putting it right

UKVI apologised to Mr K. We decided that further compensation was not warranted in light of the goodwill payment of just under £460 that UKVI had already offered.

Organisation we investigated

UK Visas & Immigration (UKVI)

Summary 474/November 2014

Children and Family Court Advisory and Support Service error delayed a father's contact with his daughter

Mr Y complained that the Children and Family Court Advisory and Support Service (Cafcass) had submitted biased reports to a family court hearing. He also complained that Cafcass had delayed arranging a contact meeting between him and his daughter.

What happened

After their relationship broke down, Mr Y and his ex-partner asked a court to determine how much contact Mr Y should continue to have with their daughter. Cafcass wrote several reports to the court outlining its view of what was in the child's best interests. However, Mr Y complained that the reports were biased towards his ex-partner and had not fully taken account of his views. Cafcass told Mr Y that, if he was unhappy with the reports, he would need to challenge them in court.

During the proceedings, the court asked Cafcass to arrange some supervised meetings between Mr Y and his daughter. However, Mr Y felt that Cafcass took too long to make these arrangements.

What we found

We partly upheld this complaint. What Cafcass had said about the reports was reasonable. Cafcass's reports were essentially a piece of evidence that the court needed to consider when it made its decision. It was up to the court to decide what weight to place on the Cafcass reports, and it was under no obligation to follow any recommendations made by Cafcass.

If Mr Y had wanted to challenge the evidence Cafcass had presented, he could have done that in court.

Having said this, we upheld Mr Y's complaint about the delay in arranging the contact sessions between him and his daughter. Cafcass could and should have done more than it did to make sure these meetings began as soon as possible.

Putting it right

Cafcass apologised to Mr Y for the delay in arranging the contact sessions. It paid Mr Y £150 to recognise the frustration he experienced as a result of this delay.

Organisation we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 475/November 2014

Children and Family Court Advisory and Support Service failed to help woman understand its processes

Because the Children and Family Court Advisory and Support Service (Cafcass) did not give her enough information, Mrs L was left confused and frustrated about what she could expect from Cafcass during family court proceedings.

What happened

Mrs L complained that Cafcass had given inaccurate and misleading information to a court. The court then made a decision that was not in Mrs L's favour. Mrs L also complained that Cafcass did not recognise that she was representing herself during these proceedings and so should have had more support from Cafcass than she did.

What we found

We partly upheld this complaint. Cafcass had rightly explained to Mrs L that its reports were based on its professional opinion of Mrs L's situation and that if she did not agree with that opinion, she should challenge it in court. We also found that Cafcass was right to tell Mrs L that it could not give her legal advice during these proceedings and this was something that she would need to find for herself.

Cafcass should, however, have given Mrs L more information about what she could expect from it during the court proceedings. In particular, it should have answered her specific questions about Cafcass.

Putting it right

Cafcass apologised to Mrs L for its failure to give her the information she was entitled to. It paid her £350 in recognition of her frustration.

Organisation we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 476/November 2014

Delays and misinformation resulted in a lost opportunity to investigate the actions of attorneys

Mrs R complained that the Court of Protection (a court that makes decisions that involve people who lack mental capacity) took 18 weeks to tell her that she needed to contact the Office of the Public Guardian about her concerns about her father's attorneys. The Office of the Public Guardian then gave her wrong information, which it corrected too late.

What happened

Mrs R's father made an Enduring Power of Attorney (a legal document that appoints a person to make decisions on another person's behalf if they can't make decisions at the time they need to be made) in spring 2003. He appointed Mrs R, her stepmother and her stepbrother as his attorneys. The Office of the Public Guardian received an application to register (place on record) the Enduring Power of Attorney in summer 2011. Mrs R applied to the Court of Protection to object to the registration. In spring 2012, the Court of Protection dismissed her objections and asked the Office of the Public Guardian to register the Enduring Power of Attorney. It was registered in early summer 2012. The Court of Protection ordered that Mrs R would have no further participation in the management of her father's affairs, but that the remaining attorneys were to keep proper accounts and records of all transactions involving her father's estate. The Court of Protection ordered the attorneys to give Mrs R a copy of the annual accounts.

Between spring and late summer 2013, Mrs R contacted HM Courts & Tribunals Service (HMCTS) about her concerns that the attorneys were not giving her the information she was entitled to. This correspondence was eventually sent to the Court of Protection, which is part of HMCTS. It replied in late summer and advised Mrs R to contact the Office of the Public Guardian.

Mrs R then contacted the Office of the Public Guardian. At first it told her that it could not investigate her concerns. Mrs R's father died in early autumn. Soon after, the Office of the Public Guardian decided that it could investigate; however, it was now unable to do so as its jurisdiction, and that of the Court of Protection, had ended when Mrs R's father died.

HMCTS accepted that there had been delay in dealing with Mrs R's correspondence and that it should have told her to contact the Office of the Public Guardian sooner. It offered her £100. The Office of the Public Guardian accepted that it had not handled Mrs R's correspondence correctly and apologised for the frustration this had caused her.

What we found

We partly upheld this complaint. As a result of failings by both organisations, Mrs R was denied the opportunity to have her concerns about the actions of the attorneys properly investigated.

We could not say with any degree of certainty what the outcome of an investigation by the Office of the Public Guardian would have been. This was due to the limited time that was available to the Office of the Public Guardian to conduct an investigation before Mrs R's father died. HMCTS's delays limited this time.

However, our investigation clarified that the Office of the Public Guardian would have investigated Mrs R's concerns if there had been time to do so before her father's death, and that a probable outcome of that investigation would have been an application to the court to enforce the Court of Protection's spring 2012 order.

Putting it right

While we could not identify a tangible loss to Mrs R as a result of the failings by both organisations, we felt that the actions of HMCTS in particular had led to a loss of opportunity, and that both organisations should offer some financial remedy for their failings.

We felt that the impact of the Office of the Public Guardian's failing was relatively small and that a payment of £100 was sufficient. In terms of HMCTS, the impact of its failings was greater and we recommended that HMCTS increase its offer to Mrs R from £100 to £400. This gave Mrs R total financial redress of £500, which we considered, together with the apologies and explanations already given, to be a suitable outcome to her justified complaint.

Both HMCTS and the Office of the Public Guardian accepted our recommendations in full.

Organisations we investigated

HM Courts & Tribunals Service (HMCTS)

The Office of the Public Guardian (OPG)

Summary 477/November 2014

UKVI's incorrect advice led to woman losing her permanent status in the UK

Mrs P had previously lived in the UK and had been granted permanent settlement here. UK Visas & Immigration (UKVI)'s incorrect advice led her to lose her permanent status in the UK on her return.

What happened

Mrs P and her British family wanted to return to the UK having lived some years in her home country, New Zealand. Previously they had had Indefinite Leave to Remain (ILR) status, but this had expired. Before returning to the UK Mrs P telephoned UKVI to enquire about visas. She explained that she had previously lived in the UK and had permanent status here but she was not advised to apply for a Returning Resident visa, which would have been the correct visa in her circumstances. Instead, she was advised to apply for a spousal visa valid for 27 months, costing her an extra £570. On the expiry of that visa she would then need to apply for a new visa, incurring further costs.

Once in the UK Mrs P complained to UKVI but it did not agree that it had done anything wrong.

What we found

We listened to the telephone calls and found that UKVI had not given correct advice to Mrs P in her circumstances.

UKVI state that its staff does not give immigration advice. That is a reasonable approach as staff would be unlikely to be able to probe a potential applicant's circumstances in sufficient detail to give reliable advice over the telephone.

However, in Mrs P's case, UKVI gave advice which had turned out to be incorrect, albeit perhaps for trying to be helpful.

This was poor customer service.

Putting it right

UKVI reinstated Mrs P's permanent status in the UK. It also refunded the difference between the two types of applications (£570) and paid £600 in recognition of the distress, upset and frustration caused.

Organisation we investigated

UK Visas & Immigration (UKVI)

Summary 478/November 2014

Errors and poor service at county court

Mr B complained about the poor service he received from HM Courts and Tribunal Service (HMCTS). He said that his case was unnecessarily delayed as a result of a series of mistakes by court staff.

What happened

Mr B made a small claim in early 2013 which was dealt with by his local county court. In late 2013 the court found in Mr B's favour. That decision was later set-aside because the defendant had not received notice of the hearing. In early 2014 the case was re-heard and the court again found in Mr B's favour.

What we found

There was a series of errors and poor service by the court early in Mr B's case. The court arranged a hearing on a date Mr B had asked them to avoid; it did not recognise this error and told Mr B he had to make an application to change the hearing date; it failed to log Mr B's payment which led to a hearing being struck out; and court staff members spoke to Mr B in an unacceptable manner and were uncooperative.

The court also did not alert Mr B to the fact that the defendant had changed address in September 2013 as it should have done. The court failed to recognise this error because it did not look at the court file. It only looked at its computer records when it considered Mr B's complaints

Putting it right

HMCTS apologised to Mr B for its errors, and for not identifying its failure to send out the notice of the hearing in autumn 2013. The court reimbursed him £150 for the cost of the hearing, paid him £250 for the inconvenience and frustration caused by its poor service, complaint handling, errors and delays, and to compensate him for the cost of copying papers. It also paid him £100 for lost earnings.

It made staff aware that responses should be evidence-based when dealing with complaints, and that this would usually entail checking the file to ensure that mistakes are not overlooked.

Organisation we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 479/November 2014

UK Border Force failed to compensate company for damaged goods

UK Border Force damaged several sacks of bran during a routine inspection. Although the sacks then had to be destroyed, UK Border Force refused to pay the company compensation for the loss of their goods.

What happened

The company supplies cereals to manufacturers in the UK and Europe. A number of sacks were being returned from Poland because of a problem in the outer packaging. The lorry from Poland was stopped at Dover and UK Border Force officials carried out a search. They used sticks to probe the contents of the sacks which the company said damaged the packing to the extent that the contents could no longer be used and would have to be destroyed.

It asked UK Border Force to compensate them for the financial loss but the UK Border Force said that the sacks were rejects and therefore it was not liable for the cost of the damage. The company said that the goods would have been re-packaged and redelivered, and were not therefore rejected and of no value.

What we found

UK Border Force, by using sticks to examine the sacks, did damage the contents so that they were not saleable by the company. We did not find the use of the sticks inappropriate but UK Border Force should have spoken with the company about the contents to check whether the goods were still saleable. It should have compensated the company for the damage it did to the goods.

Putting it right

We recommended that UK Border Force pay the company a sum of over £12,000 including interest, to compensate for the financial loss of the sacks of damaged bran, and also apologise to the company.

Organisation we investigated

UK Border Force

Summary 480/November 2014

Errors and delays in making a decision on asylum seeker's application

UK Visas & Immigration (UKVI) did not give Mr T, an asylum seeker from an African country, the correct information on making further representations, and erroneously put his case in storage. This led to a delay in a decision and caused him stress and anxiety.

What happened

Mr T came to the UK in 2004 and applied for asylum. UKVI rejected his claim. In autumn 2010 Mr T asked UKVI to grant him leave as he now had a partner and was well settled in the UK. He wrote again at the end of 2010, but UKVI put his case into storage in early 2011. During 2011 Mr T, his representatives, and his MP all contacted UKVI asking for an update on his case.

In early 2012 UKVI told Mr T that he had to make further representations in person, which he did in summer 2012, telling UKVI that he now had two British born children. At that point UKVI took his file out of storage but did not work on his case until early 2014. In spring 2014 UKVI granted Mr T discretionary leave to remain for 30 months (until autumn 2016).

What we found

UKVI should have told Mr T in 2010/early 2011 that he needed to make further representations in person, but it did not do so until January 2012. UKVI should not have placed his case in storage without first checking whether he or his representatives were in contact with UKVI. If his case had not gone into storage we can see no reason why it would not have been decided by early 2012, once he had had the opportunity to make his further representations in person. His case should not have stayed in storage until summer 2012 because Mr T and his MP made contact with UKVI in 2011. There was no good reason for UKVI delaying eighteen months to make a decision once Mr T had put in his further representations.

If UKVI had made a decision in early 2012, it was likely that it would have made a positive decision. This unnecessary delay caused Mr T anxiety and frustration. Mr T was denied an opportunity to look for work for 12 months.

Putting it right

UKVI paid Mr T a consolatory payment of £500 for the anxiety and lack of opportunity to look for work that he experienced as a result of its errors. We also recommended that UKVI apologise to Mr T.

Organisation we investigated

UK Visas & Immigration (UKVI)

Summary 481/November 2014

UKVI's failure to provide appropriate information caused emotional and financial injustice

Mr N complained that UK Visas & Immigration (UKVI) mishandled his application to extend his civil partner visa in the UK. He said UKVI misdirected him and caused him anguish when he was trying to deal with a family emergency. Mr N also said that UKVI cost him money.

What happened

In summer 2012 Mr N, an American national, applied for an extension to his civil partner visa and provided UKVI with his passport. In autumn 2012, Mr N contacted UKVI three times to advise them that he needed to return home for a family emergency; his brother had been in a serious car accident.

UKVI told Mr N that if he requested his passport back his application would be treated as withdrawn and his application fee would not be refunded.

Mr N then asked for his passport, but UKVI did not return it. Mr N returned to the USA using an Emergency Travel Document (ETD).

At the end of 2012, Mr N's passport was finally returned to him, his application was treated as withdrawn and his application fee was kept by UKVI.

Mr N complained to UKVI but was told its actions were appropriate.

What we found

It was technically correct for UKVI to treat Mr N's application as withdrawn following his request for his documents to be returned in autumn 2012. However, other circumstances led us to counter that view. Namely, that during Mr N's three contacts with them in autumn 2012 UKVI had failed to tell him that he could ask for his application to be expedited because of a family emergency.

UKVI should have asked Mr N about the nature of his family emergency. If it had done so, Mr N's circumstances meant that he would probably have been eligible to have his case expedited and that he would probably have chosen that option. If Mr N had taken that option, his application would have been determined and his passport returned. Also, there would have been no need for him to obtain an ETD.

UKVI mishandled Mr N's case. It failed to react sensitively to his family emergency and did not provide him with appropriate information. We found that this caused Mr N distress, that he lost his application fee and had to pay for an ETD.

Putting it right

UKVI apologised for its handling of Mr N's case. It also reimbursed Mr N for the full cost of his summer 2012 application and for the costs associated with obtaining his ETD.

UKVI paid Mr N £500 in recognition of the worry and distress it caused him at a time when his brother had been in a serious accident and later died. We partly upheld the complaint.

Organisation we investigated

UK Visas & Immigration (UKVI)

Summary 482/November 2014

Poor complaint handling and investigation

The Pension, Disability and Carers Service (the Pension Service) and the Independent Case Examiner (ICE) failed to properly consider a complaint about advice on deferring state pension.

What happened

In spring 2008 Mr V called the Pension Service. According to his recollection of the telephone call, he was essentially told that he could defer his state pension. The advantage of deferring a state pension is that you get a higher pension later on.

In March 2010, Mr V decided to claim his state pension and was told that he had not been able to defer his state pension because he had continued to claim carer's allowance.

Mr V complained that he had been misadvised and asked the Pension Service for a special payment to, in effect, treat matters as if he had been able to defer.

The Pension Service rejected Mr V's claim and ICE upheld that decision.

What we found

Mr V contacted us towards the end of 2013. There was no documentary evidence of what was said during the telephone conversation in April 2008. This was not because of an error by the Pension Service, but because it had routinely destroyed its records at the right time before Mr V realised he had a complaint.

With a lack of evidence, we could not make any clear finding on whether the Pension Service misadvised Mr V during this call. For that reason, we did not uphold this part of the complaint or recommend that the Pension Service should meet Mr V's claim. However, there were failings in the way that the Pension Service and ICE considered this case. Consequently, we partly upheld the complaint.

There were key failings in the Pension Service and ICE's complaint handling.

Mr V had taken a written note of the spring 2008 telephone conversation, but this was no longer available for us to see. However, it had been available to the Pension Service and possibly ICE as well. The Pension Service did not keep a copy of that evidence and neither it, nor ICE, took account of it during its considerations.

The Pension Service noted that there was no trace of the telephone call in spring 2008. However, that was irrelevant because at the time of Mr V's complaint any record of the call would have been routinely destroyed. The absence of a record did not indicate that the call was not made.

The Pension Service said that Mr V had called one telephone number, when in fact he had called another. The number that the Pension Service thought Mr V had called was less likely to give advice on deferring a state pension. We found that the Pension Service's misunderstanding would have affected its decision making.

The Pension Service said that Mr V had had a leaflet prior to his call in spring 2008. It advised customers to call it or to seek financial advice. The Pension Service concluded that Mr V should have sought financial advice. We said that this was not a reasonable conclusion as Mr V's enquiry was straightforward and he had followed the advice in the leaflet by contacting them with his query.

Putting it right

ICE and the Pension Service apologised to Mr V, and each made a consolatory payment of £150 to him for causing Mr V frustration through their poor complaint handling.

The Pension Service also visited Mr V to consider whether he is entitled to receive anything in addition to his basic state pension. In particular, whether he is entitled to receive pension credit and, if so, whether there is potential to backdate that benefit.

Organisations we investigated

Pension, Disability and Carers Service (Pension Service)

Independent Case Examiner (ICE)

Summary 483/November 2014

Health and Safety Executive correctly handled case

Mr M wanted the Health and Safety Executive (HSE) to inspect the floor he slipped on

What happened

Mr M slipped and injured himself in a care home bathroom.

He wanted the HSE to inspect the floor but it refused to do so. Mr M believed the HSE's refusal to act was irresponsible and put others at risk of harm.

What we found

The HSE investigate only the most serious incidents where there has been a potential breach by an employer of their duties under health and safety legislation.

The HSE took the issue Mr M reported seriously and sought further information from the care home. The HSE reasonably balanced Mr M's concerns against priority issues that it investigates, before deciding that no further action was necessary.

We saw that the HSE took appropriate action at every stage of its handling of this matter. Its decisions were evidence-based, in line with its enforcement policies and clearly communicated to Mr M.

When Mr M complained about the decision, the HSE reviewed the matter at a more senior level and provided him with further explanations for why it would not be taking any additional action. Those explanations were clear and courteous.

We did not uphold this case.

Organisation we investigated

Health and Safety Executive (HSE)

Summary 484/November 2014

UK Visas & Immigration failed to properly consider a request to put things right after an error

UK Visas & Immigration (UKVI) was responsible for delays in allowing Mr G to apply for indefinite leave to remain in the UK. Mr G said this caused him financial loss, stress and inconvenience. UKVI did not fully consider that request.

What happened

UKVI should have granted Mr G indefinite leave to remain in the UK at the end of 2011 but due to an error, it did not make that decision until the beginning of January 2014 (although it did give Mr G limited leave to remain in the UK during those three years). Mr G asked UKVI to rectify its mistakes and for financial compensation. UKVI offered Mr G £500 as well as the chance to make an early application for residency in the UK.

What we found

Although UKVI reached sensible decisions about the financial impact of its error, it did not consider the stress and inconvenience its error had caused Mr G. We considered whether the UKVI's offer of £500 was reasonable to compensate Mr G for this and we decided that it was.

We partly upheld the complaint.

Putting it right

We were satisfied that UKVI's offer to put things right was reasonable. We made no other recommendations.

Organisation we investigated

UK Visas & Immigration (UKVI)

Summary 485/November 2014

Asylum seeker waited two years and eight months for a decision on his application from UK Visas & Immigration

Mr D complained about UK Visas & Immigration (UKVI)'s delay in deciding his application. He said that he had been unable to support himself and his partner and that this had left him feeling distressed.

What happened

Mr D, who is from Turkey, came to the UK in 2002 and claimed asylum. His claim was rejected, and he subsequently made an application to stay as a self-employed business person, which UKVI also rejected in 2006. Between 2006 and 2010 Mr D did not maintain contact with UKVI. In February 2010, contrary to its guidance, UKVI placed his case in long term storage without thorough checks to try to establish his whereabouts. Despite receiving documents from Mr D during this time, UKVI left his case in storage.

In spring 2011 Mr D applied to stay in the UK on human rights grounds on the basis that he was in a relationship with a British citizen, but UKVI did not take any action. Mr D wrote to UKVI in summer 2013 saying that he was no longer with his girlfriend and had been in a new relationship for the previous two years. UKVI rejected his application at the end of 2013. Mr D subsequently made two further applications which UKVI rejected. He also made a legal challenge which remains outstanding.

What we found

We partly upheld this complaint.

UKVI could have made a decision on Mr D's case in early 2010. However, it wrongly left it in long term storage. UKVI also failed to deal with Mr D's spring 2011 application within a reasonable timescale. It is likely that if UKVI had concluded his case earlier, it would have refused his application.

UKVI's delay benefitted Mr D as it allowed him to remain in the UK. As Mr D has now received a decision on his application, and has also made further applications that have been rejected, UKVI have dealt with the main effect of its poor handling of his case. We did not find that this had caused him to suffer an injustice.

Putting it right

As we found no outstanding injustice, we did not make any recommendations.

Organisation we investigated

UK Visas & Immigration (UKVI)

Summary 486/November 2014

Failed asylum seeker should have had decision on case two and a half years earlier

UK Visas & Immigration (UKVI) should have made a decision on an application from a Zimbabwean asylum seeker by summer 2011.

What happened

Ms A came to the UK in 2002 and unsuccessfully claimed asylum. However, she remained in the UK. In 2009 and 2010 she asked UKVI to consider again whether she could stay in the UK as she said she had new information for them to consider. Her case was put in the backlog of old asylum cases which UKVI had promised to conclude by summer 2011. However, UKVI did nothing more on her case until the end of 2013 when it refused her permission to stay in the UK.

What we found

UKVI made a decision on Ms A's case at the end of 2013 to refuse her permission to stay in the UK but it should have done so by the summer of 2011. Even if it had made a decision by summer 2011, Ms A would still have had a negative decision.

UKVI communicated poorly with Ms A by not updating her about the lack of progress with her case. UKVI's poor communication and unnecessary delay of two and a half years to conclude her case caused Ms A anxiety and uncertainty.

Putting it right

We recommended that UKVI write to Ms A to apologise for the anxiety and uncertainty she experienced in not knowing what would happen with her case from summer 2011 to the end of 2013.

Organisation we investigated

UK Visas & Immigration (UKVI)

Summary 487/November 2014

Excessive delay in dealing with an application from a vulnerable asylum seeker

Miss P complained about UK Visas & Immigration (UKVI)'s delay in deciding her application. She said that this so seriously affected her physical and mental health that she was on medication and in constant fear.

What happened

Miss P, who is from Rwanda, came to the UK in 2002 and claimed asylum as a dependent of her then partner. UKVI rejected her partner's claim, and she subsequently separated from him because of domestic abuse. In spring 2005 Miss P made an application on compassionate and human rights grounds. UKVI failed to record the correct category for her case, and did not identify that it should have been dealt with as part of a backlog of asylum cases. Instead it placed it in long term storage, and did not retrieve it until summer 2011 when Miss P's MP contacted UKVI.

UKVI did not then reach a decision until spring 2014. It acknowledged that it had mishandled Miss P's case and that she was vulnerable due to psychiatric problems.

It accepted that its delays could have had a negative effect on her wellbeing. Therefore, exceptionally, instead of giving her a fixed period of discretionary leave it granted her leave to settle in the UK.

What we found

We considered whether UKVI should have prioritised Miss P's case before 2011 because of her vulnerability but she did not bring this to UKVI's attention before then. Nonetheless, UKVI's delay in dealing with Miss P's case was excessive. Under its policy for dealing with its backlog of asylum cases, it should have reached a decision by summer 2011. Instead, Miss P faced a further delay of two years and eight months. After 2011, UKVI should have prioritised her case in line with its policy to help vulnerable applicants, and it failed to respond to her MP's requests for information.

It was likely that if UKVI had concluded Miss P's case in summer 2011, it would have granted her leave to settle in the UK at that stage. We considered that the long delay caused deterioration in her mental health.

Putting it right

UKVI agreed to apologise to Miss P and has paid her £1,000 compensation for the delay in deciding her application and the worsening of her mental health that this caused.

Organisation we investigated

UK Visas & Immigration (UKVI)

Summary 488/November 2014

Highways Agency did not use all available evidence to investigate complaint

Mr L's car had been hit by a sign on the M25. He reported it to the Highways Agency and asked it to pay for the damage to be repaired.

What happened

The Highways Agency investigated Mr L's claim, seeking information from its contractors, who were responsible for maintaining that particular piece of road. The investigation was split between the Highways Agency and one of the contractors. The conclusion was that the Highways Agency did not accept the claim. Mr L remained unhappy at the end of the process and so the Independent Complaints Assessor (the ICA), who acts on behalf of the Department for Transport, considered his complaint.

What we found

We partly upheld this complaint.

The splitting of the investigation between the Highways Agency and its contractor meant that the complaint was not handled well. There were a number of problems with the way that the contractor had investigated the complaint. For instance, its appeals procedure did not appear independent and there were errors in correspondence. That caused Mr L confusion, distress and inconvenience.

The Highways Agency did not look to see if there was any CCTV footage available that might have resolved the complaint, and that was a failing in its investigation. It also did not get some, and did not retain other, information useful to its investigation such as whether there were any unscheduled road works being carried out that the sign could have come from. The impact of those failings was that the opportunity to potentially resolve the complaint was lost.

The ICA mistakenly believed that it was the Highways Agency's policy not to use CCTV footage to resolve complaints. It did not identify that the Highways Agency should have looked for relevant CCTV footage as part of its investigation. The Department for Transport accepted responsibility for that, saying that it had not made it sufficiently clear to the ICA how far it should go to satisfy itself whether something is policy or not. Mr L suffered further inconvenience and distress because the complaint was not resolved at the ICA stage.

Putting it right

The Highways Agency and its contractor had already taken some action to improve its complaints processes. At our recommendation the Highways Agency took additional action to ensure that the investigations by its contractors are robust, in particular that it agreed to develop guidance about when it would be appropriate to look for CCTV footage. The Highways Agency also apologised for its, and the contractor's failings and the impact of these on Mr L. It paid Mr L £150 for the confusion, distress and inconvenience that he experienced.

The Department for Transport apologised to Mr L for the ICA's review not picking up the CCTV issue, and agreed to ensure that our findings about the ICA's review are taken into account in its ongoing consideration of how ICA's operate.

Organisations we investigated

Highways Agency

Department for Transport

Healthcare cases

Summary 489/October 2014

Distress of miscarriage was made more upsetting

Mrs E suffered a miscarriage. Her distress was made worse by poor communication and poor record keeping.

What happened

Mrs E was in the early stages of pregnancy when she had some bleeding. She had two scans at the Trust in four days, and staff recorded that she had a threatened miscarriage. Soon after, she passed some tissue that she thought might have been a foetus, and she returned to the Trust.

Trust staff put the tissue in a box and took it away for examination. Staff did not tell Mrs E why they had taken the box. The Trust analysed the tissue and told Mrs E it was tissue associated with a pregnancy, but was not foetal tissue. Mrs E had a scan the following month that showed she had had a complete miscarriage.

Mrs E complained that Trust staff had taken the box without her permission. The Trust said that if it had found foetal tissue, it would have sent this to the mortuary or pathology laboratory, for which it would have got consent. Mrs E was dissatisfied and confused by the complaints process and came to us.

What we found

We partly upheld this complaint. Record keeping was poor. There was no printed record of the findings of one of the scans because it was performed using a portable scanner, so the Trust's response to Mrs E's complaint was not as complete as it could have been. We sought advice from one of our clinical advisers, who felt that the Trust was mistaken in its explanation of the tissue Mrs E gave staff.

Putting it right

The Trust apologised that its response was not as thorough as it should have been because a printed report of the scan result was not available. It also apologised for the inaccuracy regarding the contents of the labelled box.

Organisation we investigated

Pennine Acute Hospitals NHS Trust

Location

Greater Manchester

Region

North West

Summary 490/October 2014

Mistakes in continuing care funding decision

Mr R complained that the Clinical Commissioning Group (CCG) had declined his request for a refund of his legal and personal costs incurred after it wrongly decided that his mother was not eligible for NHS continuing care funding.

What happened

A primary care trust (PCT) assessed Mrs R for NHS continuing care funding in spring 2008. It found she was not eligible for funding. Mr R disagreed with this decision and corresponded with the PCT about this. The PCT agreed to review his mother's eligibility for NHS continuing care with the family's consent.

Mr R next contacted the PCT in spring 2010 about the funding decision. The PCT subsequently reassessed his mother's eligibility for funding in early 2013. It found she could have funding.

In the interim, the local authority issued a summons to Mr R for nursing home fees that had not been paid. Mr R employed a solicitor to deal with this while he was waiting for the PCT to complete the reassessment.

The PCT paid the debt to the local authority once the reassessment was complete. Mr R asked for his solicitor's fees to be paid, but the PCT declined. Mr R complained about this to us.

What we found

We partly upheld this complaint. When it decided whether to reimburse Mr R's costs, the CCG, which took over this case when the PCT ceased to exist, did not consider all the circumstances of his case. We said that it should have taken account of the delay before this case was finished, and the impact this had on Mr R. Although we would not usually expect CCGs to compensate people for the time they spent on an appeal against an NHS continuing care cost decision, Mr R experienced exceptional inconvenience.

We could not link the wrong continuing care funding decision and Mr R's legal costs.

Putting it right

The CCG apologised to Mr R and paid him £250 compensation. It also agreed to draw up an action plan to address the failings.

Organisation we investigated

Cumbria Clinical Commissioning Group (CCG)

Location

Cumbria

Region

North West

Summary 491/October 2014

Dental practice provided inadequate care

A dental practice did not address a young patient's dental concerns properly, although she said she was in pain.

What happened

Miss C, a young NHS patient, told her Dental Practice over the course of 16 months that her teeth were causing her pain. Practice staff said that she did not need dental work and should improve her dental hygiene. It took X-rays in winter 2011 to help it decide about treatment but did not repeat these. In spring 2013, Miss C saw the Dental Practice again and staff gave her the same information and did not take any X-rays. Some four days later, Miss C went to an emergency dentist in severe pain. The emergency dentist found extensive decay and a need for treatment.

What we found

The X-rays taken in winter 2011 show that Miss C had significant decay that needed treatment. The Dental Practice's failure to identify this and treat Miss C at that time or at subsequent appointments was not in line with established good practice. As a result of these failings, Miss C suffered unnecessary discomfort and distress and her teeth deteriorated much more than if they had been treated.

Putting it right

The Dental Practice wrote to Miss C to acknowledge and apologise for the failings. It developed an action plan to ensure this could not happen again. The Dental Practice paid Miss C £500 in compensation for the distress she suffered and the probable additional costs of future dental care.

Organisation we investigated

A dental practice

Location

East Sussex

Region

South East

Summary 492/October 2014

Woman developed severe pressure sore while in care home run by BUPA

Mrs F, who was in a care home, developed a red area on her hip. The red area developed into a severe pressure sore that needed hospital treatment.

What happened

Mrs F was at high risk of developing a pressure sore. She had a red area on her hip following a fall and staff called a GP to the care home. The GP thought it was an abscess. However, the wound deteriorated and hospital staff saw Mrs F at an outpatient appointment. A doctor decided she had a pressure sore.

