Parliamentary and Health Service Ombudsman

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

July to September 2015

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and Health Service
Ombudsman

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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 eighth 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 organisations that provide services 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.

May 2016

Complaints about UK government departments and other UK public organisations

Summary 977/July 2015

Poor service from Jobcentre Plus led to inconvenience and frustration

Ms Y complained that Jobcentre Plus and the Independent Case Examiner (ICE) both failed to deal properly with her complaints about how an assessment to decide whether she was too unwell to work was carried out. She said that her experience with Jobcentre Plus left her traumatised.

What happened

Ms Y made a claim for Employment Support Allowance (ESA) because she was unable to work due to ill health. She had to attend a Work Capability Assessment to decide if she was too unwell to work and, in the meantime, Jobcentre Plus gave her ESA. Ms Y filled in an ESA questionnaire before the assessment with Atos Healthcare (a company that conducted the assessments on behalf of Jobcentre Plus) and submitted it to Jobcentre Plus. However, when she attended the assessment, the doctor noted that he had not got the ESA questionnaire. He completed a medical report for Jobcentre Plus anyway.

Based on the Atos Healthcare report, Jobcentre Plus concluded that Ms Y was not too unwell to work. It then refused her ESA claim and stopped her benefit immediately. Ms Y appealed against that decision on the basis that the Atos Healthcare assessment had been conducted poorly. Jobcentre Plus reinstated Ms Y's ESA at a lower rate until the appeal was decided. However, Ms Y went back to work and her ESA stopped altogether.

While working, Ms Y continued to communicate with Jobcentre Plus. She asked why it had not replied to some of her letters or responded to her complaint about Atos Healthcare. Jobcentre Plus apologised for not dealing with Ms Y's letters properly and paid her £75. It said she needed to make her complaint directly to Atos Healthcare, so she did this. Atos Healthcare looked into Ms Y's complaint and found that Ms Y's assessment had not been conducted properly by its doctor. It recommended that Jobcentre Plus ask Ms Y whether she wanted a fresh assessment or for the appeal tribunal to decide her claim. Jobcentre Plus took no action and Ms Y's appeal went ahead but the appeal tribunal didn't uphold the appeal.

Ms Y then complained to ICE (the organisation that investigates complaints about Jobcentre Plus) and while it looked into the matter, Jobcentre Plus implemented Atos Healthcare's recommendations and offered Ms Y a fresh assessment. Ms Y attended the assessment with the original ESA questionnaire she had completed. Despite the appeal tribunal's decision, Jobcentre Plus concluded from the new assessment report that Ms Y should have been awarded ESA. It calculated the arrears and paid Ms Y over £800.

ICE found Ms Y's complaint about Jobcentre Plus' handling of her letters justified and that the £75 it had paid to her was a '*sufficient and appropriate remedy*' for the poor service she experienced. But ICE could not look into the ESA paid because it was outside the scope of its investigation.

What we found

We upheld Ms Y's complaint about Jobcentre Plus, and partly upheld her complaint about ICE. We found that Jobcentre Plus had mishandled Ms Y's complaint about Atos Healthcare. It should have told her sooner to complain directly to Atos Healthcare or passed her complaint on to it. This further delayed a response to her complaint.

Jobcentre Plus should also have acted on Atos Healthcare's recommendation to put things right for Ms Y by offering her the choice of a fresh assessment or the appeal. We also found that Jobcentre Plus' decision to replace the appeal tribunal's decision had been incorrect. Also there was no evidence that the appeal tribunal had not looked at all the facts of her case. Therefore the £800 was an overpayment, which was not due to her.

ICE should have recognised that Jobcentre Plus had failed to take any action to address or implement Atos Healthcare's recommendations. This was a failing.

Putting it right

Jobcentre Plus apologised to Ms Y for its poor handling of her case and acknowledged that it had made a wrong decision by paying her ESA. It also explained to Ms Y that should her health affect her capability to work in future, she should consider reapplying for ESA. Jobcentre Plus agreed not to ask Ms Y to repay the £800 that had been paid to her by mistake.

ICE also apologised for not looking into all aspects of Ms Y's complaint.

Organisation(s) we investigated

Jobcentre Plus

Independent Case Examiner (ICE)

Summary 978/July 2015

Cafcass' delay and poor complaint handling caused distress and frustration

Ms B said that the Children and Family Court Advisory and Support Service (Cafcass) severely delayed court proceedings and then failed to deal with her subsequent complaint about that. Ms B said she was mentally and physically drained by the situation and incurred significant financial costs.

What happened

Ms B's ex-partner, Mr D, applied to the court for a residence order and a prohibited steps order (PSO), preventing Ms B from removing their children from his care. The court granted the PSO.

At a hearing in mid-summer 2010, the court made a number of orders including that Cafcass submit a report about the children's welfare (a section 7 report) by autumn 2010. The court told the Cafcass area manager to say if Cafcass could not submit the report by the given deadline and ordered for the case to be heard two weeks after the agreed deadline, on the first available date.

However, due to an office move and workload pressures, Cafcass took over six months to produce the report. It missed several deadlines and extensions. The Cafcass family court advisor (FCA) then did not attend a court hearing to answer questions about the report because she no longer worked for Cafcass. The court criticised Cafcass for the delay it had caused, the quality of the report and the FCA's failure to attend the hearing. The court also recorded that this had caused serious financial implications for the parents, who had to pay for their own legal fees.

In 2013 Ms B met Cafcass to complain about its poor service. Cafcass couldn't deal with her complaint because it was outside of its published time limit for making a complaint. Ms B then complained to us and we asked Cafcass to look at her complaint. Cafcass recognised and apologised for some, but not all, of the administrative mistakes it had made. It also agreed to pay seven months of Ms B's legal costs. However, we did not think it had gone far enough to put things right.

What we found

We agreed that Cafcass had caused a seven-month delay to proceedings. We also found that Cafcass failed to seek the court's guidance as to who should attend future hearings when the FCA left; it did not look into Ms B's complaint as it should have done when she first approached it in summer 2011; it failed to give Ms B's 2013 complaint proper consideration before refusing to investigate because it was outside of the time limit for making complaints; and it failed to consider Ms B's request for a payment for the emotional distress and frustration she had experienced.

Putting it right

We thought that Cafcass' agreement to pay seven months' worth of Ms B's total legal fees was a reasonable remedy for her wasted costs. Cafcass also complied with our recommendations and apologised to Ms B for failing to deal with her complaint properly and paid her £750 in recognition of the distress and frustration its mistakes caused her.

Organisation(s) we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 979/July 2015

Poor handling of complaint about mine shaft searches

The National Coal Board (NCB) did not tell three neighbouring property owners about mine shafts on their properties, when they purchased them between 1974 and 1980. They wanted payment to cover what their surveyor said was the loss in market value of their properties due to the presence of mine shafts.

What happened

The property owners lived in an area historically used for coal mining. The organisation responsible for providing mining search reports at the relevant time was the NCB. The NCB no longer exists and, when it did, was not an organisation that we were able to look at. Therefore, our investigation looked at the actions of the Coal Authority.

The mining search provided by the NCB to property A in 1980 stated *'the property is clear of disused mine shafts and ... as shown on our records'*. The owner of property B said that mining searches on the property were carried out in 1974 when they purchased the property and in 1984 when the property was re-mortgaged. Owners of property C believed a pre-purchase mining search was carried out on their property in 1975.

In 2011, as part of the Coal Authority's ongoing mine shaft inspection programme, it wrote to the property owners saying '*your house is close to the recorded position of an old mine shaft*' and asking for permission to inspect them. The map it attached showed three mine shafts, one on each property. That was the first any of the property owners had heard about a mine shaft being located on their property.