Care home staff subsequently did not take appropriate action and the pressure sore deteriorated to grade 4, which is very severe. This was distressing for Mrs F and she had to go into hospital. She was eventually discharged to a different care home.

What we found

We partly upheld this complaint. Mrs F's wound should have prompted care home staff to take further action. The care home had not addressed fundamental issues about the assessment, prevention and management of pressure sores. Nursing staff needed more education and training in this fundamental aspect of care.

We found no fault in other aspects of Mrs F's care.

Putting it right

BUPA put systems in place to monitor the result of any education and training that it gave nursing staff about pressure sore management.

BUPA apologised to Mrs F's daughter and acknowledged its mistakes.

Organisation we investigated

Bupa Care Homes (CFHCare) Ltd

Location

Merseyside

Region

North West

Summary 493/October 2014

Patient's concerns could not be investigated because his records had been destroyed

Mr A's complaint about the care he received in A&E could not be independently investigated because the Trust had destroyed the A&E records.

What happened

Mr A went to hospital after he fell over. Staff told him to go to a nearby hospital to be seen by the maxillofacial team, who treat injuries to the mouth and jaw, as they suspected that he would need specialist treatment.

Mr A went to the second hospital, where he recalls he waited for over an hour to be seen. He was moved to the minor injuries unit but had to wait another hour before he was assessed by a maxillofacial doctor. The doctor told him it was too late to save one of the teeth that had come out. Mr A told staff about other injuries and had a dental X-ray but it appears that he was discharged without further treatment.

Mr A complained to the Trust about his care and treatment, and came to us when he was not satisfied with the Trust's response.

The Trust told us that the records of Mr A's visit to hospital had been destroyed. This made a robust investigation impossible as we did not have any evidence other than Mr A's recollection and that of the doctor to consider.

What we found

We upheld Mr A's complaint about the Trust because its failings denied him the opportunity of resolving his concerns through the NHS complaints process. As a direct result of the destruction of the records, we could not carry out a robust investigation. However, we were pleased to note that the Trust has changed its policy and this should prevent similar situations happening again.

Putting it right

The Trust apologised to Mr A and paid him £500 to acknowledge that its failure to provide us with the records had denied him the opportunity to have his care comprehensively reviewed independently.

Organisation we investigated

South Devon Healthcare NHS Foundation Trust

Location

Devon

Region

South West

Summary 494/October 2014

Dental practice handled complaint poorly

Mr P was unhappy that he could not get a dental appointment within a month. He could not speak to the dentist, and the Practice manager then sent him a letter to say he should find another dentist. Mr P complained to the Dental Practice's head office.

What happened

Mr P telephoned the Dental Practice and spoke to a receptionist. He explained he was not in pain but was worried about a leaking filling. He was unhappy about the offer of an appointment a month later. He asked to speak to his dentist for reassurance and was concerned when this was refused. He said staff told him he would have to pay £17.50 if he wanted to speak to his dentist on the phone.

Mr P discussed his concerns with the Practice manager. She later wrote to him and said patient trust was a vital part of any treatment and without it, treatment could be compromised or not work. For this reason, she felt it was in Mr P's best interest to find another dentist. Mr P was upset but did so promptly.

Mr P complained to the Dental Practice's head office. Staff explained that a dentist can refuse to treat a patient if there has been a breakdown in the relationship. The relationship with Practice reception staff and the Practice manager had broken down, and they are an essential part of the Practice team. Head office staff told Mr P that the dentist would have seen him if it had been possible, but all his time was booked. They spoke to the dentist, who said he would have given Mr P the same information the receptionist had. Head office staff said Mr P would not have been charged to speak to a dentist, but would have been charged for a telephone consultation or to see the dentist.

Mr P remained unhappy and rang the head office a number of times but received no response. He also wrote two letters, which head office staff did not acknowledge or respond to. We asked the head office about this, and staff agreed that they should have called Mr P and that they neither acknowledged nor fully responded to his letters. They explained they would stop this happening again by setting formal reminders in its system. The head office asked us to pass on its apologies to Mr P and offered to pay him £50 in recognition of the frustration he experienced.

What we found

The Dental Practice's offer of the next available appointment was reasonable. The decision to ask Mr P to find a new dental practice was in line with NHS regulations.

The head office's explanations about the issues raised were reasonable. However, there were failings in its handling of Mr P's complaint so we partly upheld his complaint to us.

We considered that the head office's acknowledgement and apology, along with its actions, were reasonable but we felt that the head office should write to Mr P to apologise and give him more information about this.

Putting it right

The Dental Practice's head office wrote to Mr P and apologised that it did not acknowledge or respond to his letters and phone calls. It paid Mr P £50 for the frustration he suffered.

Organisation we investigated

A dental practice

Location

Bristol

Region

South West

Summary 495/October 2014

Dying woman did not get adequate pain relief and a trust did not fully acknowledge failings in care

Miss L complained about the care provided to her mother, Mrs M, by two Trusts. She was unhappy about the delay in diagnosing cancer and about poor nursing care, which distressed Mrs M and her family.

What happened

Mrs M was seen and treated by two Trusts. The first Trust investigated her symptoms and worsening health over several months but did not diagnose cancer. It discharged her. Mrs M went to the second Trust shortly after, and was diagnosed with advanced lung cancer. The second Trust discharged her to a hospice, where she died.

Miss L complained about a delay in diagnosing her mother's lung cancer at the first Trust. She said this meant that Mrs M did not get palliative care as soon as she should have.

Miss L complained that the second Trust provided inadequate nursing care during the last week of Mrs M's life. As a result, Mrs M suffered unnecessary pain and discomfort. This caused Mrs M's family further distress.

Miss L also complained that both Trusts failed to address her complaints about the care provided for her mother.

What we found

We partly upheld this complaint. There were no failings in the first Trust's care or complaint handling.

There were failings in the nursing care given to Mrs M at the second Trust. As a consequence of this, Mrs M suffered unnecessary, pain, distress and loss of dignity. Her family was distressed when they witnessed this.

The second Trust failed to identify, acknowledge and apologise fully for these failings, which caused Miss L further frustration and distress.

Putting it right

The second Trust acknowledged and apologised fully for the identified failings in care and paid Miss L £1,000 to recognise the distress caused.

It drew up an action plan to address the failings.

Organisations we investigated

Bradford Teaching Hospitals NHS Foundation Trust (first Trust)

Leeds Teaching Hospitals NHS Trust (second Trust)

Location

West Yorkshire

Region

Yorkshire and the Humber

Summary 496/October 2014

A GP investigated symptoms appropriately, but did not follow prescribing guidelines

Mr B complained that his GP should have referred him for hospital investigations sooner, which might have prevented the acute onset of debilitating neurological symptoms he suffered soon after. He also complained that the GP did nothing but prescribe ibuprofen.

What happened

Mr B went to the GP soon after he began to experience mild neurological symptoms. In the next two months, he went twice more for the same reason. The GP prescribed non-steroidal antiinflammatories and arranged an X-ray, which Mr B had shortly before going on holiday. Mr B became acutely ill while abroad and was hospitalised. He returned to the UK where he suffered DVT and pulmonary emboli, underwent surgery and remained in hospital for four months.

What we found

We partly upheld this complaint. The GP could not reasonably have foreseen the sudden onset of Mr B's neurological symptoms and should not have referred Mr B for investigation earlier than he did.

However, the GP contravened NICE guidelines by prescribing three non-steroidal anti-inflammatories simultaneously, and did not take measures to protect Mr B's stomach.

The GP's record keeping was inadequate, but the CCG had already put measures into place to remedy this.

Putting it right

The GP underwent further training on prescribing and apologised to Mr B.

Organisation we investigated

A GP practice

Location

West Yorkshire

Region

Yorkshire and the Humber

Summary 497/October 2014

Trust's clinical management was appropriate but there were shortcomings in nursing care

Mr B complained about clinical management, nursing care and staff attitude during his wife's final hospital admission.

What happened

Mrs B had several serious chronic conditions, including kidney failure and inoperable cancer. She went into hospital in severe pain. Trust staff planned to stabilise her so she could have treatment, but she died two days later.

What we found

We partly upheld this complaint because we did not find fault in all of the areas Mr B complained about.

The Trust did not make sure that Mrs B had sufficient fluids, and staff did not adequately monitor her fluid intake.

Although there were shortcomings in basic care, the Trust acknowledged these and took steps to rectify them.

The attitude of some ward staff was inappropriate but the Trust apologised for this and took steps to address the problem. We did not find that the doctor who spoke to the family shortly before Mrs B died was disrespectful.

Putting it right

The Trust apologised for failings in fluid monitoring and making sure that Mrs B had sufficient fluids.

Organisation we investigated

University Hospitals Coventry and Warwickshire NHS Trust

Location

West Midlands

Region

West Midlands

Summary 498/October 2014

A GP did not change his consulting style for a patient with a learning disability

Mr K went to a GP appointment with his brother, Mr L. Mr K said the GP would have missed important information had he not been there, because he did not allow for Mr L's learning disability.

What happened

Mr K's brother, Mr L, had long-standing gastrointestinal symptoms that had been investigated, but no cause could be found. Mr K took Mr L to the Practice when his symptoms got worse, and saw a GP. This was the first and only time that this GP saw Mr L. The GP said recent tests had shown nothing sinister and focused instead on whether Mr L was eating enough. A week later, a GP who had seen Mr L frequently referred him urgently to hospital. He died of cancer three months later.

What we found

With a different approach, the GP who saw Mr L once could have found out more about his symptoms and considered them more seriously. This GP did not change his consulting style to allow for Mr L's learning disability and did not follow NICE guidance about referring patients for suspected cancer.

Putting it right

The Practice apologised to Mr K and the GP had more training to improve how he interacts with patients with learning disabilities.

Organisation we investigated

A GP practice

Location

Manchester

Region

North West

Summary 499/October 2014

Mistakes and complaint handling delays led to payment

Mr D's application for continuing care funding was turned down and he believed that NHS England, who made the final decision on it, had not dealt with the application properly or reached the correct decision. Mr D asked us to look into what had happened.

What happened

Mr D applied for continuing care funding for his wife, Mrs D. His application was turned down. NHS England upheld the decision to refuse the funding. Mr D complained to us that NHS England did not interpret Mrs D's needs correctly. The local clinical commissioning group (CCG) had been involved in the application.

What we found

We partly upheld this complaint. NHS England had dealt with Mr D's continuing care application correctly, so we did not uphold this part of the complaint.

However, the CCG had made mistakes earlier in the process. Although the CCG had acknowledged and apologised for these, we felt that it should provide a more tangible remedy. The CCG agreed to this, so we upheld this part of the complaint.

Putting it right

The CCG paid Mr D £200 compensation to recognise the failings and the inconvenience it had caused him.

Organisations we investigated

Bristol Clinical Commissioning Group (CCG)

NHS England Clinical Commissioning Board

Location

Bristol

Region

South West

Summary 500/October 2014

Wrong diagnosis led to three years of unnecessary steroids

Mrs M was wrongly diagnosed with lupus. She took steroids for this for three years while the Trust carried out more investigations. Her correct diagnosis of fibromyalgia was found and treated by a different trust.

What happened

Mrs M's GP referred her to the first Trust's rheumatology department in summer 2010 after she reported long-standing joint pain in her knees, hips and lower back. The GP's referral letter included recent blood test results that showed antibodies which can indicate lupus. This is a complex and poorly understood autoimmune condition that affects many parts of the body. The GP had not found any features of lupus and had therefore requested specialist input.

The first Trust arranged further investigations. Trust staff saw Mrs M relatively frequently over the next three years, during which time the first Trust continued to prescribe steroids for lupus. However, the first Trust's tests had borderline results that were open to interpretation.

While she was under the first Trust's care, Mrs M was also prescribed another medication that her GP stopped three months later because of abnormal liver test results. The first Trust acknowledged this was prescribed to her in error and was intended for another patient. It apologised for the mistake.

In summer 2013, Mrs M was still in pain so she asked her GP for a referral for a second opinion. She went to the second Trust in autumn 2013, and staff there diagnosed her with fibromyalgia (a long-term condition that causes widespread pain). The second Trust told Mrs M that there was no suggestion she had lupus and told her about steps she could take to improve her symptoms. Mrs M told us that her joint pain improved once she stopped taking the medication prescribed by the first Trust.

What we found

It was unreasonable for the first Trust to have diagnosed Mrs M with lupus because she did not have the clinical indicators for this condition. The medication the first Trust prescribed her for lupus was therefore unnecessary, although it was unlikely to have had any long-term impact.

We also found that the first Trust had already acknowledged prescribing a drug in error and we were satisfied with the actions it took to resolve this concern.

Putting it right

The Trust wrote to Mrs M to acknowledge its failing and apologise for it. It paid her £2,000 to recognise its misdiagnosis, failure to provide a correct diagnosis and lack of symptomatic relief in the three years that she was under its care.

The Trust drew up an action plan to show that it has taken steps to prevent similar failings happening again.

Organisation we investigated

Cambridgeshire Community Services NHS Trust

Location

Cambridgeshire

Region

East

Summary 501/October 2014

Doctor gave inadequate regard to lasting power of attorney

Mrs P had a lasting power of attorney that gave her authority to make decisions on her mother, Mrs Q's, behalf. She complained that a doctor pressured her into agreeing that her mother could be moved to another hospital for emergency treatment when this was against Mrs Q's wishes.

What happened

Mrs Q had dementia. In summer 2012, she was in a community hospital after a bout of diarrhoea. Blood tests showed that she had high potassium levels, which is a medical emergency. Nursing staff consulted an out-of-hours GP, who was employed by Harmoni, an organisation that provided out-of-hours services to the NHS. The out-of-hours GP said that in order to be successfully treated, Mrs Q should be transferred to a different hospital. Mrs P, who had a lasting power of attorney to make health and welfare decisions on Mrs Q's behalf, was adamant that she did not wish Mrs Q to be moved from the community hospital and treated for her acute condition. She explained to the out-of-hours doctor that this was not what Mrs Q would have wanted and that she wanted her mother to have palliative care only.

After she saw Mrs Q, the out-of-hours GP explained that Mrs Q's condition was reversible and she discussed the treatment options with Mrs P. She explained that the situation was a medical emergency but that treatment could only be given at a different hospital. After a lengthy discussion, the out-of-hours doctor took legal advice about her preferred decision to arrange Mrs Q's transfer for treatment. Mrs P was then led to believe that her lasting power of attorney did not apply to the decision and she reluctantly agreed that Mrs Q could be transferred to a different hospital for treatment. While at this hospital, Mrs Q had a fall and died a few days later. Mrs P complained that, despite her lasting power of attorney, the out-of-hours GP intervened to arrange hospital treatment contrary to her wishes. She said that she was pressured into agreeing to this, and her mother's previously expressed wishes were overridden.

Mrs P also complained that the NHS England local Area Team, which commissioned the out-of-hours service, did not take her complaint seriously.

What we found

We partly upheld the complaint because we found no fault in how the local Area Team dealt with Mrs P's complaint.

We upheld Mrs P's complaint about Harmoni, which is now part of Care UK. The lasting power of attorney made Mrs P her mother's legal proxy in relation to the decision in question.

The out-of-hours GP told us that she felt that the decision made was in Mrs Q's best interests. She did not think that she had pressured Mrs P into making the decision and she believed that they had reached a consensus.

However, after we looked at all the evidence, we concluded that the out-of-hours GP did not take account of the authority given by the lasting power of attorney. Moreover, in reaching a view about what was in Mrs Q's best interests, the out-of-hours doctor focused on the clinical issues. She did not think about other factors, including what Mrs Q's legal proxy, in this case, her daughter, told her was what Mrs Q would have wanted.

Putting it right

Care UK, which took over Harmoni in winter 2012, apologised for the failings and paid compensation for the injustice that Mrs P suffered. It also drew up plans to learn lessons from the failings.

Organisation we investigated

Care UK (formerly Harmoni)

Location

Worcestershire

Region

West Midlands

Summary 502/October 2014

Family distressed by trust's poor record keeping and complaint handling

Mr F was very ill when he went into hospital at the Trust. Ms F, Mr F's sister, complained that the Trust did not discuss his treatment appropriately, and that its poor care and treatment caused his death. We found failings in record keeping and complaint handling.

What happened

Mr F was extremely ill with cancer when he was admitted to hospital, where he died. It was unclear from the medical records if the Trust was giving palliative care or actively treating Mr F.

The Trust acknowledged it did not complete a treatment escalation plan or take the opportunity to discuss its approach with Mr F or Ms F. This would have given them the opportunity to discuss possible treatments Mr F may have benefited from.

Mr F's medical records indicated that staff did not treat his sodium and electrolyte levels. The Trust admitted that it had missed these when it treated him.

Ms F complained about the way the Trust handled her complaint. The Trust did not identify all of the shortcomings we found, and there were failings in documentation.

What we found

We partly upheld this complaint. While there were no failings in most of Mr F's care, it was unreasonable that Trust staff did not treat his sodium and electrolyte levels.

The documentation, including the failure to complete a treatment escalation plan, and the lack of discussion about palliative care, was also inappropriate. We concluded that the failings we identified were unlikely to have caused Mr F's death. However, as the failings were serious and needed to be addressed, we asked the Trust to take certain steps to put things right.

The Trust's responses to Mrs F's complaint did not acknowledge these failings. For that reason, we found failings in the way the Trust handled this complaint.

Putting it right

The Trust created action plans to address the failings in the care and treatment it gave Mr F. The failings included not completing a treatment escalation plan form, poor documentation and failings in complaint handling.

Organisation we investigated

South Devon Healthcare NHS Foundation Trust

Location

Devon

Region

South West

Summary 503/October 2014

GP and acute trust failed to diagnose cancer

Mrs W complained that she had gone to her GP and A&E at the Trust regularly but they did not properly investigate her symptoms. She was later diagnosed with cancer.

What happened

Mrs W went to her GP Practice and saw four different doctors over a two-year period. During this time, the Practice missed seven opportunities to arrange for her symptoms to be fully assessed and did not act on abnormal blood results. When it finally referred Mrs W to hospital, the Practice did not give enough information on the referral and so the Trust did not treat it as urgent.

Mrs W went to A&E five times in a five-month period. On the first two occasions, staff assessed her properly, but they should have done more at the next three visits to find out what was wrong and what was causing Mrs W's ongoing pain.

What we found

The Practice should have taken a better history, followed up test results and carried out further blood tests. The GPs should have reviewed Mrs W's previous visits each time they saw her and should have made a detailed referral to a specialist.

The Trust should have taken more action on Mrs W's third visit to A&E. When Mrs W went to A&E for the fourth time, the doctor should have noted and acted on symptoms that could have indicated a more serious problem. After Mrs W's fifth visit, staff should have arranged urgent scans.

The delay in diagnosis caused Mrs W pain and anxiety. Although it has not shortened her life, some of her symptoms are irreversible and she may have permanent pain.

Putting it right

The Practice produced an action plan to identify what had gone wrong and what needed to happen to stop this happening again. The Practice paid Mrs W £5,000 to compensate her for the poor outcome caused by the delays in getting appropriate treatment, and £140 to refund the cost of a private consultation she paid for when the Practice did not arrange appropriate investigations. The Practice also apologised to Mrs W.

The Trust apologised to Mrs W. It also produced an action plan to identify what had gone wrong and what needed to happen to prevent a recurrence. The Trust paid Mrs W £1,000 to compensate her for the pain and mental distress she suffered, as well as the failings in care.

Organisations we investigated

A GP practice

East Kent Hospitals University NHS Foundation Trust

Location

Kent

Region

South East

Summary 504/October 2014

No failings in treatment of elderly patient

Mrs S had a fractured hip and multiple illnesses. She went into hospital, where she died two weeks later. The Trust gave her good care throughout.

What happened

Mrs S, who had a history of chronic obstructive pulmonary disease, fell at home and fractured her hip. She was admitted to the Trust and had an operation on her hip. Although the operation was a success, Mrs S did not fully recover and developed kidney problems. Two weeks after she went into hospital, she developed pneumonia and died.

What we found

The Trust assessed, monitored and treated Mrs S appropriately throughout her time in hospital. The care it gave was in line with guidance and recommendations. The Trust appropriately responded to Mrs S's daughter's complaint.

We did not uphold this complaint.

Organisation we investigated

The Newcastle Upon Tyne Hospitals NHS Foundation Trust

Location

Tyne and Wear

Region

North East

Summary 505/October 2014

Although a trust gave satisfactory care, its response to a complaint was delayed and inaccurate

Mrs M complained that her son (Mr M) was not fit for discharge when the Trust sent him home from hospital. Mrs M also complained that there were inaccuracies in the Trust's response to her complaint, and delays in complaint handling.

What happened

Mr M had liver disease. He went into hospital after he had two seizures. Staff sent him home a few days later, but he went back into hospital the same day.

His condition deteriorated and he died two weeks later.

What we found

We partly upheld this complaint. The Trust's decision to discharge Mr M was clinically appropriate. However, it was slow to respond to Mrs M's complaint and some of its responses were inaccurate.

Putting it right

The Trust apologised to Mrs M. It drew up an action plan to address its failings in complaint handling.

Organisation we investigated

North Middlesex University Hospital NHS Trust

Location

Greater London

Region

London

Summary 506/October 2014

GP practice's removal policy was wrong

When a GP practice removed a man from its patient list, it did not act in line with its contract.

What happened

Mrs G had an operation in spring 2013. Her husband contacted the Practice by telephone the next morning at 9.45am to arrange a visit from a district nurse. He heard nothing, so went to the surgery in the early afternoon and discussed his concerns with a receptionist who was unaware of his earlier telephone call. Unfortunately, the receptionist could not arrange a visit because the district nurse had left for the day.

Mr G was unhappy that the Practice could not arrange a home visit. He became upset and, by his own admission, loud from frustration. The Practice manager felt Mr G was intimidating and was becoming aggressive so she asked him to leave and said she would call the police if he did not. Mr G left the building after another staff member asked him to.

The Practice wrote to Mr and Mrs G to tell them that it had removed them from its patient list because of Mr G's unacceptable behaviour. Mr G complained to the Practice. It responded fully to the points he raised and sent him a copy of its removal policy to support its decision.

What we found

We looked at the Practice's removal policy and the procedure it followed when it considered removing a patient from its list. In Mr G's case, it had followed its policy for situations in which staff believed the removal was straightforward because it was the result of, for example, persistent failure to attend appointments or inappropriate behaviour or language.

The Practice's removal policy, however, was not in line with the law that governed the Practice's contract to provide healthcare. The law says that the Practice's removal policy must include an agreement to warn patients before removing them. The Practice's policy did not have this agreement.

The Practice should have acted in line with its contract, which stated that the Practice's policy must include warning patients about a possible removal. There is no evidence that the Practice considered issuing a warning to Mr G. Instead it removed him from its list immediately.

Putting it right

The Practice wrote to Mr and Mrs G to acknowledge that it had not handled their removal properly. It apologised for removing them immediately rather than warning Mr G about his behaviour.

It also reviewed its policies to bring them in line with the relevant laws.

Organisation we investigated

A GP practice

Location

West Midlands

Region

West Midlands

Summary 507/October 2014

Delay in arranging meeting to discuss complaint about delay

Mr J went to A&E because he was suffering chest pains. He had to wait six hours before he saw a doctor.

What happened

When Mr J went to A&E at the Trust, he had to wait a long time to see a doctor. The doctor diagnosed Mr J with an infection and he went home.

Mr J complained to the Trust about how long he had to wait. The Trust apologised and said its A&E department was very busy that day. Mr J was not convinced by the Trust's explanations, and it agreed to arrange a meeting to discuss his concerns. Four months later, the meeting had still not taken place. Mr J was unhappy and complained to us.

What we found

We partly upheld this complaint. It took too long for Mr J to be seen by a doctor in A&E, but the Trust acknowledged this. Its letters to Mr J included a reasonable amount of detail to show that A&E was extremely busy and that it had been taking action to treat patients as quickly as possible. We agreed that this was enough to put things right.

However, the Trust took too long to arrange the meeting with Mr J after he complained, and it had not kept him updated about the arrangements.

Putting it right

The Trust apologised to Mr J for taking too long to organise a meeting to discuss his complaint, and it did not keep him updated about this. It also explained how it will stop this problem from happening again.

Organisation we investigated

County Durham and Darlington NHS Foundation Trust

Location

County Durham

Region

North East

Summary 508/October 2014

Woman distressed by Trust's poor complaint handling

Ms D had several complaints about her gynaecological surgery. She said she did not have enough information before and after the surgery, that she did not know how her arm was injured, and a nurse did not apologise when she did not give good care. Ms D also complained that the Trust took too long over her complaint and did not give her proper explanations or an appropriate remedy.

What happened

Ms D had surgery to remove fibroids. However, because of heavy bleeding after the operation, she was taken back to theatre and doctors removed her womb. During surgery she also suffered an injury to her arm when fluid going into a vein in her arm accidentally went into the soft tissues around the vein.

Ms D first complained to the Trust in winter 2010, and it responded in spring 2011. Ms D told the Trust that she was dissatisfied but it closed the case.

In the following months there were attempts to set up a meeting. Ms D wanted a written response to her concerns before a meeting. The Trust provided a response in autumn 2012, and there was a meeting in spring 2013. The surgeon and the ward sister that Ms D had complained about did not attend the meeting, but it was agreed that they would both apologise to Ms D. The Trust sent its final response to Ms D in summer 2013, acknowledging that the complaint had not been handled well. It enclosed an apology from the ward sister only.

What we found

The Trust was unable to find Ms D's medical file. It could only provide some electronic records and a statement from the surgeon. Because of this, we could not confirm what staff had told Ms D before and after surgery. However, the Trust had not given her an appropriate explanation of what happened. Because the records were missing, the issue was still unresolved, which was an ongoing injustice to Ms D.

The Trust told Ms D about the injury to her arm, and she had an appropriate apology from the ward sister. The complaint process was overlong, however, and the Trust should have tried to arrange a meeting with Ms D very much earlier, rather than closing the complaint in spring 2011.

The Trust had never told Ms D why doctors needed to remove her womb, although she had specifically asked for an explanation. We considered it was very unfortunate that neither the surgeon nor the ward sister attended the meeting, and that it was wrong to offer an apology from the surgeon when he was not there. The Trust did not tell Ms D why there was no apology from the surgeon.

The Trust was wrong to say it could not offer financial compensation for the poor complaint handling that it had already acknowledged.

Putting it right

Following our investigation, the Trust explained to Ms D why doctors had needed to remove her womb.

It apologised for the failings, including the loss of her records, and paid her £750 as compensation for her distress.

The Trust also agreed to put together an action plan to show how it had learnt from its mistakes so that they will not happen again.

Organisation we investigated

Barts Health NHS Trust

Location

Greater London

Region

Greater London

Summary 509/October 2014

Trust delayed progressing IVF treatment within the 18-week pathway

When Mrs B was referred for fertility treatment, the Trust unreasonably delayed this. It also failed to tell her about the progress of her appeal for extra funding when she turned 40 and became ineligible for NHS funded treatment.

What happened

Mrs B was 39 when she was referred to the Trust for fertility treatment. She saw a consultant obstetrician and gynaecologist and had a laparoscopy (a procedure to look at the contents of her abdomen and pelvis). Because of an administrative error, her next appointment was delayed and she did not start her first cycle of treatment until eight months after her referral.

When Mrs B turned 40, she no longer qualified for NHS funded fertility treatment. Her consultant lodged an appeal for extra funding because of the delays, but this was eventually declined. However, he did not tell her this until 16 months later.

What we found

The Trust unreasonably delayed Mrs B's progress through her treatment, but there were no failings in the treatment for a condition she developed.

Communication with Mrs B during her appeal was poor, and the Trust did not handle her complaint in line with the appropriate regulations.

Putting it right

The Trust apologised and paid Mrs B £2,000 to compensate for the failings. It put a plan in place to learn lessons from the failings and make sure they did not happen again.

Organisation we investigated

Royal Cornwall Hospitals NHS Trust

Location

Cornwall

Region

South West

Summary 510/October 2014

Honeymoon disrupted by painful tooth after poor treatment

When Mr J's dentist replaced a temporary filling, he did not remove all of the earlier dressing. This became infected, and Mr J had to interrupt his honeymoon to get treatment.

What happened

Mr J had emergency dental treatment for a temporary filling. He went to the Dental Practice a week later to have a permanent replacement filling put in.

Two months later, while on honeymoon overseas, Mr J had intense pain in the same tooth and went to a local dentist. This dentist removed the permanent filling and found a cotton wool dressing underneath. This had been left behind when Mr J's dentist put the permanent filling in the tooth. The cotton wool dressing had become infected, causing Mr J's pain. Mr J had to pay for treatment and medicine abroad, and he also suffered pain and disruption on his honeymoon.

Mr J complained to the Dental Practice because he thought that the cotton wool dressing was left behind when the dentist at the Practice put in the permanent filling. The Practice said this was not the case, and that the emergency dentist must have left the cotton wool dressing in place.

What we found

We considered it highly likely that the emergency dentist had left the cotton wool dressing in Mr J's tooth, as the Dental Practice suggested.

However, our Adviser explained that when a filling needs to be replaced, it is good practice to remove the whole of the temporary filling before replacing it. The records show that the dentist at the Dental Practice removed part of Mr J's temporary filling before he placed the amalgam filling on top. This is not in line with established good practice.

In failing to remove all of the temporary filling, the dentist at the Dental Practice did not check the work that the emergency dentist had done on Mr J's tooth. Without checking, the dentist at the Dental Practice did not know what the emergency dentist did when putting in the temporary filling.

Putting it right

The Practice paid Mr J £1,100 to acknowledge the failure to provide treatment in line with established good practice, the pain and distress that occurred as a result and the inconvenience of this happening during his honeymoon. It also apologised to Mr J for the failings identified.

Organisation we investigated

A dental practice

Location

Greater London

Region

Greater London

Summary 511/October 2014

Family had no choice but to put vulnerable man with dementia in private care over Christmas

Mr Q was in his seventies and had dementia. He lived at home with his wife, Mrs Q. On Christmas Eve he had several falls and an ambulance took him to A&E.

What happened

Mr Q was discharged from A&E on Christmas Day to a mental health unit run by another Trust. This unit was inappropriate for him and his family took him out and put him in a private care home.

Mr Q became more ill, but his GP did not visit him at the private care home. The care home registered Mr Q with another GP, who immediately visited him. Mr Q went back into the first Trust's hospital that day with pneumonia. Mr Q had spent eight days in the care home. He was in hospital for another six days before he died.

What we found

Mr Q's discharge from A&E was unsafe. The first Trust should not have sent him to the second Trust's mental health unit because it was an unsafe environment for him.

His GP should have visited him at the private care home. There was also evidence of inadequate record keeping by GPs at the Practice.

Putting it right

Both Trusts reimbursed Mrs Q for the cost of private care (half the amount each). They also each paid her £350 to recognise the injustice they had caused her. The GP Practice paid her £150.

Both Trusts and the Practice drew up action plans that showed the lessons they had learnt from Mrs Q's complaint.