The inspection took place and the property owners wanted compensation and explanations. They initially approached us when the Coal Authority had simply told them it was too late to make a negligence claim (their purchases had taken place in the 1970s and 1980). We asked the Coal Authority to properly consider and respond to the complaint. The property owners returned to us because they were not happy with the Coal Authority's subsequent response.

What we found

As part of our investigation we asked the Coal Authority and the Department for Energy and Climate Change (DECC) to work out where the relevant responsibilities and liabilities of the NCB passed to. Both organisations were satisfied that it was DECC (although it remains the Coal Authority's responsibility to consider specific concerns raised with it in relation to past and present coal mining operations and issuing mining search reports).

We found that the Coal Authority had not handled the complaint well. It had not worked out which organisation was responsible for any previous errors by the NCB, and it had not made it clear to the property owners that, for it to respond to their specific queries, it needed certain information from them (information it did not have itself). The property owners' journey to get to a point at which their concerns were dealt with was therefore delayed, which caused them unnecessary worry and inconvenience.

Putting it right

As a personal remedy, the Coal Authority accepted our recommendations. It apologised to the property owners for its failures in complaint handling and made a £500 payment to each of them for the impact of the poor complaint handling. It also wrote to them confirming the transfer of the NCB's liability and responsibility to DECC and set out what information the property owners needed to provide in order for the Coal Authority to consider their specific circumstances. It confirmed that, if the complainants did that, it would consider and respond to them.

The Coal Authority had made changes to improve its complaints process so we did not make any recommendations in relation to service improvement.

Organisation(s) we investigated

Coal Authority

Summary 980/July 2015

Cafcass wrongly intervened in case

The Children and Family Court Advisory Service (Cafcass) took action outside of its professional role. It also failed to keep a proper record of its contact with Mr H.

What happened

Mr H applied to a court for more contact with his daughter, and the court asked Cafcass for its view of the situation.

Mr H's daughter did not want more contact with her father, so Cafcass advised her to write to the court (and Mr H) to explain her reasons. The child did this and Cafcass wrote a report recommending that the court act in line with the child's views. Following this, the court did not grant Mr H's application. However, it decided it would review the situation a few months later.

Shortly before the review hearing, Mr H's daughter contacted Cafcass and told it she no longer wanted any contact with her father. Although Cafcass was no longer involved with her case at that time, she asked it to pass on her views to the court. She also asked Cafcass to talk to Mr H on her behalf. Cafcass agreed to both requests.

When Cafcass spoke to Mr H, he said he felt his daughter's views were being heavily influenced by her mother and that he had evidence to prove it. He asked Cafcass to pass this on to the court, but Cafcass refused, saying it was no longer involved in the case.

Mr H complained to Cafcass about what had happened. He said Cafcass' original report had been biased against him and had failed to recognise the negative influence his former partner had on his daughter. He also complained that Cafcass had treated him and his daughter differently.

Cafcass considered Mr H's concerns but was satisfied it had acted reasonably. Mr H remained unhappy and he complained to us.

What we found

We partly upheld Mr H's complaint. We found no evidence Cafcass had been biased against Mr H or that it had ignored his concerns about his former partner's influence on his daughter. We also found that, if Mr H had disagreed with Cafcass' report, he could have challenged it in court.

We found that Cafcass should not have passed Mr H's daughter's views to the court shortly before the review hearing. Nor should it have agreed to her request to speak to Mr H on her behalf because it was no longer professionally involved in the case at that time. We felt Cafcass should not have intervened in what was, in essence, a private matter. We felt this would have been upsetting to Mr H, particularly as he already felt Cafcass was acting against him. But we accepted that, in doing these things, Cafcass felt it was acting in the child's best interests.

During our investigation, we found that Cafcass had failed to keep a record of some of the contact it had had with Mr H while dealing with his case. Although we found no evidence this affected the outcome of the court hearings, we felt the poor record keeping would have been frustrating for Mr H.

Putting it right

Cafcass apologised for its failures. It also paid Mr H £250 in recognition of the upset and frustration he experienced because of these failures.

Organisation(s) we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 981/July 2015

Legal Aid Agency's miscalculations caused financial worry and distress

The Legal Aid Agency (LAA) unfairly refused to accept Miss T's rent as part of her monthly outgoings when calculating her legal aid contributions because she did not pay the rent on a monthly basis. She wanted the LAA to use its discretion to reduce the amount she needed to pay.

What happened

Miss T applied to the LAA for emergency legal aid for a non-molestation order against her ex-partner. The LAA granted her legal aid but she was also asked to make contributions towards it. The LAA requested that Miss T make two types of contributions. First, a one-off capital contribution based on her amount of savings. Secondly, an ongoing monthly amount based on her disposable monthly income.

Due to her uncertain financial circumstances, Miss T had secured a private rental property by agreeing to pay six months' rent in advance, followed by a further six-month instalment to cover the rest of the 12-month tenancy. The LAA refused to accept Miss T's rent as an outgoing because she did not pay it on a monthly basis. She had also already paid the first six months' rent before the calculation was done.

Despite several complaints, the LAA insisted that Miss T's rent was not allowed as a deduction from its income calculations because she did not pay it monthly. The matter remained unresolved and her legal aid certificate was cancelled. She then became liable to repay the legal costs in full. The debt remained outstanding and Miss T brought her complaint to us.

What we found

We partly upheld Miss T's complaint. The LAA had treated Miss T unfairly. Although she was not paying her rent during the six-month period, the LAA failed to recognise that she needed to save during this time to be able to meet the next six months' rent instalment. As such, we found that the LAA could and should have included this in its income calculations. Had it included the rent, Miss T would have been asked to pay a significantly lower monthly contribution. However, Miss T was not affected financially because she did not actually make any monthly payments.

We found that the rent exemption would not have affected her capital contribution, which had been calculated correctly.

Ultimately, the final legal aid bill was covered by the capital contribution so the monthly calculations had no effect on the final amount owed. Miss T was still required to pay the full legal bill.

By miscalculating her income the LAA had asked for high monthly contributions, which would have been very stressful for Miss T. We also found that the LAA's complaint handling could have been better. It consistently failed to accept that it should have included her rent in its calculations and that it had treated her unfairly.

Putting it right

The LAA apologised to Miss T, paid her £150 and made improvements to make sure staff were clear about when advance rent instalments could be an allowable deduction from monthly income.

Organisation(s) we investigated

Legal Aid Agency (LAA)

Summary 982/July 2015

HMCTS should not have referred case to bailiffs

Mr S complained that HM Courts & Tribunals Service (HMCTS) referred his case to bailiffs when it should not have done so. As a result, the bailiffs harassed him for the payment of their fees. Mr S wanted a consolatory payment for the inconvenience caused.

What happened

In summer 2013 Mr S was convicted of a driving offence at a magistrates' court. The magistrates' court banned him from driving for six months and ordered him to pay a fine. Mr S appealed the driving ban and fine at a crown court and the bailiffs who were managing payment of the debt were told about this. The crown court heard the appeal and the ban was reduced to three months but the original fine was not changed. The bailiffs were told the outcome of the appeal and issued a notice telling Mr S the fine had to be paid within ten working days or further action would be taken.

Mr S queried this with the bailiffs and HMCTS because he was concerned that the appeal had overlooked his objection to the fine. The bailiffs put the fine on hold until autumn 2013. At the same time Mr S asked the crown court how he could appeal the decision. Mr S said the crown court told him to apply for permission to appeal to the Court of Appeal. HMCTS said that it was unlikely the crown court told him that, given that it is not permitted to give legal advice, but accepted that there may have been a misunderstanding.

Mr S called the bailiffs to tell them about his intention to appeal and he submitted the necessary application form to the crown court. The crown court replied telling Mr S that appeals heard at the crown court from the magistrates' court could not be appealed at the Court of Appeal. It advised him to seek legal advice. The bailiffs issued a distress warrant (a permit authorising the seizure of someone's property for money owed).

Mr S continued corresponding with the crown court and the bailiffs. But the crown court took no action until early 2014 when HMCTS considered his query and put the fine on hold. The judge confirmed that the fine still stood and Mr S paid it. However, he was also liable for the bailiff fees, which he did not believe to be fair in view of HMCTS' delay in dealing with his query.

Mr S complained to HMCTS who accepted that it had given confusing information about his appeal and overlooked his autumn 2013 correspondence. It offered him £100. However, HMCTS maintained that it was right to have instructed bailiffs. Mr S was not satisfied with the outcome because he had wanted HMCTS to allow him to pay the fine directly to it without the addition of any fees and/or charges, which he believed were still outstanding. He also wanted payment for the inconvenience caused.

What we found

Had HMCTS not given Mr S confusing information about his route of appeal and had it dealt with his autumn 2013 correspondence appropriately, then his fine would have been put on hold while the matter was considered. In view of Mr S's clear intention to pay the fine once his query had been addressed, there was a strong possibility that he would have done this before the need for HMCTS to instruct bailiffs. We recognised that HMCTS had accepted its failings, and offered Mr S £100. However, we felt that it needed to do more to put things right.

Putting it right

HMCTS accepted our recommendations and settled the outstanding debt of more than £180 with the bailiffs on Mr S's behalf. It also gave Mr S a further payment of £100 on top of the £100 already offered for the distress of having the bailiffs visit him.

Organisation(s) we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 983/July 2015

Cafcass apologised for an inaccuracy in a report

Ms F complained that the Children and Family Court Advisory and Support Service's (Cafcass') report to the court was biased, contained numerous inaccuracies and failed to protect the health, safety and wellbeing of her son. She said Cafcass dismissed her complaint and as a result she felt exhausted and emotionally drained by the process.

What happened

Ms F was involved in court proceedings relating to contact between her son and his father. She raised many complaints about the Cafcass officer (the officer), including the contents of the Cafcass report and the officer's recommendations. She felt that the report should have focused on what was best for her son but instead focused on her own mental health, which she considered to be irrelevant.

Part of Ms F's complaint was that the officer told her that she did not need to meet her son again but was happy to see him if Ms F wished. The officer had already interviewed Ms F's son. However, the report said that the officer had 'offered to meet the child but Ms F had not facilitated this request'.

Ms F felt that this was unfair and it had made her look obstructive. Ms F complained to Cafcass but was unhappy with how it dealt with her complaint. She wanted Cafcass to admit fault and make a payment to her for the distress caused.

What we found

We found that while many of Ms F's concerns were matters for the court, the sentence in the report relating to meeting the child did not accurately reflect the situation and could have been worded better. By using the word 'request', the officer had suggested that Ms F had failed to do something she been asked to do, when in fact the officer had not asked to meet her son.

Putting it right

The officer accepted that the sentence could have been worded better and that she had not intended for it to be a criticism of Ms F. Cafcass apologised to Ms F, amended the report and sent a copy to the court.

Organisation(s) we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 984/July 2015

Woman left out of pocket by court's mistakes

Mrs A was owed money. HM Courts & Tribunals Service (HMCTS) instructed bailiffs to collect the debt and Mrs A had to pay £100 for this. The court should have added this to the amount the debtor owed, but it failed to do this.

What happened

The defendant owed Mrs A over £2,000. She submitted a claim form to HMCTS. The county court ordered the defendant to pay Mrs A. But when the defendant failed to pay the money, the county court issued a warrant to the bailiffs to collect the debt. Mrs A had to pay a fee of £100 for the warrant.

The bailiffs made attempts to collect the debt and notified Mrs A of their continuous efforts. However, during the process HMCTS altered the original judgment many times because the defendant had applied to stop enforcement action, but the warrant was not updated in line with the judge's orders. In the final order the judge included the warrant fee that had been missed in the previous orders. HMCTS could not give evidence that it had updated the warrant with the final order.

The debtor paid the amount written on the incorrect court order, but did not settle the remaining £100 warrant fee that was included in the final court order. HMCTS did not keep Mrs A updated on the action its bailiffs took on her case. When Mrs A complained to HMCTS, it did not identify that it had failed to amend the warrant in line with the court order and it did not respond to all aspects of Mrs A's complaint. Mrs A complained to us because HMCTS's administrative errors caused her distress and she wanted it to pay the bailiffs' fee of £100.

What we found

The bailiffs made reasonable attempts to enforce the warrant, but HMCTS made mistakes with the court orders. Even though HMCTS corrected its mistakes quickly, it did not update the warrant with the correct information about the debt owed. Had the warrant information been updated correctly, the defendant would most likely have paid the remaining £100 owed to the court.

HMCTS' communication and complaint handling was also poor. It should have given Mrs A more information about the bailiffs' attempts to collect the debt. This caused Mrs A unnecessary stress and frustration at an already stressful time and meant she had to bring her complaint to us.

Putting it right

HMCTS apologised to Mrs A and paid her £200. This was made up of the £100 she would otherwise have received from the defendant for the bailiff's fee and £100 consolatory payment for the stress, frustration and inconvenience she experienced as a result of HMCTS' mistakes. HMCTS also reviewed what it had learned from this case, particularly in relation to record keeping.

Organisation(s) we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 985/July 2015

Cafcass did not deal adequately with mother's complaints

Ms G said the Children and Family Court Advisory and Support Service (Cafcass) did not properly investigate her concerns about the cause of her son's stammer. She also complained that the Cafcass officer acted inappropriately at court. Ms G wanted her concerns to be addressed.

What happened

Ms G was involved in a residency dispute with her ex-partner. She believed that her son's contact with his father had caused him to have an intermittent stammer. She said this was due to the father's abusive behaviour towards her son. She raised her concerns with a Cafcass officer (the officer).

In late 2012, in preparation for the first hearing about the dispute, the officer submitted a safeguarding letter (this letter relates to the issue of safety only) to the court, in which she included information about the child's stammer.

In early 2013 at another hearing, the court ordered Cafcass to submit a report about the child's welfare (a section 7 report) to the court by spring 2013. Ms G also gave the court a statement in which she referred to her son's stammer and details about when it had occurred.

When the officer submitted the section 7 report, she again mentioned the child's stammer but said she wouldn't go into details about it because she was sure this issue had been addressed in previous proceedings. However, there was nothing in Cafcass' records to suggest that the child's stammer was explored in those earlier proceedings.

Ms G complained to Cafcass that it was biased and had taken the word of the officer to be correct. But when Cafcass dealt with this issue as part of its complaint response, it told Ms G that the court would have been aware of her concerns through the safeguarding letter and her statement. It said that it was up to the officer's professional judgement what information to include in the section 7 report. If Ms G felt that not enough weight had been given to her son's stammer, then she should have challenged this in court. Cafcass also did not find evidence of bias.

Ms G also raised concerns about the officer's behaviour at the court. She said the officer had acted inappropriately when she sat with the child's father and they were laughing, which made her unhappy. Cafcass investigated this matter and said that it believed this had happened when the officer was waiting to see Ms G. Ms G disagreed with Cafcass' version of events. However, Cafcass agreed that it would have been more appropriate if the officer had been able to sit at more of a distance from the father. It said that the officer's manager would discuss with the officer how she might have given the impression of favouring one party over another.

Ms G complained to us because she wanted her concerns to be addressed.

What we found

We partly upheld this complaint. We found that Cafcass did not handle some aspects of Ms G's complaint as well as it could have. In relation to the child's stammer, we agreed with Cafcass that it was the officer's professional judgement to consider what information to give to the court and, if Ms G felt that insufficient weight was given to this issue, she should have raised the matter in court. However, because there was no evidence that the child's stammer had been considered in earlier proceedings, as Cafcass had stated, we did not believe the officer should have made this statement without checking if it was factually correct.