Organisations we investigated

A GP practice

Southend University Hospital NHS Foundation Trust

South Essex Partnership University NHS Foundation Trust

Location

Essex

Region

East

Summary 512/October 2014

A&E staff failed to notice a cannula was inserted incorrectly

Mrs B's father, Mr E, was incorrectly discharged from hospital and returned the following day as an emergency. Staff failed to recognise that a cannula had been incorrectly placed, and Mr E lost blood when it was removed. Mrs B said the Trust did not acknowledge its failures in care.

What happened

Mr E went to A&E in winter 2011 with a painful knee and poor mobility. Staff assessed him and discharged him home with pain relief. The next day he returned to A&E because his condition had deteriorated.

Staff put a cannula into Mr E's groin. However, they placed it incorrectly, and did not realise this for some hours. When staff took the cannula out, Mr E bled considerably. His condition deteriorated and he went into the critical care unit, where he died in early 2012. Mr E had had a heart attack and had failing kidneys and a lung infection when he died.

What we found

The Trust's assessment when Mr E first went to A&E was appropriate. However, staff did not consider Mr E's mobility before they discharged him, as they should have. Had staff thought about Mr E's mobility, they would not have sent him home in discomfort to sleep on an inflatable bed in his lounge.

There were failings in how staff placed the cannula and in how they took it out. Wrongly placing a cannula is a known risk, so staff should have seen and acted on this promptly. They did not. It was four hours before anyone noticed the error.

Staff should have checked Mr E carefully once they had discovered the wrongly placed cannula because he was taking medicine that would affect how his blood clotted.

The records of what happened are not clear. There were also delays in completing a serious incident investigation and the Trust handled Mrs B's complaint poorly. At first, it did not acknowledge the fault and it did not fully address the issues Mrs B raised.

Putting it right

The Trust wrote to Mrs B acknowledging and apologising for the failings. It paid her £3,000 to recognise her distress.

It drew up an action plan that set out what it had done or will do to stop the failings happening again.

Organisation we investigated

North Middlesex University Hospital NHS Trust

Location

Greater London

Region

London

Summary 513/October 2014

Trust gave mental health patient too much medication too quickly

Mrs P complained that Trust staff gave her mother, Mrs N, too much antipsychotic medication and this made her almost comatose and caused her to fall, fracturing her spine. Doctors then delayed diagnosing the fracture, leaving Mrs N in pain. The Trust's response to Mrs P's complaint did not acknowledge the poor care provided.

What happened

Mrs N was an inpatient at a psychiatric hospital. She was suffering from distressing hallucinations, and staff prescribed an antipsychotic medication to reduce her distress. Doctors prescribed an initial low dose, and then increased this later the same day. After she had the first dose, Mrs N became drowsy and sleepy and seemed sedated. A nurse asked a doctor whether to give Mrs N the second dose despite her condition. The doctor said that if Mrs N was drowsy or sleeping, she should not have the second dose; but if she awoke distressed by her hallucinations, she should be given the medication. Mrs N's distress continued and staff gave her the second dose in the evening.

Early the following morning, Mrs N fell while getting out of bed. Staff documented some injuries and sent Mrs N to hospital for a pelvic X-ray. This did not show a fracture, but revealed another potential (unrelated) problem. Mrs N then had a bone scan, which also did not show a fracture. Two days later, Mrs N had a CT scan, which showed she had a fractured vertebra in her lower spine.

When Mrs P complained, the Trust said that staff gave Mrs N necessary and appropriate medication and this could not account for her overall deterioration. It said there was no delay in diagnosing the fracture.

What we found

While it was appropriate to give Mrs N the antipsychotic medication, the prescription was for too much too quickly. Mrs N should not have had the second dose so soon, and especially not because she was experiencing side effects from the first dose.

The prescription was for an unlicensed use of the medication. This is common and reasonable in psychiatry but doctors should give the patient clear information about this before they give the medication. No one gave Mrs N such information. We could not say, however, that the medication caused Mrs N to fall.

There was no delay in diagnosing Mrs N's fracture. Although she had clearly suffered injury as a result of falling, those injuries did not include the fracture, which could have occurred either significantly before, or several days after, her fall.

When it responded to Mrs P's complaint, the Trust should have acknowledged that staff had given Mrs N too much medication too quickly, and that the medication was used off-label, and that Mrs N had not had all the information she needed.

It did not do this, and it told Mrs P it would take no further action on her complaint. This was inappropriate, given the clear failings it should have identified.

Putting it right

The Trust acknowledged and apologised for its failings, and paid Mrs P £1,750 compensation. It agreed to draw up an action plan showing learning from mistakes to prevent the same mistakes happening again.

A doctor involved agreed to discuss what had happened with the person responsible for his revalidation.

Organisation we investigated

Dudley and Walsall Mental Health Partnership NHS Trust

Location

West Midlands

Region

West Midlands

Summary 514/October 2014

Dental practice did not explain why it removed a patient from its list

A dental practice did not follow its own procedures when it dealt with a situation that led to a breakdown in its relationship with Mr Z. It compounded this failing with poor complaint handling.

What happened

Soon after a consultation with his Dental Practice, Mr Z had a letter from the Practice telling him that it was no longer willing to offer him treatment because of a breakdown in communication.

Mr Z had been happy with the treatment from his Practice so he complained and asked for a more detailed explanation of the reasons for his removal from the Practice. Although it had several opportunities to give Mr Z more detailed information, the Practice did not do so and simply repeated that there was a breakdown in the relationship.

Mr Z subsequently took his complaint to NHS England which, initially, did not uphold his complaint. After further correspondence, NHS England agreed to look into the complaint again and, after investigation, took the unusual step of reversing its previous decision. It upheld the complaint on the basis of poor complaint handling, noting that it had taken the Practice some significant time to give NHS England the information and explanations that Mr Z sought. NHS England recommended the Practice apologise to Mr Z and make a financial remedy of £500.

Mr Z subsequently contacted us when he received no contact from the Practice to suggest that it would comply with NHS England's recommendations.

What we found

The Practice followed the requirements of its contract in issuing Mr Z with a notice of his removal from its list. The Practice was also within its rights to request payment for treatment in advance. Equally, although Practice staff statements about Mr Z's alleged inappropriate behaviour were not written until some eight to nine months after the alleged incidents, we could not challenge these and could not uphold the part of the complaint that related to Mr Z's removal from the Practice's list.

However, the Practice did not follow its own internal process for dealing with incidents where the patient/Practice relationship was in danger of irrevocable breakdown. The Practice had not given Mr Z, in its complaint response, the more detailed reasons that he wanted for his removal from the Practice list. It had the opportunity to do so on a number of occasions.

This was a failing by the Practice that caused Mr Z distress in seeking the explanations he wanted. He had had to escalate his complaint to NHS England, which was inconvenient.

Putting it right

The Practice apologised to Mr Z for the distress caused by these failings and paid him £250.

Organisation we investigated

A dental practice

Location

Derbyshire

Region

East Midlands

Summary 515/October 2014

A hospital did not think about the needs of woman with learning disabilities and Down's syndrome

Ms G, who had learning disabilities and Down's syndrome, developed pneumonia. She could not swallow and Trust staff had difficulty helping her to eat. Trust staff decided that admitting Ms G to intensive care and attempting resuscitation in the event of a cardiac arrest would be futile because of her poor condition. Ms G's family strongly disagreed and thought that the doctors were discriminating against Ms G on the basis of her disabilities.

What happened

Ms G, an adult who lacked the capacity to make decisions about her own care and treatment, went into hospital with pneumonia. Staff found she could not swallow safely because of the high risk of fluid or food going into her lungs. Clinicians fed her through a tube in her nose but she repeatedly pulled this out. Staff tried another way of feeding Ms G, but this was unsuccessful.

Doctors made the decision that Ms G's condition was so poor that admitting her to intensive care and attempting resuscitation in the event of a cardiac arrest would be futile. Ms G continued to receive care and treatment on a ward but her condition did not significantly improve. Ms G's family disagreed with the decisions not to escalate Ms G's care and a meeting was held between them and the doctors but no agreement was reached. Following this meeting a third method of feeding (a radiologically inserted gastronomy) was attempted but Ms G suffered a recognised complication of this procedure (a perforated bowel) and died shortly after.

Ms G's family complained that the care and treatment the Trust provided was inadequate.

What we found

We found service failure in the management of Ms G's nutrition because the hospital missed opportunities to employ strategies that might have helped her accept the tube feeding, and took no proactive steps to make it work. We concluded that this caused her distress and discomfort that might otherwise have been reduced.

There was service failure in the Trust's assessment of Ms G's needs and its communication with her family and carers. The Trust did not develop a person-centred care plan and did not work in partnership with her family and carers. We decided that this led to her being unhappy and frightened to a greater extent than she might otherwise have been.

We also found that the Trust failed to follow the correct process when making decisions about Ms G's best interests. This did not mean that those decisions were wrong, that Ms G was treated less favourably because she had learning disabilities, or that the outcome is likely to have been different. However, because Trust staff did not follow the correct process, Ms G's family were excluded from the decision-making process and were denied the opportunity for an independent decision about her best interests while she was still alive.

Putting it right

The Trust acknowledged the failings we identified, and apologised for them. It paid Ms G's sister £2,500 to acknowledge the distress she and her family suffered.

It agreed to prepare an action plan that ensured that lessons have been learnt.

Organisation we investigated

Croydon Health Services NHS Trust

Location

Greater London

Region

London

Summary 516/October 2014

GP's diagnosis without assessment delayed treatment

Mrs N complained that poor care and treatment by a GP contributed to her mother's painful and premature death.

What happened

Mrs M (Mrs N's mother) had dementia, took blood thinning medication and had a history of urinary tract infections (signs of which included agitation). She had recently moved to a care home and changed her GP to a local practice.

Mrs M became agitated a few weeks after moving to the home and staff called her new GP. The GP did not visit the home or examine Mrs M, but prescribed quetiapine – an antipsychotic drug. Mrs M continued to deteriorate. The care home staff reported that she was bleeding from her mouth, and had poor mobility and a reduced appetite. A GP visited but could not see any fresh blood. He reduced her quetiapine. A few weeks later, the care home staff came to wake her and she had momentarily stopped breathing. Staff called an ambulance and Mrs M went to hospital. Mrs M died the following day of sepsis and a urinary tract infection.

What we found

The GP should not have prescribed Mrs M quetiapine without assessing her condition, history or circumstances. The GP should have arranged for a blood test when the care home staff reported seeing blood in Mrs M's mouth. Additionally, because there was no proper assessment when Mrs M was initially agitated, we cannot know whether Mrs M had an infection at the time. As such, there was a missed opportunity to accurately diagnose her. If the GP had completed a proper assessment and diagnosed Mrs M with a urinary tract infection, the correct treatment could have started.

Putting it right

The GP acknowledged her failings and apologised to Mrs N. The Practice drew up plans that showed what staff had learnt from the failings we identified, and what it would do to make sure that staff were up to date with current guidelines about medication.

Organisation we investigated

A GP practice

Location

Kent

Region

South East

Summary 517/October 2014

Complaint response was confusing

Mr P complained to us about care and treatment he received, which he felt caused damage to his eye. He did not understand the Trust's response to his complaint.

What happened

Mr P had an operation on his eye. He was worried that this had caused permanent damage. He was also concerned that the treatment from one doctor was different to the treatment that he had from another doctor soon after. He complained to the Trust, which answered his complaints. However, parts of its response were confusing and it did not answer all his concerns.

What we found

We partly upheld this complaint. The Trust's care and treatment of Mr P were appropriate. However, we agreed that the Trust's response to Mr P's complaint did not answer all of his concerns, and part of the response was confusing and had caused unnecessary worry.

Putting it right

The Trust apologised for the confusion caused.

Organisation we investigated

The Princess Alexandra Hospital NHS Trust

Location

Essex

Region

East

Summary 518/October 2014

Patient received poor nutritional and pain care

Ms C, Mr B's niece, complained to the Trust that her uncle received poor care and treatment for his gangrenous toe, and had poor nutritional care and pain management. She was also unhappy about its communication with her.

What happened

Mr B was 79 years old and had multiple medical problems, including severe vascular dementia, a disease caused by reduced blood supply to the brain, and diabetes. Mr B developed gangrene in two of his toes, and went into hospital. Doctors prepared him for surgery, but later decided not to operate. They prescribed antibiotics and discharged him.

Mr B went back into the hospital a week later with the same problem. Doctors again prepared him for surgery, but again decided not to operate. They wanted to try to avoid surgery because Mr B was a high-risk surgical patient, and was likely to have a poor outcome. Over the following weeks, Mr B's condition worsened, and he appeared to be in pain. Doctors subsequently amputated Mr B's leg above the knee to try to control his pain. Mr B's condition deteriorated, and he died.

What we found

We partly upheld this complaint. There were failings in the nutritional care the Trust gave Mr B and also in the way it managed his pain and distress. This meant the Trust missed opportunities to plan and deliver appropriate care. We could not establish that the Trust met Mr B's nutritional needs during his first admission, and he may have suffered unnecessary pain and distress. This was upsetting and distressing for Ms C.

There were some significant shortcomings in the Trust's communication with Ms C about her uncle, and these made her feel extremely frustrated and upset.

The care and treatment the Trust provided for Mr B's foot were in line with established good practice.

We also identified some serious shortcomings in the Trust's complaint handling, but did not find that these amounted to maladministration.

Putting it right

Following our report, the Trust wrote to Ms C to acknowledge the failings in nutritional care, pain management, and communication, and to apologise for the impact of these. It also paid her £500 compensation, and agreed to update its action plan to make sure it had learnt lessons from these failings.

Organisation we investigated

West Hertfordshire Hospitals NHS Trust

Location

Hertfordshire

Region

East

Summary 519/October 2014

Trust failed to give necessary medication

Mr E complained about the care and treatment the Trust gave his father when he was admitted with complex medical needs. Mr E was unhappy about his father's weekend care, specialist input, medication and nutrition, and the attitude of a nurse towards his mother when she raised concerns.

What happened

Mr E's father went into the Trust's hospital from intensive care at another trust with complex conditions including meningitis, encephalitis and ventilator acquired pneumonia. Mr E's father remained very unwell and was transferred to a medical centre at yet another trust for a neurological procedure to relieve pressure on his brain a week later. He returned to the Trust to continue his recovery.

What we found

We partly upheld this complaint. On both of his admissions to the Trust (which occurred over weekends) Mr E's father was properly assessed and received the specialist input he needed. We did not consider that Mr E's father was adversely affected because he was admitted over a weekend.

Mr E's father had complex needs which affected his nutritional intake but we did not find failings in the nutritional support provided by the Trust.

There were failings in the medication given by the Trust. Because of problems eating, Mr E's father did not receive thyroid medication he was prescribed and he missed important antiseizure medication for five days. While Mr E's father was not harmed by the lack of thyroid medication, he had a seizure as a result of missed medication and the seizure resulted in aspiration pneumonia.

Our investigation also identified failures in record keeping at the Trust and our investigation was delayed when the Trust lost key documents, which it later found.

Putting it right

The Trust apologised to Mr E's family for the incomplete prescription charts and the failures in record keeping.

It drew up an action plan that set out how it would stop the same things happening again.

Organisation we investigated

Sherwood Forest Hospitals NHS Foundation Trust

Location

Nottinghamshire

Region

East Midlands

Summary 520/October 2014

Trust did not keep clear records or appreciate risk

Mr S had a history of depression and had had previous psychiatric inpatient stays. During an inpatient stay, the Trust did not keep clear records that showed his clinician's working diagnosis and treatment plans. It also did not properly appreciate how risks to him changed as his mental health deteriorated.

What happened

Mr S had a history of depression and previous psychiatric admissions. He went into hospital at the Trust voluntarily after he had taken an overdose with the intention of killing himself. Although he initially responded to treatment plans put in place, his mental health started to deteriorate. He told the health care professionals involved in his care about his deterioration.
A few days after an incident when he was on unescorted leave from the hospital, Mr S's leave was changed to escorted leave. Shortly after, he left the hospital alone and took his own life.

What we found

We partly upheld this complaint. Record keeping was inadequate because it was not clear what Mr S's working diagnosis was from the records alone. The Trust had also failed to appreciate the increased risk to Mr S.

We did not find that these shortcomings affected Mr S's care.

Putting it right

The Trust agreed to complete an action plan to prevent the failings occurring again.

Organisation we investigated

Lancashire Care NHS Foundation Trust

Location

Lancashire

Region

North West

Summary 521/October 2014

Older woman died from treatable condition

Mrs D and Mr E complained that omissions in care by a GP practice caused their mother Mrs H's premature death. Their mother's death caused them considerable distress. Mrs D and Mr E wanted the GP Practice to acknowledge and apologise for the omissions in care, and wanted action to prevent similar failings from happening again.

What happened

Mrs H, who was in her nineties, was frail with several health conditions. She was essentially housebound. A GP visited early in 2013 after Mrs H developed jaundice and said that Mrs H needed further investigations in hospital or elsewhere to find out why she was jaundiced. He suspected she might have cancer. Mrs H declined further investigations.

The doctor requested blood tests to be carried out at home. These showed abnormalities and Mrs H was referred on an urgent basis to the jaundice clinic. Mrs H's condition continued to deteriorate and Mrs D asked for a home visit shortly after.

Another GP at the Practice spoke to Mrs H and decided to visit a couple of days later. When a third GP carried out a home visit, it was apparent that Mrs H needed nursing care. She went into a nursing home that day. Her condition continued to deteriorate and she went into hospital soon after. Staff diagnosed gallstones and these were removed. Mrs H's condition continued to decline and she died soon after.

What we found

We partly upheld this complaint. Much of the care provided for Mrs H was in line with national guidance. The doctors treating her meant well and thought that they were acting in her best interests. That said, they failed to be entirely frank or to set out more clearly the reasons for suggesting admission to hospital for further investigations. They also did not visit and reassess Mrs H at home soon enough.

We could not conclude that Mrs H died prematurely. Even if she had had enough information about the risk to her wellbeing if she did not go to hospital, she may well still have refused to go in when she first knew about how serious her illness was, given her fear of hospitals.

Putting it right

The GP Practice acknowledged and apologised for the identified failings. It drew up an action plan to address the failings.

Organisation we investigated

A GP practice

Location

Plymouth

Region

South West

Summary 522/October 2014

Too many ward moves caused upset and lack of confidence in care

Mr L had chronic kidney disease when he went into hospital with pneumonia.

What happened

Mr L's family complained that Trust staff did not manage his clinical care appropriately. They felt he had been moved from ward to ward unnecessarily, his insulin was wrongly reduced and he caught a hospital vomiting bug. Mr L's family believed all of this contributed to his premature death.

What we found

We partly upheld this complaint. Mr L's clinical care was appropriately managed. His insulin was properly reduced and there was no evidence he had contracted a hospital vomiting bug.

However, the number of times he was moved was unacceptable and the Trust had not recognised the upset and distress caused by this. There was also a delay in contacting Mr L's family when his condition deteriorated.

Putting it right

The Trust wrote to apologise for the upset and distress caused by the unacceptable number of bed moves. It explained what it had done to minimise moves and promote continuity of care. It also apologised for the upset caused by the delay in contacting Mr L's family when his condition deteriorated.

Organisation we investigated

University Hospitals Birmingham NHS Foundation Trust

Location

West Midlands

Region

West Midlands

Summary 523/October 2014

Trust delayed diagnosis and follow up of endometriosis

Mrs D complained the Trust delayed diagnosing her endometriosis, and this left her in severe pain. She said the delays had also severely affected her fertility and she was unable to start a family as the endometriosis had spread. She felt she had no alternative but to pay for IVF at a cost of around £5,000.

What happened

Mrs D went to the gynaecology department at the Trust in summer 2010 for bleeding between periods. She went back the next year because of severe pain. The referral from her GP specifically suggested that the diagnosis might be endometriosis.

Gynaecology clinic staff saw Mrs D in early autumn 2011, by which time she was actively trying to conceive. Staff decided that her diagnosis was more likely to be dysmenorrhoea than endometriosis. The Trust gave Mrs D a six-month follow-up appointment.

Mrs D's GP wrote again to the Trust in early 2012 asking for the follow-up appointment to be brought forward because of Mrs D's increasing pain. At the next appointment, Trust staff said that endometriosis was a possible diagnosis and arranged for a diagnostic laparoscopy with dye testing, to check Mrs D's fallopian tubes.

Another appointment had to be cancelled because Mrs D was pregnant. Sadly, she miscarried later the same month. The next month, her GP tried to rebook the laparoscopy. Instead, Trust staff booked a gynaecology appointment, at which Mrs D agreed that she would 'wait and see' how things progressed. She had a six-month follow-up appointment.

However, in autumn 2012 her GP again wrote to request an earlier appointment due to worsening pain. Mrs D had an appointment in winter 2012, and the consultant again noted findings suggestive of endometriosis. Mrs D had a laparoscopy in spring 2013 that confirmed significant endometriosis and cysts on her left ovary.

The Trust referred Mrs D to a specialist unit at a different trust. Clinicians at this trust removed the cysts in autumn 2013, but they could not remove the endometriosis as it was too severe.

A consultant at the specialist unit told Mrs D that she needed a hysterectomy. If she wanted to have a family, she would probably need IVF because, although there was a chance she would conceive normally, her endometriosis was very developed and would grow further and cause more pain.

Mrs D was referred for IVF but because of the policy in place where she lived, IVF was not at that time funded and she had to pay for it. The IVF was successful and Mrs D became pregnant in 2014.

What we found

We partly upheld this complaint. There were failings in some aspects of Mrs D's treatment that delayed her diagnosis of endometriosis. In particular, established clinical practice was to follow up cases of this type within three months not six months, which had repeatedly happened in this case.

Mrs D was left with severe pain for longer than might have been the case if treatment had been provided earlier. However, on the balance of probabilities, we did not think that her ability to conceive was likely to have been significantly affected.

Putting it right

The Trust apologised to Mrs D for failings in her care and paid her £750 in acknowledgement of her pain. The Trust also prepared an action plan to reflect on learning from this case.

Organisation we investigated

Harrogate and District NHS Foundation Trust

Location

North Yorkshire

Region

Yorkshire and the Humber

Summary 524/October 2014

Family could not be with their mother in her final hours, although she was just the other side of a curtain

Trust staff left Ms G's family outside a cubicle for five hours. The family could hear their mother's last hours and her eventual death, but they were not allowed to see her until 45 minutes after she had died.

What happened

Ms G was taken to A&E unconscious. Trust staff told her children, when they arrived, that they could not see her because she was being treated. Ms G's family was left on the other side of Ms G's cubicle curtain for five hours with no explanation about what was going on. They were not allowed to see their mother. They heard their mother have several cardiac arrests and an intubation (putting a tube into Ms G's airway) and heard nursing staff mock the state of Ms G's skin on one occasion. After Ms G's death, her children were told they could see her but they waited a further 45 minutes before taking matters into their own hands and going into the cubicle unaccompanied. It was a further 20 minutes before a nurse came to see them.

When Mr G complained about the way he and his siblings were treated, and questioned aspects of their mother's care, the Trust took five months to give him a written explanation because there was a delay in getting the clinical responses authorised by administrative managers. The Trust also took two months to organise a resolution meeting and did not do so until it became necessary for us to intervene. After our intervention, the Trust organised the meeting within a week.

What we found

We partly upheld this complaint. There were failings in how staff communicated with Ms G's children and how they treated them. Although we were satisfied that the Trust had taken action to address these issues with its staff, and had improved systems and procedures, it failed to fully acknowledge and remedy the distress its staff caused Ms G's family. The Trust's complaint handling also fell short of the expected standards.

The Trust's explanations about the cause of Ms G's death were clinically reasonable.

Putting it right

The Trust acknowledged and apologised for its failings and paid Ms G's family £500 to recognise the distress caused by its staff's poor communication. It paid £250 to acknowledge the frustration its poor complaint handling caused Ms G's family. It also put in place systems to ensure that authorising complaint responses did not cause unnecessary delay in future.

Organisation we investigated

University Hospitals Birmingham NHS Foundation Trust

Location

West Midlands

Region

West Midlands

Summary 525/October 2014

GP practice wrongly kept patient's name on its mental health register

A GP practice inappropriately included Mr A's details on registers for mental illness. It did not communicate fairly and transparently with him when he queried this.

What happened

Mr A suffered from depression. His illness did not mean that he had to be included on the registers set up in 2004 for people with severe mental illness. The Practice added him to its register in 2004 because it said the medication it had prescribed for Mr A meant he should be included.

In 2006 Mr A questioned why he was on the Practice's register and asked to be removed. A GP at the Practice acknowledged that he should not have been on it and said it had removed him, with the removal backdated to 2004. The GP confirmed Mr A had never had severe mental health problems. However, the Practice did not remove him from the register, it simply moved his details to a different register, which it described as a 'virtual' register.

The Practice failed to remove Mr G as it had promised and in its communications with him, it did not explain matters to him in an open way. In some of its record keeping, the Practice did not treat Mr A with dignity.

Mr A is no longer a patient at the Practice.

What we found

The Practice did not follow the relevant guidance for inclusion on such registers or communicate fairly with Mr A. It did not follow the Ombudsman's Principles in its complaint handling. These failings led to confusion, frustration and distress to Mr A.

Putting it right

The Practice apologised to Mr A for the distress caused. It said it would be mindful of statutory requirements and would discuss the complaint in specific meetings.

Organisation we investigated

A GP practice

Location

Cambridgeshire

Region

East

Summary 526/October 2014

Practice ignored complaint

Mr T's GP Practice sent his employer some of his medical records and took too long to deal with his complaint about this.

What happened

Mr T needed a medical report for his employers. He gave consent for his GP Practice to complete the report. However, the Practice sent about 20 pages of medical records to his employers instead of the report. Mr T complained about this in 2010 and again in 2012. He did not get a response in 2010. In response to his 2012 complaint, the Practice sent him 72 pages of his medical records.

What we found

Poor complaint handling frustrated Mr T and led to a missed opportunity to have part of his complaint put right at all. Additionally, the Practice delayed dealing with the complaint for about 18 months. We also noted continuing issues with complaint handling as part of our investigation.

Putting it right

The Practice apologised, paid compensation of £150, and carried out a system-wide review of complaint handling practices.

Organisation we investigated

A GP practice

Location

Greater Manchester

Region

North West

Summary 527/October 2014

New mother died after transfer delay

During her pregnancy, Mrs D had good care from her GP Practice and trust. However, she became ill after the birth of her child. Senior clinicians did not get involved in her care and did not refer her to a specialist unit quickly enough. Although the care and treatment she received at the specialist unit were in line with established good practice, she had a cardiac arrest and died.

What happened

When Mrs D was pregnant with her first child, she went to the GP Practice with nosebleeds. She had two episodes of bleeding during her pregnancy.

After she had given birth at the Trust, Mrs D's condition deteriorated. Trust staff cared for Mrs D on a general ward and did not transfer her to the coronary care unit until her condition got worse. Clinicians diagnosed her with abnormal blood vessel development in her lungs and other complications. Doctors suggested that Mrs D should be referred to a specialist unit at another trust, but clinicians at the first Trust took another six days to contact the specialist unit at the second Trust.

At the second Trust, Mrs D continued to deteriorate. Seven days after her transfer to the second Trust, she had a cardiac arrest. Attempts at resuscitation were unsuccessful and she died.

Mrs D's family raised complaints about the GP Practice and the first and second Trusts. Each organisation gave a number of responses to their complaint. However, Mrs D's sister was dissatisfied with the responses and complained to us.

What we found

We partly upheld this complaint. The GPs at the Practice responded correctly to Mrs D's symptoms.

Mrs D's antenatal care at the first Trust was reasonable and in line with established good practice. There was no evidence that the Trust missed an underlying medical condition at this time.

We also considered the care Mrs D received from the first Trust after the birth of her child, when her condition deteriorated. Nursing staff did not recognise that Mrs D needed more frequent observations or identify that she needed a medical review. We found, however, that more frequent observations at this point would not have altered the final outcome for Mrs D.

Nevertheless, as the Trust failed to recognise these failings, we were not satisfied that it had taken appropriate action to ensure the same things would not happen again.

The cardiology and respiratory teams should have got consultant support earlier. If this had happened, Mrs D might have been referred and transferred to the specialist unit at the second Trust more quickly. However, Mrs D's condition was severe and progressive. We did not find that more or earlier consultant involvement would have affected the final outcome.

There were failings in communication between doctors at the first Trust, and these may have delayed Mrs D's referral to the second Trust. Doctors at the first Trust also delayed contacting staff at the second Trust to discuss Mrs D's transfer. We thought that these delays had little effect on Mrs D's illness.

There were no failings in the care Mrs D received at the second Trust.

Putting it right

We recommended that the first Trust apologise to Mrs D's family for the failings we had identified. We also recommended that it prepare an action plan to describe how it would make sure it learnt from the failings identified by this complaint.

Organisations we investigated

A GP practice

Pennine Acute Hospitals NHS Trust

Sheffield Teaching Hospitals NHS Foundation Trust

Location

Greater Manchester

Region

North West

Summary 528/October 2014

Trust did not manage pain after an operation

Mr A complained about the pain he suffered after a brain operation, and about how the Trust cared for him. He was also unhappy about how it handled his complaint.

What happened

Mr A had an operation to remove a non-cancerous tumour from his brain. After the operation, some of Mr A's cerebrospinal fluid, the fluid that surrounds the brain and spinal cord, leaked, and he developed meningitis and pneumonia.

The Trust managed the fluid leak with a drain, which staff put in a week after the operation. However, a week later, Mr A had to have another operation to seal the leak. The Trust discharged him from hospital after another week.

Mr A said that failings on the part of the Trust put his life in danger and caused him to suffer intolerable levels of pain. After his operation, Mr A said, he was left with problems with his left eye and weakness in his facial muscles. He said he had daily headaches, and that his concentration, memory, and reasoning were affected. He said the events also had an impact on his emotional and psychological wellbeing.

What we found

We partly upheld this complaint. There was no fault in the operation to remove the tumour. The Trust also managed the fluid leak appropriately and there were no problems in the nursing care staff gave Mr A in the high dependency unit. However, there was fault in how the Trust gave Mr A fluids, its pain management, nil by mouth instructions, communication and complaint handling.

These faults led to a lost opportunity to manage the pain that was due to low pressure headaches caused by the fluid leak. The problems in communication and complaint handling caused Mr A and his family additional worry, frustration and distress.

Although the Trust had already taken action to improve matters for future patients, it needed to do more to put things right for Mr A.

Putting it right

The Trust wrote to Mr A acknowledging the faults we found in his care and complaint handling, and to apologise for the impact they had had on him. It paid Mr A £550.

Organisation we investigated

King's College Hospital NHS Foundation Trust

Location

Greater London

Region

Greater London

Summary 529/October 2014

GP practice did not follow correct procedures when it removed patient from its list

Mr T complained that his GP Practice removed him from its list unfairly. He was also unhappy about how NHS England dealt with his complaint.

What happened

Mr T was removed from his GP Practice after a meeting at the Practice because of allegations of unacceptable behaviour. The Practice told the police about the behaviour, and contacted NHS England about the matter. Mr T denied the allegations.

Mr T's advocate contacted NHS England, which eventually told her and Mr T that the Practice felt that the relationship with Mr T had broken down.

What we found

We partly upheld this complaint. While there was some evidence of unreasonable behaviour on Mr T's part, the Practice failed to follow the correct procedure for removing him, which resulted in distress to Mr T.

NHS England failed to address this in its response to Mr T's complaint.

Mr T had to attend a non-standard medical centre that was further from his home than the GP Practice.

Putting it right

The Practice apologised to Mr T. The NHS England Area Team reviewed Mr T's suitability to return to a standard GP list.

Organisations we investigated

A GP practice

West Yorkshire Area Team

Location

West Yorkshire

Region

Yorkshire and the Humber

Summary 530/October 2014

Nursing failure caused serious injustice

Mrs Q complained on behalf of her sister, Mrs L, about the care and treatment she received at the Trust. As a result of failings by the Trust, Mrs L lost a significant degree of independence and required much greater support from Mrs Q.

What happened

In late summer 2011, Mrs L had bypass surgery that involved creating a new route for the blood using an artificial artery connecting the collarbone artery to the groin arteries.

When she was leaving hospital, Mrs L felt or heard a 'pop' in her shoulder. When she got home, her family noticed a lump over the site of her wound and she went back to the hospital. An emergency nurse in A&E diagnosed a soft tissue injury. The nurse sent Mrs L home with advice that she should go back if she had any more problems. This was a safety net.

Mrs L's condition deteriorated and she went back to A&E by ambulance that evening. Staff admitted her and she went into intensive care. She had an emergency operation in the early hours of the next day. Doctors found that the end of the graft in Mrs L's shoulder had become detached and blood clots had blocked the graft. Blood clots had also formed in the arteries in Mrs L's legs. Doctors reattached the graft and restored the flow of blood to Mrs L's legs. Later that day, she had more surgery.

Mrs L stayed in intensive care until late summer, when she went to a ward. A few days later, doctors diagnosed a spinal stroke caused by a blockage in the blood supply to the spinal cord. In autumn Mrs L was transferred to the Trust's rehabilitation unit, where she stayed until the Trust transferred her to another trust's hospital in spring 2012 for more surgery.

What we found

Although the emergency nurse followed a recognised format for her consultation with Mrs L and appropriately put in place a safety net, she made decisions about Mrs L's further care that were not based on all relevant considerations. The nurse sent Mrs L home even though there were signs of a possible breakdown of the graft and there was bleeding around the graft. These signs should have prompted the nurse to consult and take advice from more experienced colleagues. We concluded that the nurse's actions amounted to service failure.

We also found that in providing Mrs L's care and treatment, staff in the Trust's intensive care unit and in the acute surgical ward did not act with regard for Mrs L's rights as a person with a disability.

Staff at the rehabilitation unit also did not consider her needs as a person with a disability. However, once Mrs L's family had prompted staff on this unit, they considered her individual needs. On the whole, we concluded that the failings we found amounted to service failure.

One serious consequence of the delay in recognising the failure of the graft was a drop in blood pressure, which probably caused Mrs L's spinal cord stroke. This was an injustice to Mrs L. As a result of the service failure and injustice, Mrs L had to use a wheelchair, could not use her mobility scooter and could not leave her home. Mrs Q said that her sister had carers going in to look after her, but she also had to go to her sister's home five days a week to give additional care and emotional and practical support. She said she was her sister's main point of contact, and on occasion even changed her when nursing staff were busy. Mrs Q said that the impact on her has been huge, as before the stroke she would probably visit Mrs L about once a month. This was an injustice to Mrs Q.

Putting it right

The Trust apologised to Mrs Q and paid her £25,000 to recognise the injustice. Unfortunately Mrs L died during our investigation and it was no longer possible to remedy her injustice.

The Trust drew up an action plan to ensure that the organisation and the individuals involved have learnt lessons from the failings identified.

Organisation we investigated

The Hillingdon Hospitals NHS Foundation Trust

Location

Greater London

Region

London

Summary 531/October 2014

Failings in care and treatment of a paralysed man in his eighties did not contribute to a stroke, but caused distress to his family

Mrs J complained about the care and treatment her father, Mr L, had in spring 2013.

What happened

Mr L was paralysed with no sensation from the chest down following a spinal injury. He needed full care in all aspects of his life. He had a rare medical condition that put him at risk of a stroke as a result of uncontrolled blood pressure. Among other things, this meant that he needed special bowel and pressure area care. He also had a urinary catheter. He had pressure ulcers on his lower back, buttocks and heel.

Mr L was admitted to the Trust after several days of feeling unwell, and with blood in his urine and faeces. Nurses assessed that he was at high risk of developing pressure ulcers and documented a care plan, which included nursing him on an air mattress and turning him regularly. They identified that he was at low risk of malnutrition and initially assessed that he needed four-hourly observations of vital signs, including blood pressure. Subsequently, nurses identified that Mr L needed hourly observations in line with Trust policy.

A doctor made a provisional diagnosis of urinary tract infection and acute kidney injury caused by sepsis (a life-threatening infection) and dehydration. The management plan included various investigations, intravenous fluids and antibiotics, and changing the catheter after the first dose of antibiotics. During his admission, Mr L developed pressure ulcers. An air mattress finally arrived the day before he was discharged.

Mr L was discharged after a few days at Mrs J's request because she was unhappy about the care and treatment her father was receiving. At the time of discharge, Mr L had delirium. Mr L had a stroke soon after and died the following month.

What we found

We partly upheld this complaint. Nurses did not act in line with the applicable guidance or established good practice in respect of Mr L's pressure area care, the monitoring of his blood pressure, bowel care and catheter care.

Nurses underestimated Mr L's risk of pressure ulcers and failed to start a wound chart to give a baseline against which they could measure any improvement or deterioration in the pressure ulcers. Nurses wrongly assessed that Mr L was at low risk of malnutrition (a risk factor for developing pressure ulcers) and should have referred Mr L to a dietician but did not do so. There was insufficient evidence of regular turning, and nurses also failed to make sure that an air mattress arrived in good time.

There were failings in how Mr L's blood pressure was monitored, and nurses did not call a doctor as instructed when his blood pressure rose. Nurses failed to give Mr L the bowel care he needed and did not change Mr L's catheter in accordance with the medical plan. This put him at risk of further infection. They also did not accurately record the intravenous fluids and antibiotics.

The medical care Mr L received in respect of his acute kidney injury and infection was in line with established good practice. On balance, it was acceptable to discharge Mr L without identifying the cause of his delirium. Some doctors got it right with regard to the management of Mr L's medical condition and associated risks. However, the failure to ensure that Mr L had appropriate bowel care, was, on its own, so far below the applicable guidance and established good practice that it was service failure.

Given the medical advice we received, we could not say that Mr L's stroke was caused by any of the Trust's failings. However, it was inevitable that the delay in providing an air mattress would result in pressure ulcers developing. Also, the failings in pressure area care, and the knowledge that Mr L was not given the care he needed, caused Mrs J considerable distress. This was an injustice.

Putting it right

The Trust acknowledged and apologised for its failings and put together an action plan that showed learning from its mistakes so that they would not happen again. It also paid Mrs J £750 to acknowledge the impact these failings had had on her.

Organisation we investigated

Basildon and Thurrock University Hospitals NHS Foundation Trust

Location

Essex

Region

East

Summary 532/October 2014

Serious breaches in established standards and practice in mental health ward

Mr M complained about his inpatient experience on a ward at the Trust's hospital in late 2012. He said the Trust did not give him information about his rights under the *Mental Health Act*; failed to take accurate and complete nursing records; threatened and used force to administer medication without getting his consent; denied him comfort and warmth; and deprived him of sleep. He also complained that he was detained against his will for some time.

What happened

Mr M was admitted to a ward in the Trust's hospital for just over two weeks in late 2012 under section 2 of the *Mental Health Act*.

When Mr M refused to take oral medication, staff contacted the on-duty doctor by telephone. He authorised the forcible administration of medication via two injections. Mr M was held down by four male members of staff when he had these injections. Staff had not told him about the Trust's right to forcibly administer medication.

Five or six days after this, Mr M collapsed on the ward with low blood pressure. He was transferred to a cardiac unit, where he was diagnosed and treated for an abnormal heart rhythm.

Mr M told us that, from the first day of his admission to the ward, he was woken at night every hour by staff shining a very bright torch into his face. For two days after his return to the ward from the cardiac unit, he was additionally woken each hour for blood pressure tests until he persuaded a doctor to agree to these tests happening just twice each night. He says that he was also prevented from sleeping at night time because his room was cold and his only bedding was a sheet and a thin top cover, neither of which covered him properly. When he asked for a blanket, staff ignored his request. This continued for the remainder of his admission. Mr M felt that this was bad for his mental and physical health, particularly as he had a heart condition.

During Mr M's hospital admission, he was concerned that staff regularly escorted patients who were smokers to the garden for smoking breaks, to the detriment of non-smoking patients.

When he was no longer formally detained, Mr M was in the lounge area when a fire alarm went off. He says that, although this was known to be a false alarm, staff prevented him from leaving the lounge even though he explained that the noise of the alarm was hurting his ears and causing him distress.

What we found

We partly upheld this complaint. Mr M should have been given information about his rights, including the Trust's powers to force medication, both verbally and in writing as soon as possible, but this did not happen.

Staff carried out the forcible administration of medication without a satisfactory medical assessment and there was no recorded rationale for why it was therapeutically necessary. There was no evidence that staff gave Mr M information about the proposed treatment and possible alternatives.

The Trust failed to reduce the need for force by attempting alternative strategies and therefore the level of restraint used was probably excessive and unreasonable.

The night time regime of waking and the fact that Mr M was denied adequate bedding when he was recovering from a cardiac condition amounted to a serious failing in nursing care that would have been detrimental to Mr M's physical and mental health. Mr M was denied his rights to comfort and a lack of sleep due to cold.

Additionally we criticised the Trust for maintaining a ward routine that was, or appeared to be, dominated by the needs of smokers and for acting outside its authority when Mr M was prevented from leaving the lounge area during a false fire alarm when he was no longer detained under the *Mental Health Act*.

Putting it right

The Trust agreed to apologise to Mr M and explain how it would address the issues raised by our investigation. It also agreed to pay Mr M £2,000 to recognise the distress, anxiety, discomfort and frustration he experienced due to the Trust's failure to meet some of his basic care needs; its failure to provide him with the information to make an informed choice about his medication; its failure to reassure him that he was treated appropriately, fairly, and with dignity at a time when he was vulnerable; its failure to respect his wishes when he wanted to leave the Trust's premises and had a right to do so; and its failure to provide a complete and proportionate resolution to his complaint.

Organisation we investigated

Hertfordshire Partnership University NHS Foundation Trust

Location

Hertfordshire

Region

East

Summary 533/October 2014

Trust let down former inpatient of mental health unit

A widow complained that her late husband was not given adequate care after he was discharged from a mental health unit.

What happened

Mr B received inpatient mental health care at the Trust for two months. He was then discharged into community services. Staff did not give him a written care plan on discharge but arranged monthly reviews with a community psychiatric nurse. One month after his discharge, Mr B reported a downturn in his mood and asked if he could see his psychiatrist sooner than the planned appointment, which was in two months' time.

The Trust decided that this was not necessary. When the psychiatrist reviewed Mr B, he increased the dosage of his medication. Mr B died suddenly nine days after this appointment.

Mrs B subsequently complained to us about the treatment her husband received and said that she believed his death could have been avoided. Mrs B also complained about the poor standard of record keeping and said the response to her complaint was inadequate.

What we found

We partly upheld this complaint. The Trust failed Mr and Mrs B in many ways. There was a lack of written information, care planning, crisis planning and risk assessment. There was also no evidence that staff gave Mr B information about relevant community services. We also found that the community psychiatric nurse failed to take appropriate action when Mr B reported that his mood had worsened. In addition, the Trust's record keeping was poor in parts, and the response to Mrs B's complaint was not adequate.

These failings had a significant impact on Mr and Mrs B, but we were unable to conclude that these led to Mr B's death. For this reason we partly upheld the complaint.

Putting it right

The Trust apologised to Mrs B and her family, and produced an action plan to address the concerns we identified.

Organisation we investigated

North Staffordshire Combined Healthcare NHS Trust

Location

Staffordshire

Region

West Midlands

Summary 534/October 2014

Wheelchair service delayed giving a woman a suitable wheelchair

A wheelchair service took 38 weeks to provide a suitable wheelchair for Mrs M, who has brittle bone disease, after an independent assessment found that her existing wheelchair was no longer fit for purpose.

What happened

Mrs M has a severe form of brittle bone disease. In spring 2012 the wheelchair service provided her with a new wheelchair (the first wheelchair). The wheelchair service made a number of repairs and adjustments to the first wheelchair.

In autumn 2012 Mrs M told the wheelchair service that she was finding the first wheelchair uncomfortable and painful when she went down kerbs, because the back would jolt. A wheelchair therapist (the first therapist) saw Mrs M along with a mobility technician, who fitted pneumatic tyres to the wheelchair and reduced the load to the front suspension.

Shortly after, Mrs M wrote to the former commissioner of the wheelchair service, Milton Keynes Primary Care Trust (the PCT) to complain about ongoing problems with the first wheelchair. She suggested an alternative wheelchair that she thought might be more suitable. In response, a locum wheelchair therapist (the second therapist) saw her, with a mobility technician, in early 2013. The second therapist concluded that the first wheelchair was appropriate for Mrs M's needs.

In spring 2013, responsibility for commissioning the wheelchair service passed from the PCT to Central and North West London NHS Foundation Trust (the Trust). In summer 2013, Mrs M and her husband, Dr M, met the Trust to discuss their concerns about the first wheelchair. The Trust agreed to a reassessment of Mrs M's needs by an independent occupational therapist.

In early autumn, an independent occupational therapist (the independent therapist) carried out an independent assessment (the independent assessment). The independent assessment concluded that the first wheelchair was no longer promoting Mrs M's independence or comfort and was not preventing secondary complications. It recommended that an alternative wheelchair be trialled, and said that another chair would still need to be customised.

The Trust wrote to Dr and Mrs M and provided a new wheelchair for trial the next month. Mrs M confirmed she was happy with the trial and an order was placed for a new wheelchair in early 2014 (the second wheelchair). Following correction of a manufacturing fault, the second wheelchair was given to Mrs M in summer 2014.

What we found

We partly upheld this case. Dr and Mrs M complained about the delays in the wheelchair service adequately assessing Mrs M's needs and providing her with a suitable wheelchair after she raised concerns about her existing wheelchair in autumn 2012.

It was appropriate for the Trust to try to adapt and repair the first wheelchair in the first instance in seeking to meet Mrs M's needs. It was also appropriate for the Trust to agree to replace the first wheelchair when this approach proved unsuccessful and too labour and cost intensive.

That said, it took the Trust 38 weeks to provide the second wheelchair to Mrs M against the 18 week target set out in the Healthcare Standards for NHS-commissioned Wheelchair Services. We considered that the Trust therefore failed to provide Mrs M with a suitable wheelchair in a timely manner following receipt of the report of the independent assessment.

The delays in provision are likely to have had an impact on Dr and Mrs M's lifestyle, as well as causing Mrs M unnecessary pain and stress.

Putting it right

The Trust acknowledged and apologised for its failings. It produced an action plan that addressed those failings. It paid Dr and Mrs M £1,500 compensation for the impact on them.

Organisation we investigated

Central and North West London NHS Foundation Trust

Location

Milton Keynes

Region

Buckinghamshire

Summary 535/October 2014

Poor discharge arrangements for terminally ill patient

A daughter complained that her mother, Mrs G, was inappropriately transferred from hospital to a nursing home when she was too unwell.

What happened

Mrs G had a terminal illness and was to be transferred to a nursing home to be cared for at the end of her life. Her daughter, Mrs P, was concerned that she was too unwell to be transferred. Mrs P was also wrongly told she could not travel in the ambulance with Mrs G. The transfer went ahead but there was a breakdown in communication and Mrs G arrived at the nursing home before her room was ready. Mrs P briefly returned home once Mrs G was settled into her room, but she died within a few minutes. Mrs P complained about the discharge arrangements and the communication about the transport and discharge date.

What we found

We partly upheld this complaint. It was appropriate to discharge Mrs G, although the Trust did not consider all the factors needed for a safe and smooth transfer. The Trust had given Mrs P incorrect information about being able to travel in the ambulance alongside her mother. We were unable to conclude whether there had been any failings in the communication with the nursing home about the transfer details, but we did find there was poor record keeping about this issue.

Putting it right

The Trust apologised to Mrs P, paid her £500 and produced an action plan to make sure it learnt lessons from the complaint.

Organisation we investigated

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

Location

Bournemouth

Region

South West

Summary 536/October 2014

Older woman took steroids for too long after delay in follow up

Mrs Y had been suffering from headaches. She went to A&E at the local Trust in spring 2013, after a call from her out-of-hours doctor warned her about worrying blood test results.

What happened

An out-of-hours doctor diagnosed that Mrs Y had temporal arteritis, a condition in which inflammation of an artery causes soreness around the temples and problems with sight. She went to A&E at the Trust, where a locum doctor ordered blood tests and gave her steroid medication to take home. The locum doctor told her that she would get a letter about a neurology appointment within two days.

Mrs Y did not receive a follow-up appointment as quickly as she had expected. Her GP found that the hospital could not find any record of a referral from the locum doctor. Mrs Y then got a follow-up appointment for three weeks later. When she went to the hospital, staff realised that she had been referred to the wrong department. They referred her to rheumatology, which was the correct department. In the meantime, Mrs Y's GP had referred her to a consultant rheumatologist, who found that she did not have temporal arteritis. Mrs Y's GP helped her gradually stop her unnecessary steroid medication.

Although Mrs Y was taking a low dose of steroids by the time she saw the consultant rheumatologist, she experienced a number of unpleasant side effects of the steroids, including depression, weight gain and hair loss.

What we found

We partly upheld this complaint. Mrs Y received appropriate treatment in A&E. Given the risk of blindness, it was reasonable for the Trust to prescribe high-dose steroids. However, there was no clear pathway in place for an A&E doctor to get a patient seen quickly by a specialist in an appropriate follow-up clinic. This led to delays and confusion, and meant that staff did not carry out the correct diagnostic tests at the right time. When Mrs Y was referred to the rheumatology department, the Trust did not give her an urgent appointment, as it should have done.

If Mrs Y's follow-up care had happened as quickly as it should have, the dosage of steroids would have been reduced sooner and the side effects would have cleared more quickly. Communication was also poor.

The Trust's complaint handling was generally good. It put a robust pathway in place to avoid similar problems happening in future.

Putting it right

The Trust apologised to Mrs Y for its failings and paid her £350 to recognise the discomfort and distress she experienced.

Organisation we investigated

Barking, Havering and Redbridge University Hospitals NHS Trust

Location

Essex

Region

East

Summary 537/October 2014

Dentist did not offer patient NHS treatment and NHS England did not resolve the complaint

Mrs W's dentist only gave her an option of private treatment when she was entitled to NHS treatment. NHS England could have done more when it investigated the matter.

What happened

In very early 2013 Mrs W saw her dentist about pain around a tooth. The dentist identified an infection at the site of an old root canal filling, and prescribed antibiotics. She told Mrs W to come back if the infection continued. A week later, Mrs W went back with continuing pain but she could not carry on with treatment because of a family bereavement.

Mrs W returned to the Dental Practice in spring 2013 for a check-up. An X-ray to the tooth showed that the infection had worsened. The dentist told Mrs W that she needed private treatment because the tools used in NHS treatment would not be good enough.

Mrs W complained shortly afterwards that the Dental Practice did not offer her NHS treatment and had misled her. The Practice did not accept that it had failed Mrs W, so she and her husband, Mr W, went to NHS England. As the Practice had asked them to find alternative dentists, they also asked NHS England to help them do this.

NHS England correctly told Mr and Mrs R that it was unable to act as a second tier in the complaints process, but it wrote to the Practice and told it that it had acted incorrectly by not offering NHS treatment and by stating that NHS treatment would be of inferior quality. NHS England did not respond to the request to help Mr and Mrs W find a new dentist.

What we found

Shortcomings in the dentist's treatment plan meant that Mrs W was not given the information she needed to make an informed choice about her treatment. She was misled into believing that the treatment she needed could not be provided to the necessary standard by the NHS. This falls short of the expectations of the NHS dental contract and the General Dental Council's Standards for the Dental Team. Furthermore, the Dental Practice's decision to deregister Mrs W in the middle of a course of treatment was not fair and was clearly prompted by the complaint. The Practice therefore failed to meet accepted standards in respect of this decision.

We were critical of NHS England for its delay in responding to the complaint. NHS England was aware of failings in the service given by the Practice and of inadequacies in the Practice's response to the complaint, but it failed to act in Mr and Mrs W's best interests and settle the complaint earlier. Finally, we criticised NHS England for ignoring Mr and Mrs W's repeated requests for help finding an alternative NHS dentist to carry out Mrs W's treatment.

Mrs W could not make an informed choice about her dental treatment. She did not receive timely dental treatment and she had unnecessary inconvenience and discomfort as a result. She had the trouble of having to complain and find a new dentist.

Putting it right

We asked the Dental Practice to apologise and pay Mrs W £600. We also asked it to explain to her how it would avoid a recurrence of these failings.

We asked NHS England to apologise to Mr and Mrs W, pay them £250 and explain what it has done and/or plans to do, to stop these failings happening again.

Organisations we investigated

A dental practice

NHS England Greater Manchester Area Team

Location

Greater Manchester

Region

North West

Summary 538/October 2014

A dental practice failed to give appropriate treatment

Mr G's onlay fell out. An onlay is a filling made of a solid substance fitted to a cavity or gap in a tooth that covers the tooth's biting surface.

What happened

The Dental Practice fitted a replacement onlay which soon fell out. The Practice fitted another replacement onlay, which also promptly fell out and had a hole in it. The Practice then fitted a three-quarter crown, which is the same as an onlay except that it covers three-quarters of the tooth, rather than just the biting surface.

What we found

We partly upheld this complaint. There was not enough room in Mr G's mouth for an onlay or a three-quarter crown. In an attempt to fit the two onlays, the Practice reduced them, but did so excessively. The Practice could have made room for the onlay and three-quarter crown by reducing or cutting back the tooth they were placed on, but it did not do so.

Mr G was caused inconvenience, discomfort and a gap in, and problem with, his bite, because his teeth did not meet.

Putting it right

We recommended that the Dental Practice should apologise for its service failure, pay Mr G £359 to refund the money he paid for treatment and compensate him for the injustice, and put in place an action plan to ensure that it does not repeat its failings.

Organisation we investigated

A dental practice

Location

Oxfordshire

Region

South East

Summary 539/October 2014

Nursing staff did not monitor older patient, who then suffered a pressure sore

Mrs G went into hospital with low fluid intake and chest problems. During her stay, Mrs G developed a pressure sore and her condition deteriorated. When she was discharged, she had to go into a nursing home rather than her previous residential home.

What happened

Mr D complained that his mother Mrs G's pressure sore could have been avoided and that ward staff failed to notice she was deteriorating while she was in hospital. Although the Trust acknowledged some failings in the care his mother received, Mr D did not believe it had done enough to improve services. He complained that the standard of care during his mother's admission caused her general deterioration, so she could not go back to her residential home and had to go into a care home.

What we found

Mrs G did not receive adequate pressure area care and this, on the balance of probabilities, led to her developing avoidable pressure sores. She suffered pain and discomfort, which could have been avoided.

Record keeping about staff assessments of Mrs G's condition was poor. As a result, we could not find out whether nursing staff should have been concerned about Mrs G before her son alerted them.

The standard of care Mrs G received was not directly responsible for her being unable to return to her residential home when she was discharged from hospital. It may have contributed to Mrs G's increased needs, but the causes of decline in an elderly patient can be complex and varied and therefore we cannot conclude Mrs G's admission to a care home could have been prevented.

Putting it right

The Trust acknowledged and apologised for its failings in relation to Mrs G's pressure care, the monitoring of her condition and the documentation about this. It also paid her £750 to recognise the avoidable pressure sores she developed.

The Trust agreed to prepare an action plan to address its failings.

Organisation we investigated

Wirral University Teaching Hospital NHS Foundation Trust

Location

Merseyside

Region

North West

Summary 540/October 2014

GP complained about trust's investigation

A GP complained to us that the Trust's investigation of delays in diagnosing a patient with cancer suggested that the GP was also partly responsible for the failings identified.

What happened

When Mr K, one of Dr L's patients, died of cancer, Dr L helped his family to complain about delays in diagnosing his illness. Much of the complaint focused on Mr K's management at a pain clinic Dr L had referred him to. The Trust that managed the pain clinic initially dealt with the complaint without involving the acute hospital trust where the clinic was located. When the acute hospital trust became involved, it carried out an internal investigation and shared this with the original Trust, which shared it in full with Dr L.

Dr L was very unhappy because the report suggested that the delay in Mr K's diagnosis was caused by failings across the whole primary and secondary care pathway. She also felt the report criticised her for not arranging a particular scan, although she said that access to such scans was limited for GPs at the time.

What we found

We found no evidence that Dr L should have acted any differently under the clinical circumstances. On that basis, it was unreasonable for the Trust's investigation to suggest that there were also primary care failings in Mr K's management.

Putting it right

The Trust wrote to Dr L to apologise.

Organisation we investigated

University Hospital Southampton NHS Foundation Trust

Location

Southampton

Region

South East

Summary 541/October 2014

Trust took too long to respond to complaint

A man with a sleeping disorder had to wait several months for a response to his complaints.

What happened

Mr T went to a sleep disorder clinic at the Trust after he had had poor sleep for several months. His consultant was late so he did not see a doctor on the day of his appointment, and staff gave him different reasons for the delay.

Although Mr T complained about what had happened on the day of his appointment, he did not get a detailed response until over seven months later.

The Trust offered Mr T £50 to cover his expenses and inconvenience, which he declined.

What we found

We partly upheld this complaint. Although the Trust dealt with Mr T's complaint reasonably, the initial delay in responding to him was unnecessary and unreasonable.

Putting it right

The Trust acknowledged and apologised for the failings we identified. It agreed to pay Mr T £150 compensation for the inconvenience and distress its failure caused. It also agreed to explain what it had done to ensure it had learnt the lessons from the failings in complaint handling we identified.

Organisation we investigated

United Lincolnshire Hospitals NHS Trust

Location

Lincolnshire

Region

East Midlands

Summary 542/October 2014

Error in diabetes prescription

Mr S complained that his GP Practice would not allow him to book appointments with the GP he regarded as his family doctor when he needed them. He also said the Practice's systems for allocating appointments and home visits were not fit for purpose. Mr S also complained that the Practice made mistakes in his prescription and he then received the wrong type of insulin.

What happened

Mr S phoned the Practice on numerous occasions to request appointments with his family doctor. Sometimes the family doctor was available but on many occasions he was unavailable or Mr S was told he would have to wait weeks to see him but could see someone else in the meantime if his needs were urgent.

On one occasion Mr S phoned the Practice to request a home visit for his mother who was unwell and unable to attend the Practice. The customer services manager asked Mr S about his mother's condition and also asked if Mr S's mother could call at the surgery instead of having a home visit. Mr S's mother got a home visit.

Mr S had diabetes and had been taking insulin for some time but his treatment was not successful in controlling his blood sugar and he suffered other symptoms, including thrush, as a result. Mr S's specialist recommended a change in insulin regime and asked the Practice to implement this. The Practice changed Mr S's prescription as the specialist had requested, but then changed it back to his old prescription two weeks later without documenting why. As a result, Mr S continued to receive his old insulin rather than the new prescription recommended by the specialist.

What we found

We partly upheld this complaint. The Practice was reasonable in the way it dealt with Mr S's requests to see his 'family doctor'. The NHS constitution states that people can ask to see a doctor of their choice, but a GP practice is not obliged to agree to the requests. The Practice did not refuse to give Mr S an appointment when he needed one, but the appointments it offered were not always with the doctor Mr S had asked for.

The Practice dealt with Mr S's request for a home visit for his mother appropriately. The customer services manager gathered relevant information from Mr S about his mother's condition and passed this to a GP, who reached the clinical decision that a home visit was necessary.

The Practice changed Mr S's insulin back to his old regime against the advice of the specialist diabetologist and failed to record its rationale for doing so. There were also failures in record keeping at the Practice because the GP did not record the rationale for going against the advice of the diabetologist. Mr S was not harmed by the change back to his old insulin, but an opportunity to bring his diabetes under better control was lost. We noted that Mr S could have brought the prescription error to the attention of the Practice earlier than he did.

Putting it right

The Practice apologised to Mr S for not providing him with the prescription recommended by the diabetologist. It also put a procedure in place to make sure the reasons for prescription changes are clearly recorded.

Organisation we investigated

A GP practice

Location

Merseyside

Region

North West

Summary 543/October 2014

Trust did not arrange timely hospital admission, but this did not affect outcome

Mr F, who had severe mental and physical disabilities, became ill while living in a residential home. His condition deteriorated and he died following a hospital admission.

What happened

Mr F had very limited ability to communicate and lived in a residential home funded by the Trust and the local council. He became unwell in autumn 2011. His family were concerned and reported that he had a reduced appetite. His condition deteriorated and staff at the home sought specialist advice.

The next month, home staff called a GP to see Mr F. However, the GP was unable to attend immediately and Mr F's family insisted that an ambulance be called. Mr F was admitted to hospital for treatment but died in winter 2012.

What we found

The Trust failed to ensure that Mr F was admitted to hospital in a timely fashion when his condition began to deteriorate. While staff had acted in accordance with local policy, the incident highlighted a lack of appropriate training around what action should be taken to identify and respond to an emergency situation.

While Mr F's admission was delayed, this did not affect the outcome of his care and he initially responded well to treatment. An earlier admission would not have changed the sad outcome.

Putting it right

The Trust apologised for failing to arrange Mr F's timely admission to hospital, and produced an action plan to show how it would avoid a recurrence.

Organisation we investigated

Lancashire Care NHS Foundation Trust

Location

Lancashire

Region

North West

Summary 544/October 2014

Significant failings in how Trust monitored patient

Mr M complained about the medical and nursing care that his wife received in the Trust's hospital, and how it handled his complaint.

What happened

Mrs M went into hospital in 2011 with a provisional diagnosis of pneumonia, dehydration and low blood pressure. She died within 48 hours of admission. Mr M said that despite repeated concerns expressed by his wife and her family, nursing and medical staff did not provide the necessary support.

Mr M highlighted delays in his wife's medical assessment and shortcomings when staff gave her fluids and pain relief. He also complained about faults in how staff recorded Mrs M's deterioration. In particular, although Mrs M's condition visibly worsened, it was several hours before a doctor saw her.

Mr M also complained about the way the Trust handled his complaint, and that there were records of other patients in his wife's medical records.

What we found

There were shortcomings in: timely medical assessments when patients arrived at the Trust; how staff gave intravenous fluids; and nurses' record keeping, especially about pain relief. There were also failures in improvements the Trust had promised to make in its policy for referring patients to doctors, and in the management of junior doctors.