With regard to the officer's behaviour at court, we found that the officer acted in a manner that came across as unprofessional and Cafcass did not fully address Ms G's concerns. We noted that the officer's manager confirmed that she had discussed the issue as a learning point with the officer.

Putting it right

Cafcass apologised to Ms G for the inconvenience and distress caused by its failings.

Organisation(s) we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 986/July 2015

Cafcass' mistakes added to mother's frustration and distress during a child custody hearing

Ms D said that the actions of the Children and Family Court Advisory and Support Service (Cafcass) negatively affected child custody proceedings and this caused her significant distress.

What happened

Ms D's ex-husband made an application for contact with their children. But Ms D didn't want him to have contact because of his past behaviour. The court appointed Cafcass to give advice. Three Cafcass officers were involved in Ms D's case. Cafcass interviewed Ms D over the phone and officer A wrote a letter which included details of Ms D's ex-husband's extensive criminal history and other allegations that Ms D made.

The case was then allocated to officer B who interviewed Ms D and her children. When officer B submitted a report about the children's welfare (a section 7 report), she noted that the children had mixed feelings about seeing their father and she recommended supervised contact in a contact centre setting. At a later date officer B wrote to Ms D to say that the court had ordered another report and she would be in contact with her to arrange an interview date.

But the case was later allocated to officer C, and the court ordered her to observe contact between the children and their father at a contact centre. Officer C commented positively about the children's contact with their father and his new girlfriend, and recommended overnight contact in her section 7 report. However, she submitted the report to court without interviewing Ms D.

At the final hearing, Ms D made a number of allegations about her ex-husband. But his solicitors said that some of these were not true. They argued that, if they had been true, she would have mentioned them to Cafcass officers. Ms D tried to defend herself against this by pointing out that she had not been interviewed when Cafcass completed its reports. When the judge asked officer C if this was true, she could not confirm one way or the other. This is because it was not clear from Cafcass's records whether Ms D had or hadn't been interviewed.

Ms D complained to Cafcass that it was unfair that she had not been interviewed. She said there were many issues that the Cafcass officers involved in her case didn't look into enough.

What we found

Although it was unusual that Cafcass hadn't interviewed Ms D for its reports, we did not criticise it for this. This is because Cafcass' rules do not say that it always has to interview parents and this was a matter for Ms D to challenge in court.

However, when Ms D tried to raise this matter in court her efforts were frustrated. Cafcass' records should have been up to date and it should have been able to tell the judge what level of contact it had had with Ms D. We found the fact that Cafcass couldn't was a failing and it made the hearing more difficult for Ms D than it otherwise would have been.

Putting it right

Cafcass accepted our recommendations and apologised to Ms D. It paid her £250 in recognition of the unnecessary distress that it caused her. We also recommended that Cafcass should tell Ms D what it had done to improve its record keeping.

Organisation(s) we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 987/July 2015

HMCTS mishandled debtor's case

Mr T complained that HM Courts & Tribunals Service (HMCTS) acted unreasonably and failed to take his circumstances into account when it referred his debt to the bailiffs. He said HMCTS' actions caused him significant distress and added financial problems.

What happened

Mr T had two fines outstanding from two different magistrates' courts (fine A and fine B). Fine A was for keeping a vehicle on a public road without a valid licence, and fine B was for travelling on a train without a valid travel card on a number of occasions. In both cases, the courts had told Mr T that failure to pay could make him liable for further enforcement action, including involving bailiffs, which would incur additional costs. The courts told Mr T that if he had difficulties in paying the fines, he should contact HMCTS' enforcement team at the local Collection and Compliance Centre (CCC).

Mr T made some payments towards both fines but he then became unemployed. During that time his father also died and he travelled overseas for his burial, for two weeks and later for a month. He did not notify HMCTS of his father's death nor did he tell it that he was travelling. Mr T was meant to make payments during this time but didn't because of being away.

The CCC then sent Mr T notices because he had failed to make payments. Mr T rang the CCC and agreed a payment plan for fine A but it made a mistake on its computer system. This led to an automatic distress warrant (a licence authorising the seizure of his property for money owed) being issued against him. The CCC referred Mr T's cases to the bailiffs without his knowledge. Mr T was away at the time and did not have a chance to speak to the bailiffs to try to negotiate a repayment plan.

Mr T complained to the CCC about the bailiffs' involvement in both cases. He strongly complained about the administration charges that the bailiffs had added to his fines and said that he felt harassed and stressed by their actions. He also referred to the national standards for enforcement agents and said that the bailiffs had not informed him of these standards.

He said that he never received responses to some of the letters he wrote to the courts and the bailiffs. He wanted a consolatory payment to reflect the stress HMCTS caused him and for HMCTS to improve how it informs defendants of the national standards for enforcement agents in the future.

What we found

There were failings in the way HMCTS had dealt with Mr T's first fine, which denied him the opportunity to negotiate a repayment plan with the bailiffs and a chance to avoid an escalation of his debts. But we found that, as Mr T had missed his next payment anyway, the bailiffs would still have visited his house a month later demanding payment. We did not find any failings in the way HMCTS dealt with Mr T's second fine.

We found that although HMCTS was not required to tell Mr T about the national standards for enforcement agents, it would have been customer focused if it had done so and we considered that this information should be made more generally available to debtors.

Putting it right

HMCTS apologised to Mr T and paid him a consolatory payment of £100 in recognition of the lost opportunity for him to negotiate a payment plan for fine A, and for the stress he experienced. It also reviewed the information it gives to defendants in vulnerable situations and made proposals on how to make that information available to debtors.

Organisation(s) we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 988/July 2015

Cafcass had already acknowledged poor complaint handling

Mr S was involved in family court proceedings but was unhappy with the way officers at the Children and Family Court Advisory and Support Service (Cafcass) had dealt with his case over four years. He wanted Cafcass to be held accountable and a payment for his legal costs.

What happened

Mr S wanted to have increased contact with his son. He spent four years trying to resolve matters in court so that he could see his son more often. Over this time Mr S dealt with five Cafcass officers.

Before the final hearing Mr S complained to Cafcass. Mr S was mainly unhappy with the most recent officer involved in his case, but he complained about Cafcass's involvement since the beginning of proceedings. He said all the officers were biased in favour of his son's mother. Mr S gave supporting information with his complaint, including recordings of the officers that he had made covertly, which he said contained evidence of coercion and manipulation.

Cafcass received Mr S's complaint a month before the final hearing, but it decided not to respond at that time because of the upcoming hearing. Cafcass responded to Mr S's complaint six weeks after the final hearing had taken place. Cafcass said it would not consider Mr S's recordings in line with its policy on covert evidence. Cafcass also told Mr S that if he wanted to challenge the recommendations made by the officer he must do this in court. Mr S was unhappy with Cafcass' response and asked his MP to refer his complaint to us.

What we found

We did not uphold Mr S's complaint. We could see that Cafcass had properly followed its policy when it refused to consider Mr S's covert recordings, but as we were not bound by this policy, we decided to look at the evidence (which had also been seen by the court). We did not share Mr S's concern that the recordings contained any evidence of malpractice.

These proceedings took place over a long time, but this was caused by many different factors. We could not identify any significant errors on Cafcass' part, which would have caused any undue delays.

Cafcass had failed to deal with Mr S's complaint properly by not dealing with it as soon as it received it. However, we could see that Cafcass had already apologised to Mr S for this and we decided that this was sufficient.

Organisation(s) we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 989/July 2015

HMCTS tried to avoid having to cancel hearing but inappropriately handled complaint

HM Courts and Tribunals Service (HMCTS) cancelled Ms L's final hearing of her divorce case the day before it was due to take place. As a result, she incurred additional legal costs and was distressed. She wanted HMCTS to reimburse her legal costs.