Putting it right

Following our report, the Trust acknowledged and apologised for its failings and put together action plans that showed learning from its mistakes so that they would not happen again.

Organisation we investigated

North Bristol NHS Trust

Location

Bristol

Region

South West

Summary 545/October 2014

Poor record keeping meant trust could not fully respond to complaint about hernia surgery

Mr G complained about the treatment he received from the Trust during and after hernia repair surgery. He said that he experienced significant ongoing pain following the surgery, and this had a significant effect on his quality of life. He said the pain was a simple problem but the Trust could not treat it effectively. He also said the Trust could not explain what caused the pain.

What happened

Mr G had hernia repair surgery but was readmitted to hospital several days later in severe pain. He was given pain relief but readmitted some time later, again with uncontrollable pain. It seems that over time, Mr G developed neuralgia (pain from a damaged nerve) in the area.

What we found

We partly upheld this complaint. Mr G experienced chronic pain following his operation. However, this is a well-recognised complication of hernia surgery: between one and four patients in every 100 could experience chronic pain. In Mr G's case, the most likely cause was nerve damage during the operation. This does not necessarily mean that anything went wrong during the surgery, but we could not say because the Trust was unable to supply us with the operation notes. This was a failing in the Trust's record keeping.

Before the operation, the Trust should have warned Mr G that there was a risk of chronic pain, discussed this with him, and given him a chance to ask questions. However, although the Trust recorded that it discussed other side effects with Mr G, there was no record that staff mentioned pain. Again, this does not mean that the Trust did not explain this to Mr G, but there is no evidence that it did. This was a further failing by the Trust.

It is likely that the complications Mr G experienced would have happened anyway, because there is a well-known risk of pain after this type of surgery. After the operation, the Trust carried out the standard investigations into Mr G's pain and treated him appropriately. Chronic pain after hernia surgery is a complex and difficult issue. The Trust referred Mr G to the pain clinic for ongoing treatment, which is in line with established good practice.

Gaps in the records prevented the Trust from giving Mr G a satisfactory answer to his complaint. This was frustrating for Mr G and made the complaints process longer than it should have been. Because of this we partly upheld Mr G's complaint.

Putting it right

We recommended that the Trust improve its record keeping, given that there were no notes from Mr G's operation.

We also asked the Trust to improve the consent process before surgery. We recommended it introduces the pre printed consent forms in use across many NHS trusts in England. These forms list the possible risks of a procedure with a tick box alongside each one. This helps to reduce the risk of human error.

Organisation we investigated

Sherwood Forest Hospitals NHS Foundation Trust

Location

Nottingham

Region

East Midlands

Summary 546/October 2014

Failure to take out tooth led to distress and affected future treatment

The Dental Practice did not take out Miss S's baby tooth although she was a teenager when it decided this. This distressed Miss S over four years.

Privately-funded treatment to align her teeth may have taken longer because the baby tooth was still in place.

What happened

Miss S had four appointments at the Dental Practice from 2010 until 2013, because she had a baby tooth that had not fallen out and which was affecting the alignment of the adult tooth in the same position. Miss S did not receive appropriate treatment from the Dental Practice for the retained baby tooth. This caused her distress as the adult tooth was noticeable and looked unsightly. She eventually had privately-funded orthodontic treatment that she felt was more complicated than it would have been if the Practice had removed the baby tooth.

Miss S complained to the Practice but was not happy with the outcome and so she contacted us.

What we found

At the initial appointment the dentist carried out the appropriate examinations and correctly concluded that Miss S was not eligible for NHS funded orthodontic treatment. However he did not consider extracting the baby tooth.

At the subsequent appointments, when the adult tooth had begun to grow out of line, the dentist failed to consider the option of extracting the baby tooth.

This delay in treating Miss S led to a prolonged period of distress and also had some impact on her subsequent treatment.

Putting it right

The Dental Practice apologised to Miss S for its failings and explained how it would learn from the complaint to ensure it does not repeat these mistakes. The Practice paid Miss S £300 to recognise the distress she suffered and the impact on her subsequent treatment.

Organisation we investigated

A dental practice

Location

Milton Keynes

Region

South East

Summary 547/October 2014

GPs missed opportunity to make timely hospital referral

Ms R complained that the GP Practice misdiagnosed a lump on her father's knee as a cyst when it was later found to be cancerous, did not refer him for a biopsy and did not take appropriate action when the lump grew. Ms R complained that the Trust then failed to diagnose her father's cancer. Ms R believed her father might have survived if he had had an earlier diagnosis. She said that he was in considerable pain in the last months of his life.

What happened

The Practice initially referred Mr R to the Trust for investigation of the lump on his knee. A consultant saw him and diagnosed a cyst. Over the next seven months, Mr R saw GPs at the Practice eleven times, four of which were specifically about his knee. The Practice then referred him back to the Trust, where clinicians diagnosed Mr R with terminal cancer.

What we found

We partly upheld this complaint. There were no failings in how the Practice initially responded to Mr R's knee swelling. However, it missed opportunities to make an earlier referral back to the Trust when his symptoms did not improve.

That said, this would not have prevented Mr R's death. An earlier diagnosis, however, would have meant he got appropriate pain relief and would have given him and his family time to adjust to the diagnosis and prognosis.

We found no failings in the Trust's actions. The initial diagnosis of a cyst was understandable in Mr R's case.

Putting it right

The Practice wrote to Ms R to acknowledge the failing and explained what it will do differently in future.

Organisations we investigated

A GP practice

Great Western Hospitals NHS Foundation Trust

Location

Wiltshire

Region

South West

Summary 548/October 2014

Patient discharged without appropriate support

The Trust judged that a patient was bullying staff and discharged him but failed to adequately warn him or follow the correct procedure. The Trust also failed to provide follow-up support.

What happened

Mr L went into hospital for a spinal cord stimulator to control his pain. Trust staff were concerned about his high dose of morphine and reduced this during his admission. Mr L was then in touch with the Trust on numerous occasions about his problem with the stimulator and the discontinuation of his morphine. Trust staff felt communications from Mr L amounted to bullying and discharged him from the neuroscience service. Staff recorded this in Mr L's medical records.

The pain team said staff could only support Mr L on issues in its remit and the stimulator was not its responsibility. The team did not want to put Mr L back on morphine. The pain team offered Mr L psychological therapy and his GP made arrangements with the manufacturer of the stimulator to fix the problems he was having.

What we found

The Trust's decision to withdraw Mr L's opioid medication was within the bounds of established good practice. The Trust's decision to record its perception of bullying was appropriate. However, there were shortcomings in the Trust's neuroscience team's decision to discharge Mr L without warning and without putting alternative support in place.

Putting it right

The Trust acknowledged its service failure and apologised for the injustice. It paid Mr L £500 for the injustice it had caused. The Trust also prepared an action plan to demonstrate learning from the identified failings.

Organisation we investigated

Oxford University Hospitals NHS Trust

Location

Oxfordshire

Region

South East

Summary 549/October 2014

Trust did not apologise for failings it had identified

Ms B complained about the mental health support her daughter, Miss T, received from the Trust. Ms B felt there were failings in support from in-patient and community services.

What happened

Miss T had previously suffered from depression and became unwell again in 2012. She spent several weeks at the Trust as an inpatient before she was well enough to be discharged. About a month after her discharge from hospital, Miss T took her own life.

Ms B contacted the Trust, which carried out a serious incident investigation. This highlighted some concerns about Miss T's management. There was no psychologist at the Trust during Miss T's inpatient stay in hospital and there was poor communication about her discharge. However, the Trust's investigation concluded that Miss T's suicide could not have been predicted or prevented.

Ms B complained to us because she felt the Trust had failed to accept any responsibility or apologise to her.

What we found

For the most part, the Trust's management of Miss T as an inpatient and in the community was appropriate and in line with the relevant local and national guidance. There were some failings in Miss T's treatment, but the Trust had already identified most of these.

These failings may have affected Miss T's engagement with some inpatient therapies and caused her additional anxiety when she was in the community. Despite this, there was no evidence that the Trust missed any opportunities to identify that Miss T may have had suicidal thoughts or to stop her from taking her life. However, because of the way the Trust had investigated Ms B's concerns, it had not apologised to her or acknowledged the impact of its failings.

Putting it right

The Trust apologised to Ms B for its failings. It also reviewed its investigative processes to ensure that when it identifies shortcomings, it formally recognises and addresses them.

Organisation we investigated

Derbyshire Healthcare NHS Foundation Trust

Location

Derbyshire

Region

East Midlands

Summary 550/October 2014

Ambulance trust failed to record patient care

A lack of evidence meant Mr H could not get a resolution to his complaint about what happened when he saw paramedics after a 999 call.

What happened

When Mr H's health deteriorated, his daughter called 999. She asked that Mr H was taken to a specific A&E that had the facilities to treat his suspected condition. When paramedic staff declined this request, she drove Mr H herself.

Mr H and his daughter complained about the service he had received. Among their concerns was the level of information shared by the paramedics, the paramedics' attitude, and the decision to take Mr H to the nearest A&E rather than the one requested. Mr H also complained about the length of time the Trust took to deal with his complaint.

What we found

We partly upheld this complaint. The paramedics did not fill in a patient report form, a clinical record of care given by an ambulance crew, to show the advice and care they had given Mr H. Because there was no patient report form, we could not decide, on the balance of probabilities, what happened.

We did not find fault with the time the Trust took to deal with Mr H's complaint.

Putting it right

The Trust discussed this complaint with staff, and they now know that documentation should be completed every time they go to a patient. The Trust also apologised to Mr H for the impact its poor form filling had on resolving his complaint.

Organisation we investigated

The North East Ambulance Service NHS Foundation Trust

Location

Tyne and Wear

Region

North East

Summary 551/October 2014

Trust sent patient home without appropriate investigations

Mr J, who had had a suspected heart attack, was told he must have an angiogram, a test to show the blood flow in his arteries. The Trust then discharged him without this test.

What happened

When Mr J went into hospital, clinicians diagnosed that he had had a minor heart attack. Staff treated him for this and told him he would need an angiogram to check his cardiac condition and risk.

However, staff then discharged him before he had an angiogram. The Trust referred him to another trust for an angiogram, and asked for this to be carried out 'fairly quickly'. The other trust told Mr J that it would take six to eight weeks for an angiogram appointment. Mr J was unwilling to wait so long and paid £334 for a private angiogram. This showed severe coronary artery disease and Mr J had bypass surgery.

Mr J complained to the Trust, but it said he had chosen to have an angiogram privately and it refused to reimburse him.

What we found

The Trust did not assess Mr J's risk of having another heart attack properly, as it should have. Our adviser retrospectively assessed this risk as 4.4%.

It was unreasonable for the Trust to discharge Mr J without an angiogram. Guidelines say that for patients who have had a heart attack and whose risk of another is over 3%, an angiogram should be carried out within 96 hours. This did not happen in Mr J's case and the Trust did not acknowledge this.

Putting it right

The Trust reimbursed Mr J's private healthcare costs of £334 and paid him £250 in recognition of the stress he was caused. It also apologised to Mr J for his poor experience and considered how it could improve its processes to prevent a recurrence.

Organisation we investigated

The Hillingdon Hospitals NHS Foundation Trust

Location

Greater London

Region

London

Summary 552/October 2014

Trust may have missed opportunity to prevent DVT for patient with lower limb plaster

A man suffered a deep vein thrombosis (DVT) which may have been prevented if he had been properly assessed for measures to prevent this happening when he was fitted with a plaster of Paris on his lower leg.

What happened

When Mr S went to A&E with severe pain and swelling in his leg, the Trust diagnosed tenosynovitis, which is inflammation of the tissue around a tendon. Trust staff put a plaster of Paris on his leg. The plaster was not weight-bearing.

A few weeks later, Mr S was diagnosed with cellulitis, an infection of the soft tissue or skin, and a DVT in his leg and his lung. Mr S asked why the Trust diagnosed tenosynovitis, why staff did not consider cellulitis, why staff did not think about DVT, and whether the plaster of Paris caused or worsened the DVT. He also wondered whether, if the Trust had found the DVT earlier, things could have been different.

The Trust explained the care and treatment it gave Mr S. It said several doctors saw him in A&E and they were all convinced that he had tenosynovitis. The Trust said that at that stage, there were no clear features of DVT. It added that the duration of his symptoms and that they improved in plaster supported the diagnosis of tenosynovitis, for which a plaster cast is a well established treatment. It added that a DVT is a recognised complication of being immobilised in plaster. The Trust said that there was no evidence in the records that staff missed a DVT.

There was a local resolution meeting at which Mr S's concerns were discussed and the Trust gave a final response. The Trust maintained its position that the DVT was not missed but rather was a complication of the plaster of Paris.

What we found

The diagnosis of tenosynovitis and the decision to treat it with a plaster cast was appropriate. However, there were failings because the Trust did not assess Mr S for measures to prevent thrombosis in line with the relevant guidance and did not give him a weight-bearing plaster.

We were unable to conclude that if Mr S had been assessed for measures to prevent thrombosis, he would have met the criteria for treatment or to what extent the provision of a walking plaster or boot would have reduced the risk of DVT. However, we consider that the failings we identified meant that the Trust may have missed an opportunity to reduce Mr S's risk of getting a DVT. This is upsetting for Mr S because he will never know whether an earlier intervention could have made a difference to his condition.

Putting it right

The Trust apologised to Mr S for the impact its failings had on him and paid him £250 to reflect the injustice he experienced.

It agreed to develop an action plan that describes what it will do to implement the guidance on measures to prevent thrombosis in patients treated with lower limb immobilisation, and will set up a system to redirect, when appropriate, patients who need specialist but non emergency treatment.

Organisation we investigated

Royal Cornwall Hospitals NHS Trust

Location

Cornwall

Region

South West

Summary 553/October 2014

Trust did not involve representatives in continuing care assessment

Ms J complained that the Trust did not give Mr R's representatives the opportunity to be involved in a continuing care assessment and failed to tell them about the decision.

What happened

A nurse assessor visited Mr R in spring 2013 and completed a NHS continuing care assessment. Mr R was found not eligible for funding.

Ms J (one of Mr R's representatives) later found out that this assessment had happened. She complained to the Trust that it had not involved his representatives and had not told them about the outcome.

In response, the Trust acknowledged that the systems in place for inviting representatives were not as robust as they should have been. The Trust apologised for this and the failure to inform the representatives of the outcome.

What we found

We saw evidence that the Trust had acknowledged that errors had been made and apologised for these. However, we saw no evidence that it had taken action to prevent the same problems happening again.

Putting it right

The Trust agreed to write to Ms J to explain the action it had taken to make sure that it invited individuals and their representatives to take part in continuing care assessments and that they were advised of the outcome.

Organisation we investigated

Sandwell and West Birmingham Hospitals NHS Trust

Location

West Midlands

Region

West Midlands

Summary 554/October 2014

Trust sent older confused patient to wrong address

Ms P complained about the care given to her father, Mr P. She said that his discharge was wrong and that Trust staff mislabelled his medication. She said this led to her father's physical condition seriously deteriorating. Mr P has since died.

What happened

Mr P had dementia. He was taken to the Trust's A&E department complaining of collapse and a shaking episode, abdominal pain and headache. His symptoms settled and staff discharged him with an antibiotic, Augmentin. Because of an IT issue, the transport that staff organised for Mr P took him to a previous home address without his family being told. He was then returned to the Trust, where he spent the night before he was discharged to his care home the next morning.

What we found

We partly upheld this complaint. The Trust's decision to discharge Mr P was reasonable because staff had no reason to keep him in hospital. The Trust acknowledged it had discharged Mr P to the wrong address without telling his family, which was a failing.

The way in which staff had labelled Mr P's medications meant that the instructions were not available to staff at his care home. This was a failing.

Finally, we saw no evidence that the care given caused Mr P's health condition to deteriorate.

Putting it right

We partly upheld this complaint. The Trust apologised to Ms P for the failings identified. It also shared with her its plans for preventing a recurrence of the failings around the discharge of vulnerable patients and the labelling of medication.

Organisation we investigated

South London Healthcare NHS Trust

Location

Greater London

Region

London

Summary 555/October 2014

Trust did not look at a preoperative assessment, which delayed a surgical procedure and distressed a patient

The Trust did not take account of information Miss P gave in her preoperative assessment and this delayed her procedure. Miss P says this caused her great distress and that she had to leave the Trust without having the procedure. Ms P feels that the Trust did not deal with her compassionately or sensitively, considering that her partner had recently passed away.

What happened

Miss P went to hospital two days after her partner had died of a rare brain condition. Doctors told her she needed a hysteroscopy and staff carried out a preoperative assessment that day. The assessment concluded that Miss P's partner's condition had no implication for infection control. Miss P went to the hospital five weeks later for her operation.

After waiting for several hours, staff told Miss P that her operation had been delayed because staff had referred the matter to the infection control team because of her partner's death. Miss P was too upset to go through with the procedure and left the hospital.

What we found

Staff should have considered the information in the preoperative assessment to decide whether they needed to take specific action, such as speaking to the infection control team. Staff did not adequately update Miss P about what was happening, discuss concerns with her, or keep her meaningfully informed about what they were doing to find about her infection risk.

Putting it right

The Trust paid £250 to Miss P and agreed to update her on the changes it has made to avoid a recurrence of the failings identified in the report.

Organisation we investigated

East Lancashire Hospitals NHS Trust

Location

Blackburn with Darwen

Region

North West

Summary 556/October 2014

Trust failed to communicate effectively with a patient, her GP, or its staff

After Miss A had her appendix out, the Trust did not tell her why it called her back for further tests. When she had more surgery, the Trust did not explain clearly whether a tumour had been cancerous or not.

What happened

Miss A had an operation to take out her appendix. Trust staff discharged her the next day. A member of the appointments team then rang to tell her to go back to the Trust for a scan, but could not explain why she needed this. While Miss A was trying to find out about this, she discovered that she was also booked for a preoperative appointment.

After the scan, Miss A had more surgery to remove a tumour. Miss A said the way the Trust handled things caused her great anxiety.

What we found

We partly upheld this complaint. We decided that the Trust did not explain things clearly to either Miss A or her GP. This caused her great anxiety.

The Trust managed Miss A's medication correctly and her care was in line with recognised quality standards and established good practice.

There were failings in internal communication within the Trust, but the Trust had already remedied these.

Putting it right

The Trust agreed to apologise and pay £750 compensation. It also agreed to put a plan in place to learn the lessons from the failings and make sure they did not happen again.

Organisation we investigated

Plymouth Hospitals NHS Trust

Location

Plymouth

Region

South West

Summary 557/October 2014

Poor communication about waiting times for surgery

Mr J complained that the Treatment Centre, which was run by Care UK, an independent provider of health and social care, failed to give him a date for his hernia surgery, although he contacted it several times. He was in such pain that he had the operation privately. He wanted the Treatment Centre to improve its communication and to refund the cost of the surgery. He also raised concerns about how the Clinical Commissioning Group (CCG) handled his complaint.

What happened

Mr J needed hernia repair surgery. He was assessed at the Treatment Centre, and staff found he was a suitable candidate for surgery. The Treatment Centre told him there was a problem with its booking system and it could not confirm a date. It said it would confirm a date at a later time, but did not say when that would be.

Mr J rang the Treatment Centre many times but it did not give him a date. Ten days after his assessment, Mr J went to see his GP to ask about having the surgery done privately, as the hernia was causing him a great deal of pain. The Treatment Centre then removed Mr J from its waiting list. Just over a week later, Mr J had surgery at a private hospital.

Mr J complained to the CCG. It said the Treatment Centre's communication with him could have been better. However, it said that he would have been treated within the national 18week rule guideline had he waited and not had the treatment done privately. The NHS Constitution states that patients have the right to start their consultant-led treatment within 18 weeks of referral. The CCG said that because of this, the Treatment Centre could not refund the cost of the private treatment.

What we found

All the patients who had their preoperative assessments at the same time as Mr J had their surgery the following month. The Treatment Centre said it was safe to assume that, had Mr J remained on its list, he would also have had his surgery then. We agreed that this seemed likely.

However the Treatment Centre's communication with Mr J was poor. It did not tell him how long he could have expected to wait, even though he contacted it repeatedly for information. Mr J did not know about the 18-week waiting rule. The CCG argued that this information was 'in the public domain'. We decided it was not fair for it to expect Mr J to have known about this without telling him.

There were seven working days between Mr J's preoperative assessment and when he sought a private referral. We appreciate that he was in a great deal of pain during this time. The uncertainty about when he would have the operation would not have been helpful. However, there was no evidence to say the surgery should have been carried out urgently. Therefore, if the Treatment Centre had operated within 18 weeks, this would have been in line with national standards.

Mr J would have been in a better position to make decisions about his treatment options if the Treatment Centre had given him clear information. However, we could not say with certainty that he would not have chosen the private route if the Treatment Centre had given him a firm date. For that reason, we decided not to recommend that the Treatment Centre reimburse Mr J for the cost of the private surgery.

Putting it right

The Treatment Centre took steps to improve its communication about waiting times, so that other patients do not have a similar experience.

The CCG apologised to Mr J for delays in responding to him, and took steps to improve its complaint handling.

Organisations we investigated

Care UK - a Treatment Centre

Somerset Clinical Commissioning Group (CCG)

Location

Somerset

Region

South West

Summary 558/October 2014

Delays to a review meant long wait for funding

Failings by clinical commissioning group when it dealt with a continuing healthcare funding review case.

What happened

Mrs E and Mrs L complained about the way the Clinical Commissioning Group (CCG) handled a request for a review of their mother's eligibility for continuing healthcare funding.

Mrs E and Mrs L complained about delays, failure of the nurse assessor to follow the correct process, and failure to allow family members to contribute to the process. Mrs E and Mrs L also complained that the CCG did not refer the case back to NHS England.

What we found

There were failings in the way the CCG handled this case, including unnecessary delays in reassessing the case. The CCG also did not allow family members to contribute to the process. The CCG provided a reasonable response to this part of the complaint.

The CCG failed to refer the case back to NHS England. This significantly delayed the case and caused frustration and concern to Mrs E and Mrs L. The CCG had not provided a reasonable response to this part of the complaint.

Putting it right

The CCG apologised for not referring Mrs E and Mrs L's case back to NHS England. It also paid £200 compensation for the delays and frustration caused. It prioritised the retrospective review of this case.

Organisation we investigated

NHS Surrey Downs Clinical Commissioning Group (CCG)

Location

Surrey

Region

South East

Summary 559/October 2014

Poor record keeping by Trust staff led to difficulties in investigating complaint

Mr K complained that the nurse who repositioned his wife's nasal tube used excessive force, which led to her having a severe nosebleed.

What happened

Mrs K's nasal tube was dislodged while she was in the hospital X-ray department. A member of staff repositioned the tube but did not note this in her records. By the time Mrs K returned to the ward, she had suffered a severe nose bleed that needed to be treated for some weeks.

The Trust tried its best to identify the staff member based on Mr K's description of her, but ultimately it could not.

Mr K is unhappy that the Trust has not been able to find out who the nurse was because she did not record the incident.

What we found

The staff member who reinserted the nasal tube should have recorded this incident in Mrs K's records. Her failure to do so meant that the Trust's complaints department could not find out who had moved the tube or investigate this issue properly. Mr K was understandably frustrated by this.

Putting it right

The Trust apologised to Mr K that this incident had not been recorded. It also prepared an action plan to address the concerns we had about its poor record-keeping.

Organisation we investigated

Imperial College Healthcare NHS Trust

Location

Greater London

Region

London

Summary 560/November 2014

Mistakes by NHS bursary scheme led to overpayment of bursary

Miss H complained that the NHS Business Services Authority (NHS BSA) mismanaged her NHS bursary causing an overpayment and financial hardship.

What happened

Miss H is an NHS trainee. She initially applied for a student bursary in winter 2011. In spring 2012 Miss H called NHS BSA's helpline and was advised about applying for childcare costs. The records of the call are brief and merely stated that she would be sending in a childcare allowance form, that she asked to go through an assessment, and she said that her partner would call about his income. Her bursary was recalculated a number of times over the following year based on information she gave, and her final award for year one was just over £10,300.

Miss H's year two bursary was awarded in summer 2013 at nearly £4,700. She questioned this and was told that it was the correct amount, and that there had been an error in the previous year's bursary because the NHS BSA had not factored in her partner's income. Following this, Miss H received reminders that she had been overpaid in year one and would have to pay the money back in full, although a repayment schedule could be agreed.

Miss H complained. She was told that the record of her call to the helpline in early spring 2012 did not show she had been given information. The NHS BSA said that staff should have explained to her that she was not entitled to childcare costs for one child because this was based on the information it had about her partner's income and this exceeded the limit to trigger these allowances.

However, Miss H had submitted an application for childcare costs that was processed in late spring 2012. When her childcare costs were entered into the NHS BSA's computer system, the information about her partner's income was erased, so the subsequent calculation of her allowances was incorrect. In a subsequent response, the NHS BSA said she had signed a student declaration which stated that where financial support had been given that the person was not entitled to, the money would have to be repaid. The NHS BSA said it would agree a realistic payment plan, however, the decision stood.

Miss H raised a further complaint, that the NHS BSA had mistakenly sent an update letter to her neighbour. The NHS BSA apologised for this and said that it was a typing error.

What we found

The NHS BSA's explanations about how it calculated Miss B's bursary and overpayment failed to meet the Ombudsman's Principles of being open and accountable. The NHS BSA did not give her further clarification when she asked for this. There were inadequate records of her call to the helpline in early spring 2012, but, based on subsequent actions, it is likely Miss B was not properly advised about her bursary. There was a significant error in the computer system that led to an overpayment, and the NHS BSA breached the Data Protection Act by disclosing personal information to Miss B's neighbour.

Putting it right

The NHS BSA paid £1,000 compensation to Miss H for the stress of having to repay the loan, for the inconvenience it caused by mishandling her application, and for its poor communication with her. It also paid her £250 to acknowledge her loss of confidence in the NHS BSA's administration of her bursary, and £250 for the breach of her confidentiality.

It updated its award notifications and accompanying information so customers can see how it makes its calculations. It also took steps to make sure its helpline gives customers accurate information and makes clear records of the conversations.

Organisation we investigated

NHS Business Services Authority (NHS BSA)

Summary 561/November 2014

Poor complaint handling led to Trust improving its processes

Miss A complained about her outpatient care and also how the Trust handled her complaint.

What happened

During a number of appointments at the Trust, Miss A raised concerns, mainly about her care, but also about its communication. She subsequently complained about the Trust's complaint handling. The Trust addressed the clinical issues and accepted that it had not handled the complaint well, but said it was making improvements.

What we found

There were no faults in the clinical aspects of Miss A's care.

However, the responses to her complaint did not clearly explain what had happened and why. The handling of this complaint was unclear, and the Trust missed opportunities to provide the information and reassurance that Miss A sought.

The Trust explained to us that it had undergone a recent review of its complaints policy and procedure in order to make improvements.

We acknowledged the work the Trust had done since Miss A made her complaint. However, she had not had an appropriate remedy for her complaint.

Putting it right

The Trust acknowledged the faults and apologised to Miss A for the distress and inconvenience caused to her. It also paid her £250 in recognition of the way in which her complaint was handled. The Trust produced an update showing the changes it had put in place and how it would improve complaint handling.

Organisation we investigated

Sandwell and West Birmingham Hospitals NHS Trust

Location

West Midlands

Region

West Midlands

Summary 562/November 2014

Some poor care for woman with multiple sclerosis but this did not lead to her death

Mr B complained about the care given to his ex-wife, Mrs A, while she was in hospital. Mr B said he believed this had contributed to her death.

What happened

Mrs A had advanced multiple sclerosis. She went into hospital with aspiration pneumonia and her condition improved. Staff fitted a PEG tube (a tube through the stomach to help provide nutrition) and a urinary catheter.

During her time in hospital, Mr B said staff banged Mrs A on the head when they moved her from her wheelchair to her bed. He also said that staff administered a PEG feed while Mrs A was lying flat when she should have been upright. Mr B claims that Mrs A's catheter was blocked for several days and that staff did nothing to rectify this. He also said that Mrs A was not given adequate oral care, that is, her mouth was not kept moist and clean. Mrs A developed a further bout of aspiration pneumonia and died.

What we found

Staff did not take care when they moved Mrs A, but the Trust had taken action to address this. That staff did not properly administer Mrs A's PEG feed was a serious failing, but the Trust had taken steps to remedy this by raising the matter with staff, and introducing appropriate training. This did not lead to Mrs A aspirating and therefore we did not find that it led to her death.

There was no evidence that Mrs A's catheter was blocked or not properly managed. However staff did not give Mrs A oral care as they should have done, and the Trust had not taken adequate action to address this.

Putting it right

The Trust prepared an action plan that showed what it has done, or plans to do, to avoid a recurrence of the failings in oral care.

Organisation we investigated

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

Location

Norfolk

Region

East

Summary 563/November 2014

Cause of penile pain not thoroughly investigated

Mr G thought his cystoscopy caused penile pain. We did not find evidence for this, but his pain should have been discussed and investigated further.

What happened

Mr G had suffered from pain and urinary problems. He had a cystoscopy, a procedure to examine the inside of the bladder, and felt that this had been done with excessive force, causing nerve damage and subsequent penile pain. The Trust said this was unlikely. The Trust discharged Mr G after the cystoscopy showed no blood in his urine, but without further attempts to diagnose the cause of his symptoms.

What we found

We agreed with the Trust that it was unlikely that Mr G's cystoscopy caused an injury. However, we felt that Mr G might have a condition called chronic prostatitis/chronic pelvic pain syndrome (CPPS). After Mr G's cystoscopy, staff made inadequate attempts to diagnose or treat his penile pain, and did not consider CPPS specifically.

Putting it right

The Trust apologised for the lack of discussion or attempt to diagnose Mr G's penile pain. It also arranged a further appointment with a view to investigating his symptoms and possible treatment. We said that if it transpired that Mr G had CPPS, the Trust should consider what further remedy would be appropriate.

Organisation we investigated

Heart of England NHS Foundation Trust

Location

West Midlands

Region

West Midlands

Summary 564/November 2014

Trust provided poor care for broken ankle

Mr L broke his ankle and needed medicine to help with the pain.

What happened

Mr L asked the Trust for stronger painkillers because he was still in pain. He said that a member of staff gave him tramadol, a strong painkiller to which he is allergic. He said that, as he had been told that the medication was not tramadol, he took it and was then sick. He told healthcare staff about being sick, and a few days later he was given a different strong painkiller.

Mr L complained to the Trust. The Trust said that although he had been prescribed tramadol, there was no record that he was given any.

What we found

The Trust's investigation was not robust enough. There was enough evidence, including a credible witness, to say that Trust staff gave Mr L tramadol. Moreover, Mr L did not get appropriate strong painkillers for a few days, and was left in pain during this time.

Putting it right

The Trust apologised to Mr L for the failings in his care and its investigation of his complaint. It also paid him £300 in recognition of the avoidable pain, sickness and frustration he experienced.

Organisation we investigated

Worcestershire Health and Care NHS Trust

Location

Worcestershire

Region

West Midlands

Summary 565/November 2014

Nurses did not consider the needs of learning disabled patient in hospital

Mr F's mother complained about his care and treatment during an admission to hospital.

What happened

Mr F had Down's syndrome and dementia. His mother had been his full-time carer throughout his life. He had a series of seizures and was diagnosed with epilepsy. Mr F's GP referred him to the Trust because of concerns that he was dehydrated. While he was in hospital, Mr F suffered a critical illness but gradually improved and was discharged home. He died the following year from an unrelated illness.

Mr F's mother complained about several aspects of the care her son received when he was in hospital. She was also unhappy about how the Trust handled her complaint.

What we found

There were areas of Mr F's nursing care where staff did not properly consider his rights under disability discrimination law. In planning and providing care for Mr F, staff at the Trust did not have proper regard for its obligations to him. Nurses did not follow established good practice: they were aware that Mr F was at high risk of falling and they also failed to assess his continence needs and ability to eat and drink. The Trust was not open, accountable or customer-focused in how it handled the complaint.

Mr F's mother suffered distress when she witnessed some of the poor care, and the poor complaint handling made this worse.

Putting it right

The Trust acknowledged and apologised for the failings and the injustice Mr F's mother suffered. It paid her £1,000 compensation and agreed to draw up plans to demonstrate learning from the complaint.

Organisation we investigated

Sandwell and West Birmingham Hospitals NHS Trust

Location

West Midlands

Region

West Midlands

Summary 566/November 2014

Further assessment was needed to determine health care funding

Miss T complained that the Clinical Commissioning Group did not properly review her mother's eligibility for continuing healthcare funding.

What happened

The Clinical Commissioning Group (CCG) received a request from Mrs T's daughter, Miss T, for a retrospective review of Mrs T's eligibility for continuing healthcare funded care. It did a checklist assessment in line with the national standards.

The CCG concluded that there was not enough evidence to show that Mrs T should undergo a further, more detailed assessment of her needs.

What we found

The CCG failed to consider all the relevant evidence properly. It did not see that Mrs T should have had another assessment, a decision support tool (DST) assessment, for each of the retrospective care periods it was reviewing.

Putting it right

The CCG agreed to conduct DST assessments for each of the retrospective review periods in question.

Organisation we investigated

North Derbyshire Clinical Commissioning Group (CCG)

Location

Derbyshire

Region

East Midlands

Summary 567/November 2014

Trust suggested removing patient's ovaries when this was not clinically necessary

Ms J was unhappy with her care and said the Trust did not address her concerns. It also mislaid her clinical records.

What happened

Ms J was diagnosed with breast cancer, for which she received clinical treatment at the Trust. Ms J questioned whether that treatment was enough to avoid her subsequently developing secondary cancer.

After the treatment, Ms J said, the nursing team did not manage her side effects, which caused her unnecessary pain and distress.

Staff then told Ms J that it was necessary to remove her ovaries because of a non-malignant mass not connected to her cancer. She questioned this decision via a second opinion, which concluded that the removal of her ovaries was not clinically necessary.

When Ms J complained to the Trust, it delayed giving reasonable explanations to all the points she raised, so she complained to us.

When we asked the Trust for clinical records so we could investigate the aspects of Ms J's complaint, the Trust had mislaid the records. Therefore we were unable to reach firm conclusions about some aspects of the complaint.

What we found

The treatment Ms J received for her breast cancer met the expected standards at the time, and the Trust's explanation of this was reasonable. There was no evidence that its actions would cause Ms J to develop secondary cancer unnecessarily.

The nursing care after treatment was inadequate, and caused Ms J avoidable suffering. The Trust failed initially to fully recognise those flaws.

There was no clinical need for Ms J's ovaries to be removed, and staff did not take relevant considerations into account when they decided on the treatment plan.

The Trust's handling of Ms J's complaint was unacceptably delayed and incomplete, and its loss of clinical records indicated systemic failures in the records management process.

Putting it right

The Trust agreed to audit its records management system and to give a written explanation of the actions it took to remedy the flaws we found.

It agreed to take action to make sure there was no repeat of the nursing flaws we found, and to give Ms J an explanation of the action it had taken.

The Trust agreed to arrange further training for the clinicians responsible for the decision to remove Ms J's ovaries, and to make sure that its future actions to treat ovarian cysts are in line with recognised guidance.

The Trust also agreed to pay Ms J £250 in recognition of its poor complaint handling and the loss of her clinical records, and to give her an explanation of the improvements it has made to its complaint handling service.

Organisation we investigated

Barts Health NHS Trust

Location

Greater London

Region

London

Summary 568/November 2014

Woman took excessively high dose of medication for three months after GP failed to check prescriptions

Ms G's GP Practice prescribed too high a dose of a blood thinning medication. The Pharmacy dispensed the dose when it should have done more to check it was correct. This put Mrs G's health at risk for three months.

What happened

In spring 2013 Ms G went to hospital with a weakness in her left arm. Staff suspected that she had had a stroke. They gave her a single dose of 300mg clopidogrel (a blood thinning drug) to treat this, and discharged her with an appointment at the stroke clinic. When staff at the stroke clinic reviewed Ms G, they prescribed her 75mg clopidogrel, one tablet to be taken daily.

In summer, Ms G asked for a repeat prescription of 75mg clopidogrel from her GP Practice. The Practice prescribed her 300mg clopidogrel, one tablet to be taken daily. The Practice issued two repeat 300mg prescriptions the next month. When Ms G returned to the Practice for a further repeat prescription, the Practice nurse arranged for the prescription of clopidogrel to be changed from 300mg to 75mg.

Ms G complained to us about the Practice prescribing the incorrect dose. She also complained that the Pharmacy had repeatedly dispensed the incorrect dose.

What we found

We upheld Mrs G's complaint about the Practice. It mistakenly prescribed Ms G 300mg clopidogrel three times instead of the 75mg clopidogrel she should have had. Ms G's GP's failure (or the failure of any other practitioner registered to prescribe medication at the Practice) was the root cause of the medication error.

The new prescribing protocol that the Practice set up - to make sure that all repeat prescriptions would be tagged and authorised by the GP in future - showed that it had learnt from what had happened. However, we did not think that it had explained what had happened in its response to Ms G. It had also not given Ms G an appropriate acknowledgment and apology.

We also considered that there was an increased risk to Ms G's health for a period of three months and it is possible that the bruising, dizziness and gastrointestinal problems she suffered were caused by the excessive dose of clopidogrel.

We did not uphold the complaint about the Pharmacy. There was no documented evidence to support the Pharmacy's explanation that it had queried the prescription of 300mg clopidogrel with Ms G's Practice. However, as this was a non-standard dose that would need to be specially ordered by the Pharmacy, we concluded that, on balance, this conversation did happen and it was therefore appropriate to have dispensed the prescription.

The Pharmacy apologised to Ms G for dispensing too high a dose of clopidogrel to her three times. It also discussed this incident with its staff, and amended its standard operating policy to include instructions for staff to discuss any non-standard doses with the patient (if this is not already documented) and to record those discussions.

We considered this to be an appropriate and proportionate remedy to Ms G's complaint about the Pharmacy.

Putting it right

The Practice acknowledged and apologised for its failings, and the GP agreed to discuss what had happened with his responsible officer. The Practice paid Ms G £250 compensation for the potential threat to her health and her subsequent loss of confidence in the Practice.

Organisations we investigated

A GP practice

A pharmacy

Location

Lancashire

Region

North West

Summary 569/November 2014

Trust did not make adequate follow-up plans for man with heart condition who later died

Mr W had a history of endocarditis and went to the hospital's A&E department twice in one month. When staff discharged him on the second occasion, they told him to go to his GP for follow-up tests. This did not happen and he later died.

What happened

Mr A complained to us that his partner Mr W had gone to hospital and had not been admitted. He said he went back around two weeks later and again was not admitted. Mr A said if Trust staff had admitted Mr W, he could have been treated and would not have died.

What we found

The first assessment in A&E was not as thorough as it should have been. There were no failings in the assessments and care Mr W received on the second occasion, and none in the decision to discharge him.

There were failings in the discharge plan on the second occasion because staff did not make adequate arrangements to make sure that repeat blood tests were carried out, and they did not arrange a follow-up cardiology appointment.

Mr W's death could not have been prevented, but the failings meant that Mr A would always be uncertain about this, and this would have a long-lasting and upsetting effect on him.

Putting it right

The Trust apologised to Mr A for the failings, and agreed to draw up an action plan to explain how it would prevent a recurrence. The Trust agreed to share this plan with the Care Quality Commission, which is responsible for the inspection and regulation of hospitals.

Organisation we investigated

Brighton and Sussex University Hospitals NHS Trust

Location

West Sussex

Region

South East

Summary 570/November 2014

Patient's heart rate dropped before cardiac arrest

Mrs B went into hospital and when her heart rate dropped, the Trust did not take appropriate action. Ward staff did not have details of her regular medication, so her Parkinson's medicine was delayed.

What happened

Mrs B went into hospital with hip and back pain. Her condition got worse; she developed bronchopneumonia and subsequently died.

What we found

Staff failed to carry out a medicines reconciliation process when Mrs B was admitted, which delayed her essential medication for Parkinson's disease.

Staff did not take any action when an ECG showed a significant drop in Mrs B's heart rate just before she had a cardiac arrest.

However, it was unlikely that any intervention could have been made between the ECG and Mrs B's cardiac arrest, and her death was not avoidable.

Putting it right

The Trust apologised to Miss B, Mrs B's daughter, for the delay in giving Mrs B her Parkinson's medication. The Trust also put together action plans to show how it had learnt from its mistakes with regard to medicines reconciliation and its response to a significant low heart rate, so that the mistakes would not happen again.

Organisation we investigated

Mid Essex Hospital Services NHS Trust

Location

Essex

Region

East

Summary 571/November 2014

Inadequate hospital care for patient with dementia

Mr S experienced delays and failings in nursing care during a short stay in hospital.

What happened

Trust staff left Mr S, who had dementia, on a trolley in A&E for at least 33 hours before they moved him to an assessment unit. He then stayed in the assessment unit for 42 hours. His wife, Mrs S, complained about the delays and other aspects of his care. She was also dissatisfied with the action the Trust took after the events, which did not reassure her that it had learnt from her complaint.

What we found

Mr S had to wait in both departments for too long, and nurses did not provide an appropriate care plan for him, given his needs. There were also failings in the way nurses communicated with Mr and Mrs S. This was service failure and contributed to Mr S's distress, and caused Mrs S to be upset.

The Trust's responses to the complaint gave no reassurance that the failings would not happen again.

Putting it right

The Trust acknowledged and apologised for its failings and the resulting injustice. It also paid Mrs S £500 compensation. The Trust agreed to explain what action it has taken or proposes to take to ensure that there is learning from what happened to Mr and Mrs S.

Organisation we investigated

University Hospital Of North Staffordshire NHS Trust

Location

Staffordshire

Region

West Midlands

Summary 572/November 2014

Delays in diagnosing spreading cancer

When Mr R developed a lump on his hip, staff at the Trust wrongly diagnosed it as an abscess. The Trust treated it with antibiotics instead of investigating further and correctly diagnosing it as spreading cancer.

What happened

The Trust diagnosed Mr R with terminal cancer in early 2009. He developed a lump on his hip in late 2009 and the Trust diagnosed it as an abscess in spring 2010. Staff treated this with antibiotics.

In early summer 2010, Trust staff decided that the lump could show that Mr R's cancer was spreading, and arranged scans. Doctors found widespread cancer and Mr R had radiotherapy, but before clinicians could consider or start chemotherapy, his condition deteriorated to the point where he was no longer well enough to have the treatment.

Mr R died in late summer 2010. Miss T, his daughter, complained that the delay in diagnosing and treating him meant her father could not have chemotherapy. She said he suffered unnecessary pain and discomfort because of these delays.

What we found

The care and treatment given was appropriate. There were no delays in diagnosis or treatment. However, communication with Mr R and his family about planned chemotherapy treatment was poor and caused confusion about what was happening, and distress. There were also delays in complaint handling.

We partly upheld the complaint.

Putting it right

The Trust apologised to Miss T and paid her £250 in recognition of the distress it had caused. It also took steps to make sure that staff are aware of the need for clear and correct communication with patients and their families.

It explained to Miss T what improvements it has made to make sure that it deals with complaints more quickly.

Organisation we investigated

East Lancashire Hospitals NHS Trust

Location

Lancashire

Region

North West

Summary 573/November 2014

Pregnant woman suffered avoidable distress because of poor explanation

When Ms F was pregnant, routine blood tests showed that she had caught a virus that could have caused her baby to be born with serious disabilities.

What happened

Scans showed that Ms F's baby was very small in the womb and Ms F was extremely distressed. Believing that her baby would be seriously disabled because she had caught a virus, she decided to terminate the pregnancy.

The Trust agreed to carry out the procedure but because it could not do this on the date Ms F had chosen, it referred her to another hospital for the first stage of the procedure. Doctors at that hospital said there was not enough evidence to terminate the pregnancy and arranged further tests. Ms F went ahead with the pregnancy and had a baby girl.

Ms F complained to the Trust about her care. The Trust said that the virus meant that there was a 25% chance her baby would be seriously disabled. Ms F said she had been misinformed about this and was given to understand that the risk was higher.

What we found

The Trust had not given Ms F a clear enough explanation of its view of the risk that her baby would be disabled. This meant that Ms F's ability to make a fully-informed decision about whether to proceed with the pregnancy was reduced. There was also a delay in carrying out a test that might have helped. As part of referring Ms F to the other hospital, the Trust should have found out whether the other hospital would be willing to carry out the termination. The failings in Ms F's care added to her distress at a very difficult time.

Putting it right

The Trust apologised to Ms F for not giving her an adequate explanation of the risk that her baby would be disabled. It also paid her £750 in recognition of the distress this caused. It agreed to draw up plans to improve its process for referring patients to other hospitals. As a result of Ms F's experience the Trust has already made some other improvements to how it cares for patients who test positive for this virus.

Organisation we investigated

Barking, Havering and Redbridge University Hospitals NHS Trust

Location

Greater London

Region

London

Summary 574/November 2014

Ambulance should have taken frail, sick, older woman to hospital

A paramedic decided to leave a frail woman in her eighties alone at home with inadequate support although she was suffering with diarrhoea.

What happened

Mrs D had diverticular disease and lived alone with visits from carers three times a day. In spring 2013 she started vomiting and developed diarrhoea. She sat in an armchair all night and the following morning, her carer found she had soiled herself.

The carer called an ambulance, and a clinician called back to assess Mrs D. A paramedic was sent to carry out a face-to-face assessment and decided that Mrs D's condition could be managed at home. He made a referral to the local admission prevention service for Mrs D to receive a carer visit in the afternoon to check on her.

The evening carer made a further 999 call and contacted Mrs D's son-in-law. The paramedic did not want to take Mrs D to hospital and her son-in-law had to call her daughter, Mrs A, to speak to him about Mrs D's medical history and conditions. The paramedic agreed reluctantly to take Mrs D to hospital.

Mrs D died soon after. The death certificate said she had septicaemia caused by diverticulitis and also acute kidney failure.

Mrs A complained to the Trust about the initial decision not to take Mrs D to hospital after the first 999 call and the inadequacy of the support for her. She also complained about the poor assessment and attitude of the second paramedic, particularly his view that hospitals are reluctant to take older patients with diarrhoea and vomiting because of the risk of cross infection.

What we found

We partly upheld Mrs A's complaint. Mrs D should have been taken to hospital after the first 999 call. Although she did not appear to have life-threatening symptoms, she was not able to use a commode without help, so it was not appropriate to leave her alone. The failure to take Mrs D to hospital sooner caused her avoidable distress, discomfort and loss of dignity.

The delay in getting hospital attention did not cause the sad outcome.

There were failings in the attitude and assessment of the second paramedic and some shortcomings in complaint handling.

Although there is a risk of cross infection from older patients with diarrhoea and vomiting, the decision to transport them to hospital must be based on an assessment of each person's condition, circumstances, and the risks associated with alternative courses of action. The primary consideration is the best interests of the individual patient.

Putting it right

The Trust fully acknowledged and apologised for failings in the second ambulance attendance. It has taken reasonable steps to prevent a recurrence. The Trust acknowledged and apologised for shortcomings in complaint handling and we believe that no further action is needed. As we consider that the Trust has done enough to put things right, we did not uphold this part of the complaint.

However, the Trust did not acknowledge failings in relation to the first ambulance attendance. The Trust's medical director should review this case and consider what action should be taken to learn from it so that it will not happen again.

The Trust apologised for the failure to take Mrs D to hospital in the first ambulance and for the impact this had. It has provided details of the action it has taken to improve its service.

Organisation we investigated

East of England Ambulance Service NHS Trust

Location

Cambridgeshire

Region

East

Summary 575/November 2014

Inadequate pain management for man dying of cancer in hospital

Mr B's wife was distressed during his final days when she saw him pleading for pain relief.

What happened

Mr B had renal cancer. In summer 2013 he went into hospital with severe sepsis. He died three weeks later. During his time in hospital, the palliative care team saw him every day and he had a number of painkilling medications. However, he told his wife and family at visiting times that he was left in pain because his medication was given late on many occasions.

Mrs B complained that her husband did not receive adequate painkilling medication. She said she had been tortured by images of him pleading for pain relief, which she said made her depressed and unable to sleep.

Mrs B also complained about how the Trust dealt with her complaint. She said the responses she received were not substantial enough, given the seriousness of her complaint.

The Trust met Mrs B in winter 2013 to discuss her complaint.

What we found

There was some confusion about what Mrs B expected the Trust to do after the meeting, because no minutes were taken and we could not say what was agreed. Mrs B spent many months waiting for the Trust to write to her. It apologised for the confusion, which we felt was appropriate. We did not uphold this part of the complaint.

While Mr B received good care from the palliative care team, there was a lack of initial and on-going pain assessments by nursing staff on the ward. This meant that Mr B's pain control was poor on many occasions.

The cancer pain management guidelines state that pain assessments should show the location of the pain, how severe it is, what makes it worse and the effect the pain has on the patient. These guidelines also say that accurate assessment and reassessment of pain is essential to improve pain relief.

Staff did not carry out any pain assessments during Mr B's time in hospital. This meant that on far too many occasions, he was in pain and did not get medication for the pain soon enough. This failing was serious and resulted in unnecessary pain for Mr B, upset for his wife when she visited him in hospital and also ongoing distress for her after his death. The Trust had not acknowledged any failings in Mr B's pain management and we upheld the complaint.

Putting it right

The Trust apologised to Mrs B for the failings in her husband's pain management, and paid her £1,000, in recognition of how she suffered reliving the memories of her husband's pain.

It also sent her an action plan detailing what changes it will make to help prevent a similar thing happening to other patients in the future.

Organisation we investigated

Walsall Healthcare NHS Trust

Location

West Midlands

Region

West Midlands

Summary 576/November 2014

Patient discharged herself from hospital because she was concerned about her care and treatment

Mrs S had diabetes and severe respiratory problems. She discharged herself from hospital because she lacked confidence in her medication care.

What happened

Mrs S's GP referred her to the Trust's A&E department because she had serious respiratory problems. The specialist registrar saw her and diagnosed acute exacerbation of asthma, and noted that Mrs S wanted to go home. It was agreed that she should continue with the medication her GP had prescribed and would go back to the hospital the next day to make sure that her asthma was settling.

When she returned, she saw a respiratory consultant who thought that she had not improved enough, and recommended that she was admitted the same day.

In hospital Mrs S became concerned as she did not receive either her insulin for her diabetes or the steroids she expected. She discharged herself the next day but when she tried to leave, the staff called security, who tried to stop her from leaving without signing the self-discharge form. Mrs S refused, and left with a friend.

What we found

It was more likely than not that a consultant had said that Mrs S needed the steroid but then did not write the prescription. This did not have any long-term effect on her condition but it would have made her lack confidence in her care.

The Trust's response about Mrs S's insulin was unreasonable. It initially said that staff gave her the insulin, but later accepted this was not correct and staff had not given it to her. The Trust then gave a contradictory explanation of why staff did not give Mrs S the insulin.

There were also concerns about medicine reconciliation. If good practice is in place, staff prescribe the correct medications at the right dose and at the right time when a patient goes into hospital. But this did not happen, and Mrs B's insulin does not appear to have been prescribed throughout her time in hospital.

The Trust also said that Mrs S had refused steroid medication. This was not correct and the rationale for not giving it was unreasonable. This would have led Mrs S to feel anxious about her care and was an additional factor that led to her discharging herself.

Nurses on the ward were not aware that Mrs S had diabetes and she had to ask for insulin and for something to eat. But it is clear from the assessment unit records that Mrs S was diabetic and needed frequent blood glucose monitoring. Because of a failure in communication, Trust staff did not prescribe Mrs S's insulin and did not monitor her blood glucose until the evening.

If, as is established practice, ward staff had fully reviewed her medical and nursing record from the assessment unit, they would have seen that Mrs S had diabetes.

Mrs S chose to discharge herself because she was concerned about her treatment. The Trust said that security staff were called as Mrs S refused to sign a self-discharge form, but this form is not required if a patient has mental capacity and decides they want to leave the hospital.

The care records show that nursing staff discussed the risks of discharging herself with Mrs S and that she had the mental capacity to decide to do this. Therefore, there was no need for security to be involved. This was inappropriate and added to her stress and anxiety.

Putting it right

The Trust wrote to Mrs S to acknowledge and apologise for its failings and for the impact that these had on her. It also agreed to develop an action plan to address the failings identified.

Organisation we investigated

Luton and Dunstable Hospital NHS Foundation Trust

Location

Central Bedfordshire

Region

East

Summary 577/November 2014

Dental practice did not follow guidance when it removed a patient from its list

Mr A had been removed from the Practice's list but he only found out when he tried to make an appointment.

What happened

Mr A was unhappy with several aspects of how the Practice operated and had complained about this. The Practice removed Mr A from its list of patients because he failed to go to appointments, but he felt it was because he had complained. Mr A only found that he had been taken off the list when he tried to make an appointment. He then had difficulty in finding another dentist.

What we found

Mr A's attendance was poor and in these circumstances the Practice was acting within General Dental Council guidance by removing him from its list. There was no evidence that his removal from the list was because Mr A had complained. However by not writing to Mr A to tell him of its decision to remove him, or by explaining how to find a new dentist, the Practice did not follow General Dental Council guidance.

Putting it right

The Practice wrote to Mr A to apologise for not following the appropriate guidance and paid him just over £50 for the inconvenience and distress this caused him.

Organisation we investigated

A dental practice

Location

West Yorkshire

Region

Yorkshire and the Humber

Summary 578/November 2014

Trust's failure to diagnose kidney stone

Pregnant woman told her kidney stones were a muscular problem.

What happened

When Ms S was six months pregnant she went to the Trust's A&E with severe back pain. A junior doctor told her it was likely to be a muscular problem and did not carry out further tests. The doctor told Ms S to take paracetamol and to contact her GP or midwife if she had any further problems. She was then discharged.

Ms S said that later that day, she was taken to A&E at another hospital as she was still concerned. Doctors diagnosed her with a kidney stone and admitted her for treatment. She said staff at the second hospital carried out urine and blood tests immediately and monitored her baby's heart rate.

Ms S complained to the Trust about the care at the first hospital; that the doctor had misdiagnosed her and that no one had checked on the health of her unborn baby. She said the Trust had told her when she complained that there had been no foetal distress, but that she wasn't reassured by this response because it had misdiagnosed her back pain.

What we found

The Trust had not carried out a urine test. The likely results of this would have led to further investigations. This meant Ms S may well have been admitted instead of seeking treatment elsewhere. If the doctor had suspected that kidney stones were the cause of Ms S' pain, a referral to the obstetric team as well as to urology team would have been required. Kidney stones can be complicated by a urine infection and any fever may cause a pregnant woman to go into labour.

The failings in Ms S's care caused her distress and concern for her unborn baby.

Putting it right

The Trust acknowledged and apologised for the failings in the junior doctor's assessment and the investigation of Ms S's symptoms. It acknowledged the need to consider a referral for admission to hospital or specialist follow up and obstetric review. The Trust agreed to explain what it has done to prevent a reoccurrence of these failings.

Organisation we investigated

Royal Devon and Exeter NHS Foundation Trust

Location

Devon

Region

South West

Summary 579/November 2014

Four days delay in diagnosing hip fracture

When Mr C went to A&E after falling at home, the Trust failed to take adequate X-rays to confirm that he had fractured his hip.

What happened

Mr C went to A&E after falling at home and was admitted with a possible hip fracture. The X-rays taken were inconclusive and it was only when a CT scan was done three days later that a fracture was confirmed. Mr C then had surgery to replace his hip.

What we found

The X-rays taken on admission were inadequate to show whether Mr C had fractured his hip, and more X-rays should have been taken at the time. The request for a CT scan could also have been made sooner, which would have avoided the delay in diagnosing and treating Mr C's hip fracture.

Putting it right

During the course of its own investigation the Trust revised and improved its procedure and timescale for managing hip fractures, and this is in line with guidance from the National Institute for Health and Care Excellence (NICE) and the British Orthopaedic Association. Following our investigation the Trust agreed to write to Mrs C with an acknowledgement and apology for the delay in diagnosing Mr C's hip fracture. The Trust paid £500 compensation for the pain and distress caused to Mr C by the delay.

Organisation we investigated

West Hertfordshire Hospitals NHS Trust

Location

Hertfordshire

Region

East

Summary 580/November 2014

Long wait for cancer tests and treatment

The Trust did not follow cancer waiting time targets and Mr A was kept waiting too long.

What happened

Mr A went to hospital with possible prostate cancer symptoms. There were considerable delays as he underwent investigations. When he was eventually diagnosed with prostate cancer he faced a further wait for surgery and decided to pay for private treatment.

What we found

The Trust followed the correct sequence of investigations but Mr A suffered as a result of the slow pace of his progress through the system. The cancer waiting time targets were breached by a significant margin. If he had faced further delay on the NHS waiting list, the effect on his prognosis could have been greater. Mr A suffered great distress and worry for several months as a result of this delay, which led him to seek prompt private treatment.

Putting it right

The Trust acknowledged its failings and apologised for the injustice. It paid him £5,000 in recognition of the money he spent on private treatment because of its delays. It prepared an action plan to address shortfalls in that service.

Organisation we investigated

University Hospital Southampton NHS Foundation Trust

Location

Southampton

Region

South East

Summary 581/November 2014

Area Team didn't investigate complaint about GP properly

Mr P was unhappy about the investigation into his complaint that his wife's GP failed to refer her to hospital before she died.

What happened

Mr P complained about the care that his wife received from her GP before her death. He made the complaint to NHS England which was handled by its West Yorkshire Area Team.

The Area Team received Mr P's complaint in early summer 2013 and received the GP's comments the next month. Mr P chased the response twice in the autumn but the Area Team did not respond until nearly the end of the year.

Its response was brief and said that the GP had managed Mrs P's care in line with national guidance. Mr P was unhappy with its investigation and complained to us.

What we found

There was no reason for the Area Team's delay in responding to Mr P, and it was unreasonable that Mr P had to wait over three months for a response and was not kept updated.

The information from the GP to the Area Team was limited and lacked detail about the care provided to Mrs P. However, despite this, the Area Team provided a response saying that the GP had managed Mrs P 'in accordance with national clinical guidelines'. However, there was no evidence to support this or show which guidelines it was referring to.

Mr P had made a serious complaint. He believed that if the GP had referred his wife to hospital, she may not have died. However, although this was not the case, there was no evidence that an appropriate investigation had been carried out. Mr P had no assurance that the Area Team had taken his complaint seriously, or looked into it in line with the NHS complaint regulations and its own complaints handling policy.

The Area Team should have obtained a more detailed response from the GP and then made sure it was clinically accurate before reaching its conclusion. It failed to do so, and as a consequence it added to Mr P's upset and depression following his wife's death. It also meant that additionally he had to bring his complaint to us.

Putting it right

West Yorkshire Area Team wrote to Mr P to acknowledge and apologise for the failings we identified in its complaint handling and the impact that this has had on him. It also paid him £250 to reflect the additional upset caused, and drew up plans to make sure lessons were learnt from this complaint.

Organisation we investigated

West Yorkshire Area Team

Location

West Yorkshire

Region

Yorkshire and the Humber

Summary 582/November 2014

Failings in communication about confidentiality

Ms A complained that confidential information about her was shared, when she had been assured that it would not be.

What happened

Ms A saw a hospital doctor to discuss a long standing medical issue, and as part of the consultation she spoke about personal issues which she was told would not be shared. Subsequently the doctor wrote to her GP, and included some information about her personal issues.

Ms A also complained that a treatment that she had been promised was cancelled inappropriately.

What we found

The Trust had not fully addressed the failings in communication about confidentially in its response to the complaint. It also had not fully addressed all of the issues that Ms A had raised.

Putting it right

The Trust acknowledged the failings in this case and apologised to Ms A for these.

Organisation we investigated

Blackpool Teaching Hospitals NHS Foundation Trust

Location

Blackpool

Region

North West

Summary 583/November 2014

Dental practice failed to properly treat a woman's gum disease

A woman was not properly treated for gum disease and this led to the avoidable loss of two of her teeth.

What happened

Miss G had gum disease, and went to her dental practice for appointments every six months over three years. She was not given an essential type of examination for patients with gum disease or an X-ray during that time. Her appointments were also too short to properly treat her for the condition, and she should have been seen more regularly. After Miss G moved to another practice she had to have two of her teeth extracted.

What we found

The Practice's ability to provide an open and honest response to Miss G, and our ability to thoroughly investigate her care, was hindered by the poor quality of her dental records. Considering the evidence that was available to us, the treatment provided to Miss G was not in line with relevant dental guidelines or established good practice. Our investigation concluded that on the balance of probabilities, Miss G lost her teeth as a result of the Practice's failings.

Putting it right

Following our investigation, the Practice apologised to Miss G and paid her £2,000. The Practice updated its quality assurance and clinical audit policies, and put an action plan in place to ensure quality control.

Organisation we investigated

A dental practice

Location

Bristol

Region

South West

Summary 584/November 2014

A woman with learning disabilities waited three months for psychiatric appointment

A three month wait for a psychiatric appointment left a woman with autism and learning disabilities without the help and support she required. During this time she experienced extreme symptoms from her change in medication.

What happened

Ms G has autism, mild cerebral palsy and a learning disability. Now in her forties, she has been cared for by her parents without the need for outside support, and has always taken part in conversation and led an active life. Ms G had been taking one specific antipsychotic for over 20 years for her diagnosis of childhood autism with agitation.

In early spring 2013 Ms G was referred by her GP to NAViGO Health and Social Care Community Interest Company, a healthcare provider. This was for a psychiatric evaluation of her medication because the antipsychotic was causing stiffness and rigidity in her limbs. As a result, this medication was stopped and a she was given a different antipsychotic. Ms G's health began deteriorating, and over the course of the next seven months the medication was changed twice more but her symptoms worsened.