What happened

Ms L was involved in divorce proceedings. Following a financial dispute resolution hearing, the district judge ordered a final two-day hearing of Ms L's case. HMCTS made a request to the Judicial Secretariat for a judge to hear the case in accordance with its administrative processes. The vacancy for the judge for Ms L's case was circulated to deputy district judges in the area.

Two weeks before the hearing, the vacancy remained unfilled and the advert was extended to deputy district judges in the South East of England. However, two days before the final hearing, no judge had come forward and so HMCTS, along with the Judicial Secretariat, phoned all judges qualified to hear the case.

HMCTS also made enquiries to explore the possibility of moving existing booked deputy district judges around. In addition, other courts in the area were contacted to see if they had the capacity to hear Ms L's case, but unfortunately they were oversubscribed.

The day before the hearing, the situation remained unchanged and phone enquiries continued. At some point during the day, the Judicial Secretariat informed HMCTS that they had secured a judge, but they contacted HMCTS shortly after stating that the judge had cancelled at short notice. HMCTS and the Judicial Secretariat continued making phone enquiries, but were unsuccessful and at 4pm they contacted Ms L and her legal representatives and postponed the hearing.

Ms L complained to HMCTS and said she had to wait for another 17 months for her case to be heard and as a result she incurred additional legal costs. She said she experienced severe distress and the postponement prolonged the situation. She wanted HMCTS to recognise the emotional impact this had on her and to reimburse her legal costs.

What we found

We found that HMCTS followed its processes and procedures, and took appropriate action to avoid having to postpone. However, its complaint response to Ms L could have been more helpful and been clearer about the reasons why her hearing was postponed.

HMCTS stated that the postponement was due to the district deputy judge cancelling at short notice. This was not an accurate representation of the facts, as the hearing was postponed because of the unavailability of any judge to hear the case.

HMCTS' complaint handling was not helpful and actually may have confused matters for Ms L.

Putting it right

HMCTS wrote to Ms L and apologised for the poor handling of her complaint. HMCTS also gave its staff further training on effective complaint handling.

Organisation(s) we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 990/July 2015

Cafcass had done enough to put things right

A report produced for a court hearing about where Mr D's children should live incorrectly stated that Mr D had a criminal conviction for domestic violence. The mistake was corrected, but Mr D said this took too long and influenced proceedings.

What happened

Mr D's children lived with their mother, but had regular contact with Mr D. Mr D made an application to the county court for sole residency of the children.

The children were party to proceedings and the court ordered Cafcass to appoint a guardian to represent them. The court ordered the guardian to submit a report about the children's welfare (a section 7 report) in advance of a final hearing.

In the report the guardian inaccurately stated that Mr D had a criminal conviction for domestic violence. Mr D alerted the guardian to the error. The guardian looked into this and then made the court and other people involved in the proceedings aware of her mistake. She also apologised to Mr D.

Mr D complained to Cafcass not only about the guardian's mistake, but also about her general involvement in the case and failure to take his concerns about the welfare of his children seriously, while in the care of their mother. Mr D said the guardian took too long to correct the mistake, which he believed influenced the proceedings and caused him difficulties in his personal life.

What we found

We did not uphold this complaint. In terms of the guardian's handling of the case, we found that she had acted reasonably on the concerns that Mr D raised about the children's welfare and took appropriate action.

In relation to her mistake in the report, we looked carefully at whether there was any evidence to suggest that this had impacted on the proceedings or influenced decisions made about the care of Mr D's children. We were satisfied that this was not the case, and that the guardian had acted reasonably in putting her mistake right. We also found that the time it took her to investigate the mistake was not unreasonable, given the enquiries she needed to make beforehand. Therefore, we felt that Cafcass had already done enough to put things right. It had alerted the parties to the mistake in the report and apologised to Mr D.

Organisation(s) we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 991/July 2015

HMCTS made appropriate payment for loss of files

Mr J complained that HM Courts & Tribunals Service (HMCTS) was responsible for losing six case files that he had prepared as part of his application to appeal a court decision. He was unhappy with the level of compensation that HMCTS offered.

What happened

Mr J wanted permission to appeal a decision of a judicial review hearing. He sent HMCTS an application for permission to appeal, including six bundles of case files. When he contacted HMCTS to check if it had received them, it told him they were lost and likely to have been destroyed.

Three months later, HMCTS recovered four of the bundles and returned them to Mr J. However, the two other bundles remained missing. Mr J resent all six bundles to HMCTS which cost him nearly £50 in postage fees.

Mr J complained to HMCTS and said that it should pay him over £49,000 plus VAT in recognition of the time he had spent putting this matter right. HMCTS acknowledged that it had made mistakes and apologised. It paid him £100. Mr J was not happy with this amount and also wanted a full explanation of the circumstances surrounding the loss of his case files.

What we found

We found that HMCTS gave Mr J conflicting information, which caused him worry and frustration. Then when they returned four of his bundles he still had to get together a copy of the remaining two before reposting all bundles back to the court.

Although the £100 was a long way short of the level of compensation that Mr J was seeking, we were satisfied that this covered his additional postage costs and was reasonable in the circumstances. We therefore did not uphold this complaint.

Organisation(s) we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 992/August 2015

Confusion over DWP's factsheet on insolvent occupational pension scheme

The Department for Work and Pensions (DWP) failed to clarify its own roles and responsibilities in a factsheet it produced in 2013 about a privatised company's pension scheme. This caused confusion to a number of people who contacted us with concerns about their retirement.

What happened

AEA Technology plc was formed in 1996 from the commercial arm of the publicly owned UK Atomic Energy Authority. Some staff who had transferred to the newly privatised company also decided to move their existing, public service, pensions into the new private company pension scheme.

In autumn 2012 DWP began to receive enquiries from concerned members of the company's private pension scheme. They told DWP that the pension scheme was insolvent; it could not afford its liabilities and was entering an assessment period with the Pension Protection Fund (PPF), which could compensate them for some, but not all, of their pension benefits from the failed scheme. Members felt they would have been better off if they had left their old public service pensions where they were.

Members who contacted DWP said their pensions had been protected by the Atomic Energy Authority Act 1995 when their employment transferred from the public sector to the private sector. They also raised concerns about a note issued by the Government Actuary's Department (GAD) in 1996, which had explained the different options available to staff in connection with their pensions.

In 2013 DWP produced a factsheet to answer members' enquiries. DWP involved GAD and the PPF with this, and also the Department for Business, Innovation and Skills (BIS) as it was now responsible for issues relating to the privatisation. DWP included information from all of these organisations as answers to the common questions the enquiries raised.

Several members complained to DWP that answers it gave in the factsheet were inaccurate and misleading. Members were particularly concerned about what it said about the Atomic Energy Authority Act 1995 and the advice GAD gave about this. The members said the factsheet had confused matters, and they said organisations like GAD and BIS were using the factsheet to defend themselves against complaints.

We agreed to investigate DWP's actions, but we could not look at members' complaints about GAD, the PPF or BIS. The law limits our ability to investigate specific types of complaint about GAD, the PPF and BIS, and the members' complaints did not fall within this.

What we found

We partly upheld the complaints about DWP. DWP was not responsible for the information AEA Technology plc gave to employees when it was privatised. Complaints about that should have been directed to BIS. DWP was also not responsible for the advice that GAD gave, and complaints about that should have been directed to GAD.

DWP knew this when it created its factsheet, but the factsheet did not make this clear. The factsheet also did not say what individuals could do if they were unhappy with the information in it. DWP's failure to include this information on the factsheet caused confusion and inconvenience.

Putting it right

Following our investigation DWP's factsheet accurately showed what information had been provided separately by DWP, GAD, BIS and the PPF. We could see the complainants disagreed with information GAD, BIS and the PPF gave, but that was a matter for them to take up with those organisations.

DWP apologised for the confusion and inconvenience caused by its failure to properly explain its role in the factsheet.

Organisation(s) we investigated

Department for Work and Pensions (DWP)

Summary 993/August 2015

Cafcass gave poor service to father who did not have direct contact with his children

Mr K complained about how the Children and Family Court Advisory and Support Service (Cafcass) handled his case. He said that its reports were biased, staff did not communicate with him properly, and Cafcass failed to deliver letters and cards he sent to his children, despite being ordered to do so by the court.

What happened

In late 2010 the court ordered Cafcass to submit a report on Mr K's contact with his children. It was asked to do this by spring of 2011, but Cafcass did not do this until eight months later.

At a hearing shortly afterwards, the court ordered Cafcass to pass on letters and cards from Mr K to his children, but Cafcass refused to pass on Mr K's first letter as it said some of the content was inappropriate. At the end of 2011 Cafcass closed Mr K's case but it was still responsible for forwarding Mr K's letters to his children. However, when Mr K gave them subsequent letters and cards it did not pass them on, and did not notify him of this.

In summer 2013 the court ordered Cafcass to submit a further report within three months, but it did not do this until the beginning of 2014. At a hearing at that time the court appointed a guardian from the National Youth Advocacy Service to take responsibility for the children, and the case was closed as there was no further role for Cafcass.

What we found

We partly upheld this case. There were serious shortcomings by Cafcass in failing to submit reports with the court in time. However, it was not possible to say with any certainty that if Cafcass had provided the reports to the court sooner, the case would have run a different course.

We considered that Mr K's complaint about Cafcass' reports being biased was a matter to be raised in court, rather than through the complaints procedure.

Cafcass failed to pass on correspondence to Mr K's children. The court had ordered Cafcass to be an intermediary for Mr K's letters to his children and it should have carried on with that role until the court ordered otherwise. In the absence of direct contact with his children, this was an important way for Mr K to stay in touch with them.

Putting it right

Cafcass apologised to Mr K for its failings and poor customer service, and paid him £750 for the distress, upset and frustration this caused.

Organisation(s) we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 994/August 2015

Solicitor left frustrated even though the Legal Aid Agency had already apologised for poorly handling her complaint

When Mrs B, a solicitor, complained to the Legal Aid Agency (LAA) about the way it handled her practice's legal aid account, it did not address all her complaints in reasonable time and she spent years chasing it for an explanation.

What happened

Mrs B complained to the LAA about the way it handled her practice's legal aid account. She said the LAA held back over £38,000 of her money which it said was to account for what her practice owed it. Mrs B said she had been deprived of this money which she was owed for cases she had worked on, and had been properly assessed by the courts. She wanted the money back plus interest. She said the LAA had failed to explain why it had not paid her the money and also that it had handled her correspondence about this badly. She said it had also taken away her legal aid account.

Mrs B wrote several letters to the LAA about this over a number of years but said the LAA did not respond to them all. After she pursued the matter and escalated her complaints, it eventually responded to all of her concerns in greater detail and understanding, and apologised to her.

Although the LAA reinstated her practice's legal aid account, Mrs B said the LAA had failed to explain why it had not paid her the outstanding amount that she said was due to her. Mrs B wanted an explanation for this, and also for her costs to be paid directly to her, with interest, rather than being offset against what she owed the LAA.

Mrs B complained to us about this and also said that the LAA had handled her correspondence badly.

What we found

We did not uphold this complaint. After a detailed look at what happened we decided that the way that the LAA used funds that were due to Mrs B's practice was fair. The LAA often make advance payments to solicitors as they work on a case, and then if the solicitor or their client are personally awarded costs they repay the money to the LAA.

There were failings in the LAA's complaint handling because it didn't reply to some of Mrs B's letters and she had to write several times and complain to the chief executive before she got a response to some of her concerns.

However the LAA had already identified this and sincerely apologised to Mrs B. This was enough to put the matter right, but we recognised Mrs B's frustration at having to chase the matter up.

Organisation(s) we investigated

Legal Aid Agency (LAA)

Summary 995/August 2015

Highways England asked to compensate a driver after his car was damaged by a motorway pothole

Mr M was driving to work on the motorway when his car hit a pothole. Although Highways England offered Mr M some compensation for the damage, he came to us because he thought it was not enough money.

What happened

When Mr M's car hit a pothole on the motorway, it caused serious damage to his car, affecting both the suspension and a tyre. As a result Mr M could not continue his journey.

Mr M found out that repairing his car would cost too much money, so he bought a new suspension part and a new tyre and fixed them himself. He then complained to Highways England (then the Highways Agency) and asked it to compensate him for the new car part and tyre.

Highways England originally decided it would not compensate Mr M. When he told it he was unhappy about its decision, it looked at his complaint again. Highways England decided it was likely its contractors had missed the pothole during the last motorway inspection before Mr M's accident. It therefore said it would compensate Mr M and pay towards the cost of the car part and the tyre. Highways England's original offer to Mr M was for 80% of the cost of the car part and tyre (approximately £96). It said it would not pay 100% of the cost because the part and tyre would have had some fair wear and tear to them before the accident.

Mr M was unhappy with this offer, and so complained to us.

What we found

Highways England's investigation of Mr M's accident was reasonable, and it was right to compensate him. However, Mr M had been greatly inconvenienced by sorting out this problem and Highways England's compensation offer of £96 did not recognise this. Mr M was also able to prove to us that he had only recently fitted his tyre before it was damaged, so it was unreasonable to apply a reduction to this. Mr M could not prove when he fitted his suspension, and we considered it was reasonable to agree to the reduction for that part.

Putting it right

Highways England paid Mr M £250 for the inconvenience he suffered. It also paid the full price of the car tyre, along with its original offer for the suspension parts. This came to about £110, so in total, Highways England paid Mr M approximately £360.

Organisation(s) we investigated

Highways England

Summary 996/August 2015

Taxi driver drove without valid licence or insurance for four years because of HMCTS mistake

Mr D is a private hire taxi driver. In 2013 police stopped him for a routine check. He was horrified when the police told him his licence had been revoked four years earlier.

What happened

In early 2009 Mr D was convicted of a motoring offence. The court ordered three points to be added to his licence. After the court hearing, Mr D gave his licence to HM Courts & Tribunal Service (HMCTS) and the three points were added to his licence by hand.

However, HMCTS incorrectly passed on information through its electronic system to Driver and Vehicle Licensing Agency (DVLA) that Mr D's licence had not been updated with the points. When it received this incorrect information, DVLA's computer system automatically sent a letter out to Mr D asking him to return the licence so that it could be updated with the points. The letter said the licence would be revoked if not returned.

DVLA did not hear from Mr D so it automatically issued a reminder one month later. A month after that, Mr D's driving licence was automatically revoked.

DVLA did not have to tell Mr D his licence had been revoked so it was only when the police stopped him for the routine check in 2013 that Mr D found this out.

Mr D contacted DVLA straight away and sent a faxed copy of his licence. The licence showed the three points had been added to the licence and DVLA reinstated Mr D's entitlement to drive the same day.

What we found

We upheld the complaint about HMCTS but not about DVLA. HMCTS had updated Mr D's licence but failed to tell DVLA that it had done so. We could not find out why this mistake happened as the court file had been destroyed. Nevertheless, HMCTS should have told DVLA the licence had been updated manually and the failure to complete this crucial part of the licence endorsement process was a serious failing.

HMCTS' mistake was the catalyst for DVLA's subsequent actions and we were satisfied that DVLA acted appropriately in response to the information it received from HMCTS. DVLA automatically sent letters to Mr D asking him to return his licence for endorsement, but Mr D did not receive them although there is evidence that the letters were sent to him.