NAViGO delayed a psychiatry appointment for Ms G by three months, leaving her parents with no option but to seek and pay for private psychiatric treatment. In late 2103 Ms G had a breakdown and needed to be admitted to a mental health unit where she was given her previous dose of the original antipsychotic. She has steadily but slowly improved since, but now requires antidepressants and tranquilisers to counter the effects of the health deterioration.

What we found

We partly upheld this complaint. The decision to change the medication was reasonable, owing to the negative effects the original antipsychotic was having. This was done over a three week period and while relatively quick, is in line with guidance.

The replacement antipsychotics were reasonable, in both the timeliness of their introduction, their type and their dosage.

Unfortunately Ms G suffered from both drug withdrawal and the new medication, but this was not unreasonable in light of the decisions to change her medication.

NAViGO did provide adequate access to support services for Ms G and her family.

While we understood that the psychiatric appointment was cancelled owing to the psychiatrist taking urgent leave, it was unreasonable that the appointment was rescheduled for three months later. Particularly in light of the symptoms Ms G was suffering, this left her family with no option but to seek and pay for private psychiatric care. It was unreasonable for them to have to wait three months.

We were satisfied that NAViGO's responses did not cover up any aspect of the care, but agreed with Ms G's parents that it did not consider all aspects of the complaint.

Putting it right

NAViGO apologised and acknowledged its failings. It paid Ms G £1,400 to reimburse the costs of the private psychiatric care she had as a result of its rescheduling delay, and to acknowledge the worry, concern and distress caused.

It drew up three action plans to address its failure to properly inform Ms G and her parents about the potential side effects of medication; its failure to link the support team's actions with Ms G's specific needs; and its complaint handling failings.

Organisation we investigated

NAViGO Health and Social Care Community Interest Company

Location

Lincolnshire

Region

East Midlands

Summary 585/November 2014

Failings in the assessment and care of a patient with meningitis delayed his diagnosis and treatment but did not result in an unavoidable death

Mr R complained that his late brother, Mr J went to the Trust's A&E department in spring 2013 with signs of infection but he was not treated for this for eight hours. Mr R believed that hospital staff judged his brother had alcohol related issues.

What happened

Mr J was in his thirties. He lived with his mother, who he cared for, and he was due to start an alcohol rehabilitation programme two days after he went to A&E. On the day he went to A&E, Mr J's sister found him in his bedroom suffering from the aftermath of a fit. She noted that he had a high temperature, was unable to stand unaided, was audibly chesty and had a superficial injury to his head. She called an ambulance.

In the ambulance Mr J was given paracetamol and arrived at A&E at about midday. Mr J's family say that from the outset they heard staff imply in their comments that his condition was probably related to alcohol use.

At triage Mr J's diagnosis was alcohol withdrawal and a head injury with confusion. The confusion was thought to be the result of the head injury, infection or alcohol withdrawal. He was started on the alcohol abuse care pathway and referred for a CT scan of his head which returned a normal result. He was given medication for symptoms of alcohol withdrawal and referred to the medical team. His condition continued to deteriorate. In the evening he was diagnosed with a possible chest infection and possible encephalitis and started on antibiotics.

Later that night Mr J was transferred to the high dependency unit, placed in an induced coma and diagnosed with bacterial meningitis. The next day Mr J's sedation was withdrawn but he failed to improve. A CT brain scan showed extensive, irreparable brain damage. On the following day Mr J's respirator was switched off and he was declared dead.

The Trust acknowledged and apologised for delays in initial triage and medical assessment due to high demand in A&E that day. However it denied that Mr J suffered as a consequence.

The Trust accepted no failing in the triage rating or any unreasonable delay in reaching the correct diagnosis. It stated that there was no obvious sign of infection and no indication to start antibiotic treatment at an earlier stage.

What we found

There were delays in triage, and lost opportunities in A&E for earlier medical review and possibly earlier medical intervention.

There were a number of missed opportunities to identify the seriousness of Mr J's condition that were not acknowledged by the Trust. Earlier triage and an earlier initial assessment by an A&E doctor should have prompted an earlier review by a senior doctor. Indications that Mr J needed to be seen by a senior doctor in the afternoon and evening were missed.

If a more experienced doctor had seen Mr J earlier, and particularly in the afternoon when CT and blood test results were available, it is possible that the diagnosis would have included a central nervous system infection. This may have resulted in the earlier use of antibiotics and referral to the critical care team.

Although we agreed with the Trust that Mr J's death was probably unavoidable, there were significant failings in his care in A&E which the Trust had not addressed in its response to this complaint. We therefore made recommendations for systemic improvement.

We partly upheld this complaint.

Putting it right

We asked the Trust to prepare an action plan describing what it had done or planned to do to address the failings we had identified.

Organisation we investigated

Wirral University Teaching Hospital NHS Foundation Trust

Location

Merseyside

Region

North West

Summary 586/November 2014

GP failed to examine patient's painful knee

Although Miss T had a history of arthritis, her GP failed to examine her when her knee became painful again.

What happened

Miss T has a history of arthritis from her childhood. When she consulted the GP Practice with a flare-up from her knee in late 2012 she said that the GP did not examine her knee. Six weeks later Miss T returned to the Practice as she was still in pain. A different GP agreed to refer her to a specialist. However when Miss T contacted the Practice again the following year, it was discovered that the referral had not been received. Miss T saw the original GP again and another referral was made.

Miss T complained to the Practice. The first GP said he was unable to recall if he had examined her knee. However the Practice told Miss T she had received the 'standard treatment'. Miss T remained unhappy and asked us to investigate.

What we found

There was no evidence that the first GP examined Miss T's knee. This was not consistent with published NICE guidance. Miss T should have been referred by the first GP and should not have needed to return again six weeks later. We were satisfied that the referral to a specialist was sent, and we found no evidence the Practice was aware of any problem until Miss T contacted them again the following year.

A rheumatology specialist told us there was no evidence that the delay had any significant impact on Miss T's condition and explained her treatment would have been the same even if the referral had been made sooner. However they agreed that an earlier referral would have been likely to rapidly improve

Miss T's symptoms. We partly upheld the complaint.

Putting it right

The Practice apologised to Miss T and paid her £250 in recognition of the delay in making the original referral. The GPs have made sure they are up to date with the latest guidance on the management of knee pain.

Organisation we investigated

A GP practice

Location

Greater London

Region

London

Summary 587/November 2014

A four day delay in a cancer diagnosis, and Trust ignores independent review

Mrs A's family struggled to get acknowledgements and improvements from the Trust even after independent evidence.

What happened

Mrs A was admitted to hospital in early 2013 after suffering a stroke. While she was an inpatient, she developed abdominal pains which were initially thought to be related to acid reflux. Her appetite reduced during her stay and she continued to suffer with pain in her abdomen and back. Mrs A was discharged eight weeks later.

Mrs A remained unwell after her discharge and was readmitted to hospital with jaundice in spring 2013. Following a number of tests, Mrs A had a CT scan which revealed that she had pancreatic cancer. Mrs A died shortly afterwards.

What we found

Our investigation highlighted a number of shortcomings and failings in the way that Mrs A was treated both during her first and second admission. We cannot say it is more likely than not that her cancer would have been diagnosed during the first admission had the tests been carried out, but we can definitively say that she should have been diagnosed at least four days earlier, during her second admission. Regardless of this, more tests should have been completed and there should have been better communication between the multidisciplinary teams (MDT).

The Trust's failings are likely to have resulted in unnecessary discomfort for Mrs M and it denied her family an opportunity to better prepare for her death.

We were disappointed that the Trust did not choose to alter its view following receipt of the independent opinion, which clearly conflicted with the opinions of its own staff, and those expressed during local resolution.

We partly upheld this complaint.

Putting it right

The Trust acknowledged the service failure we identified, and apologised for the injustice that Mrs A's family have suffered as a result.

We recommended the Trust produce an action plan to show how it will learn from this complaint and make sure that others do not suffer in the future. In particular it must ensure it reflects on the quality of the handover of clinical information and communication between the MDT; reviews policies and procedures regarding scans; and considers how complaint handling can be improved in the future.

Organisation we investigated

Great Western Hospitals NHS Foundation Trust

Location

Swindon

Region

South West

Summary 588/November 2014

Family not told about elderly patient's bed sores

Miss F complained that when her mother was discharged from hospital, her family were not told that she had pressure sores; had an untreated urine infection and her nutrition and hydration needs were not met. She said she was too unwell to leave hospital.

What happened

Mrs F, who was in her eighties and lived at home with her family, was admitted to hospital with breathing difficulties related to a lung condition. She was discharged three weeks later and her family found she had pressure sores and was generally very unwell. Mrs F's family and her carers were concerned at this and arranged for her to be admitted to a local community hospital. She was diagnosed with a urine infection and died two days later.

What we found

Although the Trust initially assessed Mrs F's risk of developing pressure sores and took some appropriate action to minimise this, there were failings in Mrs F's ongoing pressure area management. The record keeping was inadequate, the family were not told that Mrs F had developed a pressure sore as they should have been, and a referral was not made to the district nursing service, so that the necessary pressure area care could be continued at home.

We saw no evidence that Mrs F had a urine infection on discharge from hospital. However, we could not rule this out as there was insufficient record keeping about her condition on the day of discharge. There was no management plan in place to make sure Mrs F could urinate before leaving hospital, and after she had her catheter removed.

Mrs F's nutritional needs were managed appropriately but there was an insufficient record of her fluid intake.

The record keeping was so poor that we were unable to say if Mrs F was well enough to be discharged from hospital. However, we did not conclude Mrs F's death would have been avoided had she remained in hospital.

Putting it right

The Trust acknowledged and apologised for the failings and the upset caused to the family. We asked the Trust to produce an action plan to explain how it would address the failings we found.

Organisation we investigated

Heart of England NHS Foundation Trust

Location

West Midlands

Region

West Midlands

Summary 589/November 2014

Elderly lady's leg fractured by ambulance crew

Ambulance crew did not use a hoist to transfer older lady who could not stand in and out of the ambulance.

What happened

Mrs Y, who was in her nineties, was taken from her nursing home to her local A&E by ambulance because she had a suspected gastric bleed.

When the ambulance arrived, the manager of the nursing home told the ambulance crew that Mrs Y needed to be transferred using a hoist, as she was unable to stand or to move her legs. The manager was then called away and did not see what happened next.

When Mrs Y was admitted to hospital, she was found to have a fractured left tibia (shinbone). She told her daughter and nursing home staff afterwards that she had been transferred without a hoist. She said that the crew had ignored her warning about not being able stand and she experienced great pain in her leg during the transfer. Mrs Y passed away in early 2013 and her death certificate stated that the fracture was a contributory factor to her death, although not the direct cause.

Mrs Y's daughter complained to the Ambulance Trust and it carried out an investigation. It found that the ambulance had been supplied by an independent provider commissioned by the Trust. This had been necessary because the Trust themselves did not have sufficient capacity to meet the need in the area at that time.

The Trust's investigation was hampered because it could find no Patient Care Record for the journey. This is the written record which should be completed for every ambulance journey; one copy should be retained by the Trust and the other copy should be filed in the patient's hospital records. Neither could be found in this case. There was a delay before the ambulance crew were asked for their statements about the complaint, by which time they said that they could not remember the incident.

The Trust concluded that it could not clarify what happened, but apologised that the standard of care she had received was below what was expected.

What we found

On the balance of probabilities, Mrs Y's leg was broken while she was under the care of the ambulance crew as a result of an inappropriate transfer without a hoist. It was likely that no Patient Care Record had been completed for the journey. This was in breach of the independent provider's contract with the Trust.

The Trust's investigation of this incident was poor and Mrs Y's daughter was not kept updated as to the reasons for lengthy delays in the Trust's response. The response itself was inconclusive and did not acknowledge the full extent of the failings, or indicate that appropriate action had been taken to address them.

The Trust had, however, taken appropriate action to ensure that its monitoring and oversight of independent ambulance providers had been significantly improved since the time of these events. We saw evidence that it had made a number of changes to avoid similar problems happening in future. The Trust continues to make improvements both in its service and its complaint handling.

Putting it right

The Trust apologised to Mrs Y's daughter and paid her £7,000 in recognition of the distress caused by its failings.

It carried out its own retrospective Serious Incident Investigation, as this was not done as it should have been at the time. It met Mrs Y's daughter to discuss its findings

The Trust considered whether further action was needed to ensure that Patient Care Records are completed for all patient journeys and whether it takes robust action when this requirement is breached.

Organisation we investigated

East of England Ambulance Service NHS Trust

Location

Hertfordshire

Region

East

Summary 590/November 2014

Nurses did not actively try to prevent patient from falling

Nurses did not put in place a falls care plan for eight days and Mr A fell several times.

What happened

Mr A collapsed at home in the spring of 2012 and was admitted to a hospital. Staff carried out various investigations and treatments. Mr A stayed in hospital until his death nearly eight weeks later. A hospital post mortem was done and some organs removed for testing.

Mr A's wife, obtained her husband's medical records and then complained to the Trust about several things. She was upset about a note that a nurse had made of a conversation she overheard between Mr A and Mrs A that staff had told Mrs A that Mr A had only fallen twice when he fell six times. Mrs A also said that Mr A had not received sufficient help with his personal hygiene needs.

In addition, Mrs A subsequently complained to us that, following the post mortem, that the Trust did not test Mr A's internal organs and then lost them.

What we found

It was appropriate for the nurse to have noted the conversation between Mr A and Mrs A. Once contacted by us, the Trust added an addendum to the record, noting Mrs A's view of the event.

Overall, nurses responded to Mr A's personal hygiene needs appropriately.

Nurses did not implement a falls care plan for eight days and there was no evidence that they actively tried to prevent Mr A from falling. This amounted to service failure.

With regard to the post mortem examination, Trust staff examined Mr A's brain, and the organs were legally disposed of, in line with the consent given by Mrs A.

Putting it right

The Trust apologised to Mrs A. It also acknowledged the service failure we found and the impact that had on her.

The Trust prepared an action plan describing in detail what it had done to make sure it had learnt lessons from the failings we identified.

The Trust declined to investigate Mrs A's concerns as she had not complained within 12 months. While the Trust was entitled to refuse to investigate on these grounds, it would have been better if it had asked Mrs A why she had delayed in making a complaint before making that decision.

We partly upheld this complaint.

Organisation we investigated

Calderdale and Huddersfield NHS Foundation Trust

Location

West Yorkshire

Region

Yorkshire and the Humber

Summary 591/November 2014

Elderly man's food and drink not properly monitored in nursing home

Mrs J complained about the care given to her elderly father, Mr S, for the fortnight he was looked after in the nursing home.

What happened

Mr S was admitted to a nursing home to allow him to recover from an infection.

He was looked after for about a fortnight and was then admitted to hospital following a fall. He later died.

Mrs J later complained that her father's food and drink needs were not met, that his medication was missed on many occasions, and that he was not properly assessed to prevent falls. Mrs J said this led to her father's overall health deteriorating.

What we found

The home did not keep good enough records of what Mr S drank, and it looked like he had gone long periods without being given drinks.

The home tried to meet Mr S's food needs, but he was reluctant to eat and it did not properly monitor his weight. It did not do enough to stop Mr S from falling, and communication with the family was poor when he did fall.

There was no evidence to show Mr S's medication was missed.

Mr S's health had not deteriorated because of the care he was given as he was already deteriorating when he was admitted to the home. We thought this was due to his underlying condition rather than the action of the home.

Putting it right

The home wrote to Mrs J acknowledging the failings we found and apologising. The home also produced an action plan that outlined the actions it would take to prevent a recurrence and how these improvements would be audited. A copy of this action plan was sent to the Care Quality Commission.

Organisation we investigated

A care home

Location

Plymouth

Region

South West

Summary 592/November 2014

GP delayed referring patient for investigations into cancer symptoms

Dr P failed to take appropriate action when a woman in her forties attended with symptoms that suggested colorectal cancer.

What happened

Ms G went to Dr P with long-standing constipation, rectal bleeding and weight loss. Dr P prescribed laxatives but these did not improve Ms G's condition. Three weeks later, Dr P referred her to hospital for further investigations. Ms G was subsequently diagnosed with advanced rectal cancer which had spread to her liver and could not be cured.

Ms G complained that Dr P did not refer her to hospital sooner and had not recognised the significance of her symptoms. Ms G said that her prognosis would have been better if she had been referred to hospital and received a diagnosis sooner.

What we found

We partly upheld the complaint. Dr P did not examine Ms G appropriately, did not make an appropriate urgent referral, and did not record relevant information about Ms G's symptoms and condition.

We did not find that these failings had a significant impact on Ms G's prognosis as even if Ms G had been diagnosed sooner, it was likely that her cancer would still have been incurable. However, we did find that Dr P's actions caused distress to Ms G as she felt her concerns were not taken seriously, and this had caused her to have doubts about whether her prognosis could have been improved.

Putting it right

We recommended that the GP Practice produce an action plan to demonstrate what had been learned from this complaint. We also recommended that Dr P discusses this complaint during his next appraisal.

We partly upheld this complaint.

Organisation we investigated

A GP practice

Location

Greater London

Region

London

Summary 593/November 2014

Failure to carry out an appropriate medical assessment by telephone

A GP did not complete an appropriate assessment of a patient who died some days after.

What happened

Mrs A complained about the treatment provided to her late brother, Mr K, who suffered from a range of serious health problems. Mrs A said the Medical Centre failed to recognise the seriousness of her brother's symptoms and take the appropriate action.

Mrs A said that due to the failings, her brother died at home in distressing circumstances. Family members were severely affected after discovering him dead.

What we found

There were failings in the care provided to Mr K. His GP did not appropriately review Mr K several days before his death. The assessment via telephone did not gather enough information or complete a suitable clinical history. The failure to do so was a missed opportunity to complete a full evaluation of Mr K.

However we were unable to say what would have happened had Mr K been fully assessed at this time.

Mr K also had a blood test taken the day before his death. No immediate action was taken by his GP following the results of this test. The results did not indicate that immediate action was required.

Putting it right

The medical centre apologised to Mrs A for its failings in this case. We recommended that it explain to her what it has done to make sure it has learnt from this, and that this does not reoccur in the future.

Organisation we investigated

A medical centre

Location

South Yorkshire

Region

Yorkshire and the Humber

Summary 594/November 2014

Poor clinical assessment by A&E locum doctor

Mr B complained about his visit to A&E in summer 2013. He says his history and records were not checked and he was discharged without treatment. Mr B says this caused him pain, suffering and distress.

What happened

Following three previous inpatient admissions for gall bladder infections, Mr B said he had been clinically advised that if he was in severe pain he should attend the A&E department. He was already on a waiting list for surgery for gall bladder removal.

As he was experiencing pain, Mr B went to A&E and was seen by the triage nurse late at night. He said he had abdominal pain, which had worsened since the previous day. He mentioned his history of gall bladder problems and having taken Gaviscon.

The records show that he was offered pain relief medication by nursing staff but declined this. Nursing staff also took blood for testing and the results, which arrived back after Mr B's discharge, were negative for infection. The observations done by nursing staff were all normal.

Mr B was seen two hours later by a locum doctor, examined and assessed as likely to have acute viral gastritis, and discharged. Mr B said that the doctor told him to find a nurse to remove the cannula from the back of his hand, and that he did this, although he thought it was inappropriate.

Following his return home in the early hours of the morning, Mr B said he could not sleep because of pain and went to his GP. The GP diagnosed a gall bladder infection and prescribed a seven day course of Cefadroxil which relieved the pain within the following 36 hours.

Mr B had surgery for his gall bladder in January 2014.

What we found

The actions taken by the nursing staff were in line with what would be expected. However the actions taken by the locum doctor did not reflect established good practice. There was however, no indication from the observations recorded, (including those recorded by nursing staff), that Mr B should have been admitted, and the failings identified had no impact on his treatment or outcome.

There were failings in the way in which the Trust dealt with the performance of the locum doctor. We did not consider that the Trust took appropriate steps to reassure themselves that the agency which supplied the locum doctor was taking action to address serious concerns about him.

We partly upheld this complaint.

Putting it right

The Trust apologised to Mr B for the failings identified in his medical assessment and the resulting lack of confidence in his care and treatment.

The Trust prepared an action plan to show that it had learnt lessons from the failings identified with its process for dealing with the performance of locum doctors, in order to avoid a recurrence of this in the future.

Organisation we investigated

King's College Hospital NHS Foundation Trust

Location

Kent

Region

South East

Summary 595/November 2014

Poor monitoring of anti-psychotic drug

Trust did not appropriately monitor man's olanzapine prescription for four years.

What happened

Mr D was prescribed olanzapine (an anti-psychotic drug) by a private consultant in 2004. Between 2005 and 2008 he had a number of appointments at the Trust with consultant psychiatrists. Although they were all aware that he was taking olanzapine, there was no reference in the records or during his appointments to the perceived benefits of the drug, and no consideration around whether Mr D should continue taking it. At the same time, he was referred to substance misuse services.

Mr D eventually stopped taking olanzapine on his own. He said that he suffered from lethargy and generally poor quality of life while taking olanzapine and said that he only turned to substance misuse in order to treat what he now thinks are side-effects of olanzapine. He said that he shouldn't have been referred to substance misuse services, because he was not a typical substance misuser, and in his view, the effects he experienced were due to the olanzapine.

The complaint was brought to us in August 2013.

What we found

We partly upheld Mr D's complaint. The Trust did not appropriately monitor Mr D's olanzapine prescription in line with established good practice for four years. This was service failure.

Mr D's referral to substance misuse was appropriate.

We considered the impact Mr D said that olanzapine had on him during this period. But, given the length of time that had passed, the many other drugs he had taken during that time, and the lack of any evidence to show that olanzapine caused these reactions, we were unable to conclude that the injustice Mr D described arose because of service failure.

Putting it right

Although there was service failure we could not establish any injustice.

Organisation we investigated

Sussex Partnership NHS Foundation Trust

Location

West Sussex

Region

South East

Summary 596/November 2014

No consent for vaccination, and a diabetes review done incorrectly

Ms R was unhappy with her treatment at the Medical Centre and complained about lack of consent, a diabetes review, its record keeping and complaint handling

What happened

Ms R complained that the practice nurse at the Medical Centre gave her a flu vaccination without her consent. She also said that not all the procedures were followed for a diabetes review. She complained that the Centre accepted the nurse's word about what happened over hers, without a thorough investigation.

What we found

It was more likely than not, that Ms R had not consented to the vaccination. Not all the procedures were followed for a diabetes review and the nurse's record keeping was not in line with the standards set by the Nursing and Midwifery Council. The Medical Centre's response to Ms R's complaint was not based on a thorough investigation.

Putting it right

Following our investigation, the Medical Centre wrote to Ms R to acknowledge its failings, apologised and explained how it would prevent similar problems from happening again. The Centre paid her £500 in recognition of the distress she had experienced.

Organisation we investigated

A medical centre

Location

Merseyside

Region

North West

Summary 597/November 2014

Doctors failed to check man's blood pressure or to consider possible side effects of medication

Mr S complained on behalf of his father that he was prescribed Bisoprolol, a heart drug, by the Trust and was not monitored properly. Mr S also complained about the service he received when he enquired about his father's blood test results. He felt the Trust did not take his complaint seriously.

What happened

Mr D, who is in his eighties, went to an outpatient appointment at the Trust in early summer 2013 where he was prescribed Bisoprolol. He went to a further appointment in autumn 2013 when he was reviewed and discharged by the clinic. No changes were made to his medication.

Towards the end of the year his GP practice contacted Mr S to say it had received a letter from a consultant at the hospital requesting blood tests for his father. A nurse went to his home shortly afterwards to take blood samples. Later the same day Mr D collapsed at home. A nurse came to see him, and when she found Mr D had low blood pressure she had a discussion with the GP and referred him to A&E.

Mr S was concerned that Bisoprolol could be causing side effects for his father. He rang the Trust to discuss the outcome of the blood test results and whether Bisoprolol could be causing his father's symptoms.

The Trust later responded to the queries, explaining that there had been an error by the GP Practice and that the Trust had not requested any blood tests. This had been communicated to the GP Practice.

Mr S said that when the nurse visited his father again at home in early 2014 she took his father's blood pressure and then spoke with the GP who arranged to take his father off Bisoprolol.

When Mr S complained to the Trust, he was told it was the GP's responsibility to monitor his father's medication and that Trust staff had acted correctly in the way it dealt with his query about blood tests.

What we found

There were no failings in the way the Trust handled Mr S's questions about the blood tests results, or about its complaint handling.

However, there was no evidence in Mr D's records to show that doctors at the Trust checked his blood pressure before Bisoprolol was prescribed in summer 2013 or when he returned to the clinic for review in autumn that year. This was not in in line with established good practice. This was despite clear documentation by the doctors that Mr D had experienced recurrent falls. It was recorded that he had suffered 'some severe injuries that needed butterfly stitching' and that he appeared 'battered and bruised'.

We do not know for certain whether his recurrent falls and subsequent injuries were attributable to episodes of low blood pressure, or that the low blood pressure was directly or solely caused by Bisoprolol. However, there was a loss of opportunity to make an informed decision about whether Bisoprolol was a suitable medication for him in summer 2013, and a further missed opportunity to assess his blood pressure in autumn 2013 and to consider whether this was contributing to his falls.

We cannot say what would have happened if Mr D's blood pressure had been assessed. In any event, doctors may have decided to continue prescribing Bisoprolol as the most appropriate medication for him or they may have changed the medication and he could have still fallen. However, we cannot reassure Mr D that everything that should have been done was done to minimise the risk of him falling.

Putting it right

The Trust apologised to Mr D for the failings identified in the way he was monitored during his outpatient appointments in summer and autumn 2013. The Trust paid Mr D £500 in recognition that not everything that should have been done, was done, to minimise the risk of him falling. It also prepared an action plan to try to prevent similar occurrences within the same clinical outpatient department.

Organisation we investigated

The Royal Wolverhampton Hospitals NHS Trust

Location

West Midlands

Region

West Midlands

Summary 598/November 2014

Failings in the way a GP practice handled the removal of patient and his family from the Practice list

Removing Mr B and his family from the GP Practice list caused them significant problems and didn't follow relevant guidelines.

What happened

Mr B, along with his wife and child, received letters from the Practice saying they were being taken off the Practice list but it did not clearly explain why it had done this, or which member of the family this related to. The Practice had not warned Mr B about this in the previous twelve months.

Mr B complained, and the Practice said that one cause of this was that he had complained about a GP at the Practice. However, he had complained about the GP after the family had received the removal letter. Another reason it gave related to the Mr B's employment.

When we started to look at the complaint, the Practice later added further, new, reasons for the removals based on events that it had not made any record of.

The removal from the Practice's list caused problems for Mr B and his family: Mr B's wife could have appointments in her native language at the Practice, but can't do this at her new practice, and Mr B has had to take time of work to go to appointments with her, causing a loss of income. Because of this Mr B and his family had experienced stress.

What we found

The Practice did not follow the relevant guidance as it failed to give Mr B and his family a warning before it removed them. Also it did not clearly explain the reasons for doing this, or tell them which members of the family it related to.

It was inaccurate for the Practice to say that the Mr B's complaint caused the removals, as this happened afterwards. Also, removing a patient because they have made a complaint is not in line with the relevant guidelines.

It was inappropriate for the Practice to have removed the complainant based on his employment issues, and removing the whole family was not in line with the relevant guidelines.

There was no evidence of the events the Practice later told us had caused the removals. The Practice's complaint handling was not clear or evidence-based, and was therefore not in line with our Principles.

Both the way the Practice carried out the removals and its poor complaint handling had a considerable impact on Mr B and his family.

Putting it right

The Practice acknowledged and apologised for its failings and the impact these had on Mr B and his family. It paid Mr B £700 for the injustice and poor complaint handling that he and his family experienced.

The Practice also agreed to review its policy for new patient registrations and the removal of patients, and to make sure these are in line with the relevant guidelines and its contractual requirements.

Organisation we investigated

A GP practice

Location

Lancashire

Region

North West

Summary 599/November 2014

Consultant did not respond to requests to review knee replacement surgery

Mr T had a knee replacement operation. He was concerned about the surgery and the aftercare he received. He then had to have another knee operation.

What happened

Mr T had a knee replacement operation. He had two outpatient appointments shortly afterwards and was seen by a registrar.

He also had three appointments in the nurse-led clinic where he said that he was unhappy with his recovery. The nurse requested the consultant review him, but nothing further was done.

Mr T was discharged from the clinic, but was later referred back to his original consultant. He went on to have another knee operation.

What we found

The consultant did not respond to the request to see Mr T in line with the Trust's escalation policy. This led to an additional two months of frustration for Mr T as he had to approach other clinicians before being referred back to his original consultant.

We partly upheld the complaint.

Putting it right

We recommended the Trust apologise to Mr T for the consultant's failure to review his knee surgery when necessary, and pay him £250 for the frustration, pain and distress this caused him.

Organisation we investigated

United Lincolnshire Hospitals NHS Trust

Location

Lincolnshire

Region

East Midlands

Summary 600/November 2014

Failings by Trust meant lost opportunity to save baby's life

Investigations were not completed which meant the opportunity to deliver a baby early was lost. Later, lack of investigations led to a day of worry and distress for a couple before being told their baby had died.

What happened

Mrs A received antenatal care from the Hospital and she was seen at appointments at 33 and 36 weeks into the pregnancy. At 33 weeks it was noticed the baby's growth had slowed and at 36 weeks Mrs A reported the baby was not moving that morning. She was told to monitor the baby's movements and contact them if she remained concerned. That night she had further problems and returned to hospital. She was given an ultrasound which showed the baby had died. The baby was delivered and a post mortem done.

What we found

There were no failings in the care plan put in place for Mrs A's pregnancy. However there were failings in the care given to her at her 33 week and 36 week appointments.

The Trust should have made further investigations both at the 33 week and 36 week appointments. The missed opportunity to do this at 33 weeks meant an opportunity was lost to deliver the baby early. It is likely that this would have prevented Mr and Mrs A's baby's death.

We cannot say whether the failing to complete further investigations at 36 weeks would have avoided their baby's death, but it would have improved their experience and given them information about what was happening earlier.

We consider their distress as a result of this was further compounded by the Trust's poor record keeping and the inaccurate information which was given to them about the length of time the post mortem would take.

Putting it right

The Trust apologised and paid Mrs A £15,000. It has drawn up an action plan to improve its service.

Organisation we investigated

West Suffolk NHS Foundation Trust

Location

Suffolk

Region

East

Summary 601/November 2014

Police force entry to patient's home after Trust provides wrong information

Miss B's friend called the police as she was concerned she could not contact her. Miss B was at hospital but the Trust said she was not there.

What happened

Miss B had been feeling unwell and called a friend to say she was suffering from headaches and weakness in her left arm and leg. Miss B then went to A&E at her local hospital where she was triaged and sent to the Urgent Care Centre (which is located at the Trust but run by another organisation). She waited more than four hours to be seen by a doctor and was then sent home.

While Miss B was at the Urgent Care Centre, her friend became worried because she could not contact her and she called the police. The police telephoned the A&E department to check whether Miss B was there and an A&E staff member told the police that she was not there. When Miss B arrived home, she found the police in the process of forcing entry to her home.

Her front door, which was a double-fronted 1930s style solid oak door with a stained glass window, was very badly damaged and later had to be completely replaced.