After the police told him his licence had been revoked, Mr D contacted DVLA and it acted quickly. It reinstated Mr D's entitlement to drive as soon as it received the fax of his driving licence showing it had been endorsed by the HMCTS.

HMCTS' error could potentially have had disastrous consequences for Mr D who unknowingly had been driving his taxi without a valid licence or insurance. Fortunately, nothing bad happened, but HMCTS' error caused him unnecessary inconvenience in trying to put the situation right.

Putting it right

HMCTS accepted our recommendation and apologised to Mr D for its mistake and for the inconvenience and distress this caused him.

Organisation(s) we investigated

Driver and Vehicle Licensing Agency (DVLA)

HM Courts & Tribunals Service (HMCTS)

Summary 997/August 2015

UKVI correctly turned down application to stay in the UK because applicant had not lived here for the required 20 years

Mr H complained about UKVI's refusal to grant him permanent residence in the UK and said it breached his human rights.

What happened

Mr H made an application to live permanently in the UK in autumn 2009 because he said he had lived here since arriving from India at the end of 1992 as an asylum seeker. UKVI turned this down. At the end of 2012 Mr H applied again, but UKVI also refused this application. UKVI said that Mr H had not been in the UK for 20 years, the time set out in the legislation, so he did not qualify for permanent residence. Mr H said this breached his human rights but UKVI said its decision would not breach Mr H's human rights because there was nothing preventing him from returning to India, a country in which he had spent half his life.

In autumn 2013 Mr H made a new application. He explained he had arrived as an asylum seeker in 1992, made a claim for asylum either in 1992 or 1994, and UKVI had never made a decision about that asylum application. He said he was single, had no children and enclosed letters from friends and acquaintances showing that he had been living in the UK since his arrival in 1992.

However, the documents UKVI are able to accept as proof of a person's life in the UK only dated back to summer 2001. UKVI refused Mr H's application again because there was no proof he had been in the UK for 20 years.

In autumn 2014 Mr H complained to UKVI about its decision to refuse his application. UKVI considered his complaint and confirmed it had correctly considered his application. It told him that as he was in the UK illegally, he should leave.

What we found

We did not uphold this case. There was no evidence that UKVI had ever received an asylum claim from Mr H in 1992 or 1994 as Mr H claimed. UKVI considered Mr H's later applications properly and its decisions to refuse him permission to stay were correct. UKVI considered whether its decision would breach Mr H's human rights, but based on the information he had provided, its refusal decision did not seem unreasonable.

Organisation(s) we investigated

UK Visas and Immigration (UKVI)

Summary 998/August 2015

HMCTS caused delay to court application and failed to provide clear information about a hearing

When Mrs G applied to register her husband's Enduring Power of Attorney, HM Courts & Tribunals Service (HMCTS) took too long to refer the case to a judge for action. Its correspondence was also unclear, so Mrs G did not realise she had to attend a hearing.

What happened

Mrs G applied to the Office of the Public Guardian (OPG) to register her husband's Enduring Power of Attorney (EPA) as she believed he had lost his mental capacity when he was sectioned on a mental health ward. This EPA named Mrs G as the attorney, which would have given her control of his financial affairs. A relative then submitted an objection to this which halted the application. The matter was then referred to the Court of Protection, which is administered by HMCTS.

Following his release from hospital, Mr G became temporarily estranged from his wife and created a new Lasting Power of Attorney (LPA) appointing a professional firm as his attorney. The LPA replaced the EPA. Mrs G said that Mr G did not have mental capacity during this period and Mr G proceeded to spend his life savings.

Initially, the Court of Protection instructed the OPG to register the EPA. However, matters returned to the Court of Protection when it became aware of the LPA, and the judge decided to revoke the EPA in favour of the LPA.

Mrs G appealed this decision and HMCTS set a date for a Court of Protection hearing. But the hearing notice it sent to her was unclear about whether she was required to attend. She wrote to HMCTS and said she '*assumed she was not required to attend*' but HMCTS court staff simply replied saying that the hearing would proceed, but did not clarify if Mrs G was expected to be there. The Court of Protection hearing was then cancelled as no one attended, and as a result it did not consider Mrs G's appeal.

Mrs G believed that the EPA should have been registered and the LPA rejected. She complained to us that both the OPG and HMCTS had mishandled the EPA and LPA applications and caused delay. This led to financial loss, as her husband had access to his finances when she believed he had lost capacity.

What we found

We partly upheld this case. We did not uphold the complaint about the OPG, as the OPG had handled both the EPA and LPA applications correctly and had not caused any delay.

However, HMCTS had caused two significant periods of delay when it failed to take further action to decide whether the EPA should have been registered.

Also, HMCTS should have given Mrs G clearer information about the Court of Protection hearing. While we would not expect it to tell Mrs G whether she should attend the hearing, it should have told her that she was invited to attend to put her case forward.

As such, she lost the opportunity to make a fully informed decision about whether to attend the hearing.

Putting it right

HMCTS apologised for the errors we identified and paid Mrs G £150 for the distress and inconvenience this caused her.

Organisation(s) we investigated

Office of the Public Guardian (OPG)

HM Courts & Tribunals Service (HMCTS)

Summary 999/August 2015

Border Force responded poorly to allegation of inappropriate behaviour by immigration officers

A British citizen's complaint that she was treated inappropriately by Border Force officials when she entered the UK was not handled well.

What happened

Mrs B, a British citizen of African origin, was stopped by Border Force when she entered the UK after a holiday abroad. Officials took her to an interview room for questioning and checks on her passport.

Mrs B said that Border Force officers and privately contracted officers were aggressive and rude when they questioned her. She said that when a privately contracted officer body searched her, the search was inappropriate, rough, and watched by other officers. When she subsequently complained about her treatment, she said that she did not receive a satisfactory explanation. Border Force said that all procedures were carried out routinely and that officers were not aggressive or rude to Mrs B, but that she was aggressive and rude to them.

Mrs B said that she now feels nervous when travelling and continues to feel embarrassed and humiliated about the event itself.

What we found

We partly upheld Mrs B's complaint. There was little recorded evidence of what happened, so we relied on the accounts of the different people involved to build up a picture. Mrs B did not dispute that Border Force had a legal right to detain people entering the UK if there were concerns or suspicions about the validity of their passport. Her complaint was about how she was treated when detained. Our investigation found the immigration officer interviewing Mrs B could have communicated better with her, but we did not uphold this part of the complaint.

However, the privately contracted officer did not follow some parts of the guidance on body searches. The search was not conducted privately and no record was made of it. We upheld this part of Mrs B's complaint. It was very challenging to find out whether she was searched inappropriately and roughly due to lack of evidence and witness testimony.

There were also failings in how Border Force dealt with Mrs B's complaint; it did not refer her complaint about the privately contracted staff to the right place, and did not respond to her specific complaints. She suffered additional frustration and distress because of Border Force's poor response to her complaint, and that was an injustice.

Putting it right

Border Force apologised to Mrs B for the injustice it caused her, and gave her a consolatory payment of £250.

Organisation(s) we investigated

Border Force

Summary 1000/August 2015

UKVI did not compensate enough for hardship

Mr K complained about the amount of compensation UK Visas and Immigration (UKVI) offered him for its delay in processing his asylum appeal. Mr K suffered hardship while waiting for paperwork to grant him permission to stay in the UK.

What happened

Mr K came to the UK as an asylum seeker in 2002. UKVI refused his asylum application and in 2007 he was sent back to his home country. However, while he had been in the UK he had become a father, and in early 2010 Mr K returned to the UK illegally.

He applied for permission to stay in the UK so he could keep seeing his daughter, but UKVI rejected his application and told him to leave the UK. Instead Mr K appealed against the decision. In early 2012 a tribunal ruled Mr K could stay in the UK as being returned to his home country would breach his human rights because he would not be able to see his daughter.