What we found

We partially upheld this complaint.

When the police contacted the Trust, it was the Trust's responsibility to check not just its own premises but also the Urgent Care Centre. The Trust should have had a clear protocol in place to make sure that this happened and it was a service failure that no such protocol was in place. The Trust also gave contradictory information about its procedures to Miss B and the police in the course of her complaint.

However, this service failure was not the sole cause of the injustice to Miss B. During the call between the police and the Trust's A&E staff member, the A&E staff member said that Miss B was not there and had last attended the previous April.

She then said that she was going to check something else but before she had a chance to do so, the police asked for Miss B's date of birth. The A&E staff member agreed to call the police control room on another number with that information and the call ended with her stating that she would call right back.

It is not clear from the information we have whether that further call was made but four minutes later, the police took the decision to force entry to Miss B's property.

The actions of the Trust were not the only factor leading to the damage to Miss B's door. However, the Trust's service failure contributed to the distress she experienced and it needed to do more to put that right. Its complaint handling had been poor.

Miss B's insurance company had covered the cost of replacing the door and the stained glass window. It was not reasonable to recommend that the Trust reimburse the insurance company, or that it provide redress specifically to cover the possibility of an increased premium.

Putting it right

The Trust agreed to apologise to Miss B for failing to have a clear protocol in place at the time of these events and for giving contradictory information about its procedures.

It agreed to pay Miss B £300 in recognition of the distress she experienced as a result of its failings.

The Trust also agreed to provide a copy of its new policy for checking both A&E and the Urgent Care Centre in future, plus an explanation of how it is monitoring this new system to ensure it is effective.

Organisation we investigated

Barking, Havering and Redbridge University Hospitals NHS Trust

Location

Essex

Region

East

Summary 602/November 2014

Poor care for man at risk of pressure sores

Mrs B was concerned that her husband may have had to go into a nursing home because of his pressure sores.

What happened

Mr B had a history of Parkinson's disease and psoriasis and had a hip operation in spring 2010.

At his assessment before going into hospital, staff found that Mr B was at risk of developing pressure ulcers because he had dry and tissue paper-like skin, was a wheelchair user, elderly and had Parkinson's disease. They provided a pressure relieving mattress for him and also noticed a small sore area on his bottom that had developed before admission.

After his operation Mr B was discharged from hospital in summer 2010. Mrs B complained that her husband suffered several pressure sores and said this was due to poor nursing care. She said that as a result of this, Mr B needed to go into a nursing home and she wanted the Trust to pay for, or contribute to, the costs of the private care home she had chosen.

The Trust commissioned an independent report that found little evidence that there were firm plans in place or interventions to protect Mr B from developing a pressure injury, or guide the nurses in how to prevent further deterioration.

What we found

Although poor pressure area care may have contributed to Mr B's pressure sores, it was the overall decline of his condition that warranted his transfer to a nursing home.

The Trust had taken sufficient action to improve its service in relation to pressure area care.

Mr B needed general nursing care, rather than specialist care, and this was provided at the care home. The Trust's decision not to fund the care at the private home chosen by Mrs B was reasonable.

The complaints handling process took a long time, mainly due to the Trust's delay in clearly acknowledging the failing in care, but an independent view was provided which confirmed the failings.

We could not say for certain that Mr B would not have developed pressure sores with appropriate pressure area care. However, opportunities were missed to reduce the risk and to minimise his pain and suffering. In addition, witnessing the poor care caused Mrs B distress and the Trust had not properly acknowledged the impact of these failings on both Mr and Mrs B.

Putting it right

The Trust apologised for the poor pressure area care and paid Mrs B £1,000 in recognition of the impact of this on both her and her husband. The Trust also apologised for the poor complaint handling and paid Mrs B £750.

Organisation we investigated

Royal Berkshire NHS Foundation Trust

Location

Reading

Region

South East

Summary 603/November 2014

A couple were left without support when the husband was told he probably had cancer

There was a lack of consideration and support for Mr R and his wife when he was told he probably had cancer. He also had a long wait in A&E, and a delay in being referred to a cancer specialist.

What happened

Mr R was told by an oncologist that his condition was probably cancer and he was sent home to wait for tests. Then, during a specialist nurse assessment he was advised to attend A&E. He did so and waited almost 15 hours before he was admitted to hospital. Following a biopsy he was discharged home without support. A week later the results of the biopsy and the type of cancer Mr R had were known, and he was offered an appointment with a haematologist in two weeks' time. This was four weeks after seeing the oncologist and being told his condition was probably cancer.

Mr R and his wife were advised that the type of cancer he had was highly curable, and Mr R was admitted to hospital and started a course of chemotherapy. His condition improved to the extent that doctors felt that he could tolerate a more aggressive form of chemotherapy. This was the normal treatment for his condition and could potentially cure it. Sadly this was not the case and he died.

What we found

There was no clinical indication that Mr R should have been admitted to hospital after being told that his condition was probably cancer. But there was a lack of consideration and support for the distress and upset Mr and Mrs R suffered.

The Trust apologised for the long wait in A&E but did not use an escalation policy which would have shortened the wait and reduced the upset suffered. The Trust has carried out appropriate and significant improvement work to avoid such situations happening again.

Mr R should have been referred to another oncologist within two weeks of being told his condition was probably cancer. While the oncologist could not have given specific advice, and it would not have altered the prognosis, it would have provided reassurance and an opportunity to discuss concerns and support that could be given. It would also have been in accordance with guidance. A referral to the haematologist could have followed this. This lack of communication caused Mr and Mrs R worry and frustration.

On the whole, Mr R's care in hospital was reasonable. There was an incident which involved a lack of dignity, which the Trust correctly responded to. We found a failing in that a drug to thin the blood was prescribed but not given, but this did not adversely affect Mr R.

The type of cancer that Mr R had is highly curable and a more aggressive chemotherapy treatment was appropriate. All chemotherapy treatments are likely to cause a reduction in white blood cells. This was expected for Mr R, and he did develop infections because of this.

The Trust transferred him to the intensive care unit because it was hopeful his infection could be treated. This was not the case, and he died as a result of infection and a deterioration in respiratory function. We found no evidence that Mr R's death was avoidable.

Putting it right

The Trust acknowledged and apologised to Mr R's wife for the concern, distress and upset they both suffered when they heard that Mr R's condition was probably cancer, and that they were not given details about where they could get support.

It also acknowledged that a referral to another oncologist was not made, and this resulted in a significant delay in an opportunity to discuss Mr and Mrs R's concerns and give them support.

The Trust agreed to review its A&E policy and to make sure staff are made aware of its importance in its training.

Organisation we investigated

Northampton General Hospital NHS Trust

Location

Northamptonshire

Region

East Midlands

Summary 604/November 2014

GP practice unfairly removed family from its patient list without warning

Mrs B complained that she and her husband were unfairly removed from their GP Practice which meant a long journey to visit another GP.

What happened

Mrs B received a call at home from her GP Practice manager who wanted to speak to her daughter who was also a patient at the same Practice. Mrs B said that this breached her daughter's confidentiality because her daughter does not live with her.

The Practice manager was concerned about Mrs B's abusive behaviour on the telephone and told her that if she was unhappy with the service provided, she should consider registering at another GP Practice. The Practice then wrote to Mrs B giving her 30 days to find a new GP Practice.

Mrs B said this caused her to suffer from depression. She said it is a 10 mile round trip to visit her new GP Practice, which is inconvenient for her to get to. She was also unhappy that her husband was removed as a patient.

Mrs B also complained about how the GP Practice handled her complaint. She believes the investigation was conducted by the Practice manager, the person she complained about.

What we found

The Practice failed to give Mrs B a warning about her behaviour. The National Health Service (General Medical Services Contracts) Regulations 2004 say that a patient should be warned before they can be removed from the patient list. The Practice also removed Mrs B's husband who played no part in the events complained about.

This failing resulted in an injustice for Mrs B as she was not given the opportunity to change her behaviour. This meant she had no option but to register at another GP practice which was inconvenient for her to attend.

There were no failings in the Practice's complaint handling. NHS England dealt with Mrs B's complaint and initially asked the GP Practice to investigate. This investigation was not done by the Practice manager but a senior GP within the Practice.

Putting it right

The Practice wrote to Mrs B, acknowledging the failings in how it dealt with her and her husband's removal, and apologised. It paid Mrs B £300 in recognition of the injustice she suffered.

The Practice developed an action plan detailing how it will improve its handling of patient removals in the future.

Organisation we investigated

A GP practice

Location

Norfolk

Region

East

Note: Mrs B's daughter also made a complaint about the GP practice.

See summary number 605.

Summary 605/November 2014

GP practice unfairly removes patient from its list without warning

Miss G said she was forced to register at a different practice which is further away and which has a limited bus service. She also said that her reputation had been tarnished.

What happened

Miss G tried to book a GP appointment for her son but there was none available. The Practice subsequently found a slot and tried to contact Miss G at her mother's home. Miss G complained to the Practice manager that her confidentiality had been breached as she did not live at her mother's.

The Practice manager said because Miss G was abusive it would be better if she registered at another GP Practice. A letter was then sent to Miss G giving her 30 days in which to find a new GP.

What we found

It was reasonable that the Practice tried to contact Miss G at her mother's because she had given this telephone number as an emergency contact. We also found that Miss G was abusive to reception staff. However, the Practice should have warned Miss G about her behaviour before it decided to remove her as a patient. This is set out in The National Health Service (General Medical Services Contracts) Regulations 2004.

The failure to warn Miss G meant that she was not given the opportunity to change her behaviour and remain as a patient. This meant she had to register for GP services elsewhere, which was inconvenient for her.

Putting it right

The Practice wrote to Miss G, to acknowledge and apologise for the failings in how it dealt with her removal from its list. It paid her £200 in recognition of the injustice she suffered, and developed an action plan detailing how it will improve its handling of patient removals in the future.

Organisation we investigated

A GP practice

Location

Norfolk

Region

East

Note: Miss G's mother also made a complaint about the GP practice.

See summary number 604.

Summary 606/November 2014

Failure to respond to a complaint

Mrs D's legal representatives complained about inaccurate remarks in a formal report, which questioned their professionalism.

What happened

Mrs D's legal representatives questioned the outcome of an Independent Review Panel (IRP) convened by the North of England Commissioning Region (part of NHS England). The IRP had been considering the eligibility of Mrs D's relative for NHS continuing healthcare.

The legal representatives complained about allegations in the IRP's report which questioned their professionalism. NHS England failed to respond to this.

What we found

The available evidence supported the legal representatives' version of events.

Putting it right

We asked NHS England to delete the offending remarks from the IRP's report. It agreed to do so.

Organisation we investigated

North of England Commissioning Region of NHS England

Summary 607/November 2014

GP's poor complaint handling

GP practice did not fully respond to Mr C's complaint about the care of Mr B, his patient, although no failings were found in his medical care.

What happened

Mr B had a complex health history. He was in his eighties when he went to his GP with new and distressing symptoms of alternating constipation and diarrhoea.

For two years the GP Practice treated Mr B's alternating symptoms with medication. He was also referred to hospital for rectum and colon investigations, however, no specific cause for his symptoms was found. Mr B was also admitted to hospital twice during this time with suspected sepsis. Although, on these occasions, Mr B recovered and was discharged, he was readmitted again in summer 2013 when he was diagnosed with possible bowel obstruction. Mr B did not recover and subsequently died.

Mr C, Mr B's carer, complained to us about the GPs' care, particularly that he thought it was not appropriate to prescribe codeine phosphate to Mr B because of his constipation. Mr C also raised concerns about the treatment of Mr B's carpal tunnel syndrome and a bladder stone.

What we found

The Practice's management of Mr B's alternating symptoms was appropriate and in line with National Institute for Health and Care Excellence (NICE) guidelines. It was correct to prescribe codeine for the treatment of constipation, and Mr B had reportedly said and that this was the only medication that appeared to give him any relief. The Practice had also taken advice from the hospital on this.

There were no failings in the Practice's management or treatment of Mr B's bowel symptoms, carpal tunnel syndrome or bladder stone.

However, we could see that although these points had been raised in Mr C's complaint, the Practice had not given a response to them. This was a failing in the handling of Mr C's complaint.

This contributed to Mr C's lack of reassurance about the Practice's action. We were able to give Mr C responses to his complaints which he had not had before. It is for this reason that we partly upheld the complaint.

Putting it right

We discussed the complaint handling failing with the Practice. The Practice manager said the Practice's usual process is for a doctor to respond to complaints about clinical issues. However, he agreed that he would now check that all points raised are responded to in full before the response is sent to the complainant.

Organisation we investigated

A GP practice

Location

East Sussex

Region

South East

Summary 608/November 2014

Patient's unnecessary operation

Mr J complained that the operation he had was not necessary. He also was unhappy about other aspects of his treatment and how his complaint was handled.

What happened

Mr J was first seen by the Trust's urology department in autumn 2011 for examination of haematuria (blood in his urine). An ultrasound scan of his kidneys showed no abnormality, but a CT scan showed several tiny stones in his left kidney. Mr J was offered a cystoscopy (a telescope examination of the bladder) to check whether the haematuria was bladder related, but he did not want to undergo this procedure.

Mr J continued to experience problems and was referred to the Trust again. He was seen by a consultant urologist in late spring 2012 and X-rayed on the same day. The consultant urologist's clinic letter said Mr J was still experiencing left loin to groin pain (although Mr J said he had left sided pain) and his X-ray showed he may have a stone in the lower ureter. He was therefore booked in for left ureteroscopy (a tube to investigate) and lithotripsy (to break up stones) under general anaesthesia. The X-ray was formally reported nine days after it was taken.

Mr J completed a consent form and had his operation a month later. The Trust did not find a stone in Mr J's ureter but during the operation examined his urethra, bladder and prostate. Mr J complained over a month later that his kidney stones were not treated as he thought they would be (as shown in the earlier CT scan) and that further examinations of his bladder, prostate and urethra were carried out that he did not consent to. Mr J raised further issues when he tried to get the matter resolved locally.

What we found

The Trust's explanation of why it operated on Mr J was reasonable, however the Trust should have X-rayed Mr J again, before the operation, to make sure he still needed it. The consultant urologist had looked at the abdominal X-ray taken in late spring 2012 and thought he could see 'a small calcified speck within the line of the left ureter'.

However, when the X-ray was formally reported nine days later, it was normal and there was nothing in the ureter. Essentially the consultant urologist had relied on a CT scan taken eight months previously and the unreported X-ray of late spring to propose an investigation.

We agreed that it is good practice to avoid subjecting patients to unnecessary radiation exposure by taking another X-ray, due to the small risk of causing cancers. However, the consultant urologist failed to balance this against the potential risks and complications of an operation.

The surgeon who carried out the operation should also have questioned whether it was needed, and he should have at least carried out a further X-ray to see if the stone was still there. There were several weeks between the X-ray being taken and the operation taking place, and the stone could have passed naturally. This would have avoided a needless operation. Mr J suffered unnecessary stress and inconvenience from undergoing an operation that was not needed.

While the operation was not needed, it was not unreasonable to check Mr J's urethra, bladder and prostate while doing it. The Trust carried out the operation Mr J had consented to and we found no failings in the other clinical issues Mr J raised.

While we did not agree with the Trust's view that it was reasonable to operate on Mr J, overall his complaint was dealt with reasonably.

Putting it right

The Trust paid £1,000 to Mr J to address the stress and inconvenience he suffered, and apologised for the failing we had found. We also recommended that the Trust show what it had learnt from our findings.

Organisation we investigated

Northern Lincolnshire and Goole Hospitals NHS Foundation Trust

Location

North Lincolnshire

Region

Yorkshire and the Humber

Summary 609/November 2014

Extensive bruising during heart surgery was not due to a failing by the Trust

Mrs M complained about the care and treatment she received when she had a pacemaker inserted.

What happened

Mrs M had an operation to implant a pacemaker. She says that she was in agony after it and her chest area was extremely inflamed and bruised. She also had concerns about her aftercare and discharge arrangements.

What we found

We did not uphold this complaint as we found no failings in the care and treatment Mrs M received. Our advisers said that bruising could occur as a side effect of surgery, and did not indicate failings in care. We saw no other evidence of failings.

Organisation we investigated

University Hospital of South Manchester NHS Foundation Trust

Location

Greater Manchester

Region

North West

Summary 610/November 2014

Failure to make adjustments for patient with a physical health problem

Ms F complained about elements of the nursing and medical care she received during an admission to a residential unit operated by the Trust.

What happened

Ms F was admitted as an inpatient to a residential unit. She suffers from a serious physical ailment which requires constant monitoring. Among her concerns were the manner in which her physical illness was monitored, intrusive care, treatment of her injuries and problems with her medication.

What we found

There were shortfalls in the preparation of care plans for patients with physical illnesses, the treatment of minor injuries and the training of unqualified staff. The Trust acknowledged the problems Ms F experienced with her medication and had taken appropriate steps to prevent a repeat of this.

Putting it right

Following our report, the Trust apologised for its failings, and agreed to put together action plans that showed learning from its mistakes so that they would not happen again.

Organisation we investigated

North Essex Partnership University NHS Foundation Trust

Location

Essex

Region

East

Summary 611/November 2014

Inadequate monitoring and discharge after fall

Miss A was admitted to hospital for a cardioversion, in which the heart is given an electric shock to restore it to its proper rhythm.

What happened

After the cardioversion, Miss A fell in hospital and hit her head. She was discharged late at night without having been reviewed by a doctor and without having been given a CT scan (CT scans produce detailed images of the inside of the body).

What we found

The hospital failed to write a clear plan to monitor Miss A after the cardioversion, and did not check her often enough.

After Miss A's fall the hospital did not observe her properly.

A doctor should have reviewed her, and given her a CT scan or arranged for her to stay in hospital overnight for observation. The hospital also did not to check whether there was anyone at her home, or give her advice about what to do if she suffered certain symptoms.

The hospital put Miss A through a frightening experience as a result of the failings in its care.

We partly upheld the complaint.

Putting it right

The hospital apologised to Miss A for its failings and for her frightening experience. It also agreed to prepare an action plan to learn lessons from the failings we identified.

Organisation we investigated

Burton Hospitals NHS Foundation Trust

Location

Staffordshire

Region

West Midlands

Summary 612/November 2014

Elderly patient let down by orthotic clinics

Mrs B had problems getting the correct supportive footwear from two different orthotic clinics.

What happened

Mrs B, an older lady, needed special orthotic footwear and was referred to the hospital's orthotics in early 2009. She remained under the care of this clinic until the end of 2011 and went to many appointments during this time.

There were several problems with the fit of Mrs B's footwear and in early 2012 Mrs B transferred to another hospital's orthotic clinic, but continued to have problems. Mrs B's daughter complained to the local Clinical Commissioning Group (CCG), which explained that the difficulties with Mrs B's footwear were due to changes in her clinical condition.

Mrs B's daughter complained to us about the care from both clinics and also the complaint response from the local CCG.

What we found

There was a minor failing in the service provided by the first hospital. The initial orthotic product was not delivered within the time specified and Mrs B was not told about this, so she had an unnecessary journey to hospital.

The hospital had taken reasonable actions to measure Mrs B and order appropriate footwear for her, but her clinical condition was changing so rapidly that the footwear was not suitable by the time it was delivered.

The second hospital had failed to record important details about Mrs B's feet and legs, the prescription specification, and the clinical reasoning for its decisions. This contributed to the poor fit of Mrs B's footwear as the manufacturer did not have enough information to make an appropriate product. There were failings in informing Mrs B when her product had not been delivered in time for her appointment.

The CCG did not handle this complaint correctly as it did not see any failings in the care provided by the two orthotic clinics.

Putting it right

All three organisations we investigated apologised to Mrs B. Both hospital Trusts agreed to produce action plans to show learning from this complaint. The second hospital paid her £250 in recognition of the inconvenience and distress she suffered.

Organisations we investigated

Cambridge University Hospitals NHS Foundation Trust

Suffolk Community Healthcare

West Suffolk Clinical Commissioning Group (CCG)

Location

Cambridgeshire

Region

East

Summary 613/November 2014

Lack of preoperative medication led to patient's stroke

Mr A complained he had a stroke because doctors did not give him a Clexane injection when he had an operation.

What happened

Mr A was due to have a hernia operation in summer 2013. He was told to stop taking his usual dose of Warfarin (an oral anticoagulant) five days before his operation to avoid complications due to bleeding. Mr A went to the hospital as planned but felt unwell and left without having the operation. He said doctors told him he might need an injection of Clexane (a drug which prevents blood clots) to balance the effect of stopping Warfarin, but then decided he did not need this.

The operation was rescheduled for 12 days later. Mr A stopped taking his Warfarin again five days before the operation. He had his operation and was discharged the same day. He was not given Clexane.

Five days later Mr A was taken to hospital by ambulance with a headache and problems with his vision. He was diagnosed with a stroke and he thought this was caused by not being given Clexane.

Mr A said the stroke affected his vision, and now he is unable to drive or go outside on his own. He said this has taken away his independence, and affected his ability to care for his daughter.

What we found

There was no fault in the decision not to give Clexane to Mr A the first time he went to hospital; the Trust followed its policy correctly and the risk of stroke was low. The risk of stroke had to be balanced with the risk of bleeding which could occur if he was given Clexane.

Mr A's decision to leave the hospital without having his operation meant he had to stop taking his Warfarin for a second time when the operation was rebooked. But, as a patient, he could not be expected to know this put him at increased risk of having a stroke. There was fault in the decision not to give Clexane to Mr A the second time he went to hospital because by then, there had been two periods of Warfarin withdrawal. Not giving Mr A Clexane led to his stroke.

There was also fault in the assessment and treatment of Mr A's stroke. Assessments and a CT scan were not carried out at the correct time and there was a delay in giving Mr A aspirin. This did not affect the outcome for Mr A, but the Trust did not respond properly to this part of the complaint.

Putting it right

The Trust acknowledged and apologised to Mr A for the faults we identified and paid him £7,500. It also agreed to produce an action plan, setting out the lessons learnt from the complaint.

Organisation we investigated

Ipswich Hospital NHS Trust

Location

Suffolk

Region

East

Summary 614/November 2014

Poor communication affects family's chance to spend more time with their mother in her last days

A family complained about surgical delays, questioned the need to amputate their mother's leg and raised concerns about their experience on the morning she died.

What happened

Mrs K, a lady in her nineties, was admitted to hospital in summer 2012 because of concern about ulcers on her leg. The initial plan was to remove damaged tissue from the ulcer but this operation was delayed. Although the procedure, when it took place, initially seemed to have been successful, Mrs K began to deteriorate and her doctors decided that their only option was to amputate her leg.

Again, there was a delay before Mrs K was taken to theatre. Her daughter spent over two hours trying to find out how her mother was before being told she was 'OK'. Soon after, Mrs K's daughters were called to the hospital as Mrs K was critically ill. When they arrived, Mrs K was very distressed and there was a delay in getting her some sedation. She died soon after.

Mrs K's family complained about the delays of the two procedures and questioned whether it was appropriate to go ahead with the amputation given how ill Mrs K was.

They met with the Trust which accepted that there had been a number of shortcomings during Mrs K's admission and agreed that her family's experience on the morning of her death had been 'awful' and 'inappropriate'. The Trust said that the correct surgical decisions had been made and Mrs K's family then asked us to investigate their outstanding concerns.

What we found

The delay in both surgical procedures, while less than ideal, was reasonable under the circumstances. The decision to proceed with the amputation was appropriate as it was Mrs K's only realistic chance of survival.

There were a number of examples of service failure, in particular with Mrs K's monitoring and observations. However there was no evidence that these failings affected the decision to proceed with the amputation.

There were failings in communication with Mrs K's family. These were most apparent on the morning that Mrs K died and the evidence clearly showed she was not 'OK'. Clearer information should have been given to her family about her condition so they could have spent more time with her before she died. The family's distress was compounded by the delay in giving Mrs K sedation when she needed it.

Some, but not all of the failings had been acknowledged by the Trust, and we saw little evidence that any steps had been taken to address them.

Putting it right

The Trust apologised for the additional failings we found in our investigation and paid £500 to Mrs K's family in recognition of the avoidable distress they experienced on the morning she died.

The Trust agreed to create a comprehensive action plan to address the failings that it and we had identified.

We partly upheld the complaint.

Organisation we investigated

Ashford and St Peter's Hospitals NHS Foundation Trust

Location

Surrey

Region

South East

Summary 615/November 2014

Patient not happy with CCTV in treatment room because she felt it invaded her privacy

Use of CCTV during radiotherapy treatment was justified, however a lack of clear patient information and local policies on its operation was unreasonable.

What happened

Ms S had radiotherapy treatment at the Trust during 2013. CCTV was set up in the treatment room and used during her treatment. Ms S was concerned about this, and who could see these images. She felt her privacy and dignity was being compromised. The Trust agreed to turn off the CCTV during the rest of her treatment and used the intercom system instead for contact between Ms S and the radiographer.

Ms S complained to the Trust about the unnecessary use of CCTV and, as a result, the Trust revised its patient information leaflets. Ms S was dissatisfied with the Trust's actions and brought her complaint to us.

What we found

The use of CCTV by the Trust in the radiotherapy treatment areas was justified, and correct measures were in place to make sure the images were secure.

However the Trust had not done enough to make sure patients were given full and clear information about how the monitoring was used, when it was used and who could see the images. Without this information, patients were not able to make informed decisions about this and there was a risk to their privacy and dignity. This affected both Ms S and other patients having treatment in the radiology department.

There was a lack of effective administration by the Trust as it did not have a local policy about the use of CCTV in radiotherapy treatment areas. In the absence of such clear policy or guidelines, the Trust was not able to show how it made sure that staff were aware of the requirements of the Information Commissioner's Office Code of Practice for CCTV, and the *Data Protection Act 1998*.

It was also unable to show how an appropriate and consistent approach is taken when using CCTV during patients' treatment.

Putting it right

The Trust apologised to Ms S for the lack of information she received about the use of CCTV at the beginning of her treatment, which meant she was not able to ask informed questions about it.

The Trust agreed to review and revise its patient information leaflets to include clearer information about when CCTV is used and who can see these images. It also agreed to share with Ms S details of its policy on CCTV use in radiotherapy treatment areas.

Organisation we investigated

The Royal Marsden NHS Foundation Trust

Location

Greater London

Region

London

Summary 616/November 2014

Nurses did not alert medical staff quickly enough when older patient deteriorated

Mrs S complained that staff did not check her husband often enough on the day he died.

What happened

Mr S was taken to A&E after vomiting blood. He was also suffering with confusion. He was admitted to hospital with urinary sepsis and went on to develop aspiration pneumonia. Mrs S said the staff did not check on him enough.

He was transferred to the intensive care unit but continued to deteriorate. Mrs S said she thought her husband would not have died if he had received better care.

What we found

Nursing staff did not assess Mr S's ability to eat and drink when he was admitted, but this did not affect him.

Staff did not always keep simultaneous records of events, which meant that the timings of when Mr S deteriorated could not clearly be seen. They also did not sufficiently recheck Mr S's observations after he had a period of fast heartbeat. They did not alert medical staff as quickly as they should have done when he continued to deteriorate.

Although Mrs S believed that no one had checked on her husband, the records showed both doctors and nursing staff had checked him.

Although there were failings in Mr S's care, these did not lead to his death.

Putting it right

The Trust apologised to Mrs S and produced an action plan to ensure it learned from the complaint.

Organisation we investigated

Croydon Health Services NHS Trust

Location

Greater London

Region

London

Summary 617/November 2014

Trust failed to provide patient and his GP with clear discharge information

When Mr V was discharged following a head injury, the discharge information from the Trust did not make it clear who was responsible for setting up his follow up appointments and treatment.

What happened

Mr V was found collapsed in the street and admitted to hospital. He was bleeding from his ear and had a suspected convulsion. He had a brain injury and a fracture to one of the bones in his skull.

Following treatment, he was discharged with a 'handover of care' letter which set out how his follow up would be managed. His GP also received a copy of this letter, but it did not make clear which actions would be carried out by the Trust, and which by the GP.

As a result of this, confusion followed, and Mr V experienced a great deal of unnecessary anxiety and stress trying to get follow up care.

What we found

We found that while Mr V received good care as an inpatient, there were failings in the way the Trust managed his discharge care. The information in the 'handover of care' letter was confusing.

Putting it right

The Trust apologised and paid compensation of £550 to Mr V. It also agreed to put a plan in place to learn from the failings and make sure they did not happen again.

Organisation we investigated

North Bristol NHS Trust

Location

Bristol

Region

South West

Summary 618/November 2014

GP's failure to examine a patient delayed cancer diagnosis

Mrs A's urinary problems led her to go to her GP on three occasions during the summer of 2013.

What happened

Mrs A said her GP did not examine her during the three consultations and she thought he should have done so at least during the last two.

Mrs A was dissatisfied with her care and joined a different practice in late 2013. Her new GP carried out an internal examination and found a lump. He urgently referred Mrs A to hospital for further investigations for a suspected cancer of the womb.

Doctors diagnosed a rare cancer and Mrs A had surgery to remove it. Sadly, the cancer returned within a matter of weeks and she died in the summer of 2014.

What we found

The first GP did not examine Mrs A when he should have done. The care and treatment provided by the GP fell so far below applicable standards and established good practice that it was service failure.

We could not find that Mrs A would have survived had the GP examined her when he should have done, but it might have improved her chance of survival. The failings in Mrs A's care caused deep distress to her and her husband and this was an injustice to them. In addition, Mr A will never know if his wife's life could have been prolonged or saved but for the failings in her care. This is an additional injustice to him.

Putting it right

The Practice wrote to Mr A to acknowledge the service failure and the impact that had on Mr and Mrs A. It also paid £1,000 to Mr A in recognition of the injustice caused to him.

We noted that following its own review of its actions in Mrs A's case, the Practice's GPs developed their knowledge of the symptoms of this rare cancer and its management. In addition, the GP reviewed and changed his own practice in order to avoid a recurrence of the failings we identified.

Organisation we investigated

A GP practice

Location

Hertfordshire

Region

East

Summary 619/November 2014

NHS England failed to address a grieving widow's unanswered questions

Mrs B complained to GP practice and NHS England about the care her late husband received in the final weeks of his life.

What happened

Mr B died of cancer in March 2014. His widow made a number of complaints about the care given by his GP in his final weeks. Mrs B was not satisfied with the GP's response and complained to NHS England. After receiving NHS England's reply she asked further questions, which NHS England declined to answer. Mrs B complained to us about this.

What we found

Mr B's GP provided a good standard of care. We did not find any failings on the GP's part. NHS England's first complaint response was reasonable, but it failed to answer Mrs B's reasonable follow-up questions. We partly upheld the complaint about NHS England, and did not uphold the complaint about the GP Practice.

Putting it right

As a result of our findings NHS England apologised to Mrs B and agreed to explain what action it would take to prevent this from happening again.

Organisations we investigated

A GP practice

NHS England (Lancashire Area Team)

Location

Lancashire

Region

North West

Parliamentary and Health Service Ombudsman

Millbank Tower
Millbank
London SW1P 4QP

Tel: 0345 015 4033

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