UKVI should have implemented the tribunal decision and issued the paperwork to prove he could stay in the UK soon after it was made, but they did not do so. Without the papers to prove he could stay and work in the UK, Mr K became destitute. He was homeless and did not even have the bus fare to visit his daughter. In autumn 2012, unable to support himself any longer, Mr K got help from a solicitor under the legal aid scheme. This enabled him to get funding while he waited for the papers that would grant him permission to stay in the UK.

A month afterwards, UKVI dealt with Mr K's case and gave him 30 months' discretionary leave to remain in the UK, but this did not allow him to claim Jobseeker's Allowance (JSA) while he found work. Mr K appealed against UKVI's decision.

In early 2013 Mr K's solicitors told UKVI they intended to take legal action if it did not compensate Mr K for the losses he had suffered while he had waited for it to conclude his case. UKVI did not respond to that letter. In summer 2013 Mr K's solicitors asked us to look into Mr K's case and we asked UKVI to resolve the complaint. Two months later UKVI agreed to pay Mr K the JSA he would have received if it had dealt with his case properly. Mr K's solicitors refused this offer. They asked UKVI to reconsider the amount and to pay Mr K lost earnings instead of JSA as this would have been more money. They also asked UKVI to pay Mr K compensation for the hardship he had endured. UKVI refused to increase the amount it had offered and so Mr K asked us to look into his case.

What we found

UKVI should have taken the action that the tribunal told them to take in early 2012. And, when UKVI finally did this in winter 2013, it gave Mr K the wrong type of leave so he could not apply for JSA. When UKVI considered Mr K's claim for compensation it did not deal with it properly. UKVI offered Mr K an appropriate amount (the JSA) for his actual financial losses, but it failed to consider or offer him any compensation for the impact its mistake had had on him.

Putting it right

UKVI apologised to Mr K for the delay in implementing his tribunal appeal decision. It paid him around £2,500 for the JSA he had lost, and £1,000 for the distress and hardship its delay had caused him.

UKVI also agreed that Mr K was entitled to apply for permission to stay permanently in the UK from an earlier date to allow for its delay in making the decision.

Organisation(s) we investigated

UK Visas and Immigration (UKVI)

Summary 1001/August 2015

Border Force were right to send woman back to USA but caused her stress at the airport

Ms H complained that Border Force refused to allow her to come to the UK for six months as a visitor, and also about her treatment at the airport when it sent her back to the USA.

What happened

Ms H, who is from the USA, came to the UK in early 2013 hoping to enter the UK for six months as a visitor. She had previously been studying in the UK and had married her husband who is British. Border Force was not satisfied that Ms H was a genuine visitor, and refused her entry. Its decision was based on various factors, including her immigration history; she had no return ticket; she was applying to study; she had recently married and did not have entry clearance as a spouse; her financial situation; she held a UK bank account; and her plans to return to the flat she shared with her husband. Border Force allowed Ms H to stay with her husband for 36 hours before she had to return to the airport in the early hours of the morning to catch a return flight to the USA.

She complained about Border Force's decision to refuse to let her enter the UK as a visitor. Ms H also said that when she arrived at the airport the next morning there were long delays before she was able to get anyone from Border Force to return her passport and help her check-in for her flight. She said the experience caused her distress and worsened her anxiety and depression.

What we found

We partly upheld this complaint. Border Force had to establish, based on all the evidence before them, whether Ms H was a genuine visitor and intended to leave at the end of her stay. We thought the evidence it considered was open to different interpretations. However, based on the information Border Force had, we could not say its decision to refuse Ms H entry was completely unreasonable.

However, we did not doubt Ms H's account that when she returned to the airport no one from Border Force was on hand to return her passport and help her check-in. As a result, she had to rush to catch her flight which caused her unnecessary distress and anxiety. Border Force should have had proper processes in place to make sure that people it decides must leave the country are able to do so.

Putting it right

Border Force apologised to Ms H and her husband for the stress and anxiety caused by its failure to have effective processes in place when Ms H returned to the airport. It also showed what it had done to learn from this case and to make sure that these failings do not happen again.

Organisation(s) we investigated

Border Force

Summary 1002/August 2015

Couple prevented from arguing their case for legal aid

The Legal Aid Agency (LAA) failed to explain clearly why it had refused an application for legal aid. As a result, the applicants lost the opportunity to appeal properly against that decision.

What happened

Mr and Mrs T made an application for legal aid. This was so they could apply for a judicial review of an earlier decision about legal aid that the LAA had made. However, although Mr and Mrs T explained why they intended to ask for a judicial review, they failed to provide documents in support of their application.

The LAA refused the application, saying that it had not been possible for them to make a decision without the supporting documents. In response, Mr and Mrs T's solicitor gave the LAA the relevant paperwork. At the same time Mr and Mrs T formally challenged the LAA's refusal, partly because they felt the LAA should have already had the documents it needed to see from their earlier application for legal aid.

The LAA considered the documents the solicitor gave them but decided that, despite this paperwork, Mr and Mrs T did not qualify for legal aid. This was because, in the LAA's view, Mr and Mrs T did not have a reasonable chance of having their judicial review application accepted by a court. However, instead of telling Mr and Mrs T this, the LAA simply arranged for the matter to go to an independent adjudicator who would look at the fairness of the LAA's decision.

Mr and Mrs T said they were confused by this. They told the LAA that, as far as they were concerned, the only issue had been about whether or not they had provided the relevant supporting documents. They could not see why it would need an independent adjudicator to make a decision on this. Mr and Mrs T asked for clarification but the LAA did not provide clear responses. The couple also asked for copies of the file the LAA intended to present to the adjudicator so they could see what it was that the adjudicator would be looking at. However, the LAA refused this request.

The adjudicator considered the case and agreed with the LAA about the merits of Mr and Mrs T's application for legal aid and upheld the LAA's refusal.

Mr and Mrs T complained about what had happened. They said that, as far as they were concerned, the adjudicator had been looking only at whether the LAA had been right to refuse the application due to lack of paperwork. They said that if they had known the adjudicator was looking at the merits of the application itself, they would have argued their case in a different way.

What we found

We upheld Mr and Mrs T's complaint. If the LAA had been clearer with the couple about what the adjudicator was looking at, Mr and Mrs T would have acted differently. We could not say they would have been successful in their application for legal aid but they had lost their opportunity to argue their case in the way they would have wished.

Putting it right

The LAA gave Mr and Mrs T an opportunity to argue their case for legal aid. It also apologised for its errors and paid Mr and Mrs T £500 in recognition of the frustration and inconvenience they had suffered.

Organisation(s) we investigated

Legal Aid Agency (LAA)

Summary 1003/August 2015

No reason for HMCTS to pay compensation

Court staff's actions delayed a court case for over a year. HM Courts & Tribunals Service (HMCTS) acknowledged its failings, but did not agree with Mr J's claim that the delay left him out of pocket by nearly £25,000.

What happened

Mr J lodged an appeal against an Information Tribunal decision with the Administrative Court. However there had been a change in the law that meant that the Administrative Court could no longer hear this type of case, and instead it had to be heard by an Upper Tribunal.

The Administrative Court staff did not notice this until Mr J pointed it out. At that stage the case was passed to the Deputy Master (part of the judiciary) for directions on what should happen next. The case remained with the Deputy Master for over a year before it was passed to the Upper Tribunal to be heard.

Mr J wrote to the court several times during this time to speed things up, but it did not move matters forward.

After Mr J's legal action was finished, he complained to HMCTS. He said that the delays in his appeal against the Information Tribunal delayed other legal action he had running at the same time. He said that he could not sell his house and settle all his legal bills until all his legal action finished, and the Administrative Court's delay meant he had to pay tens of thousands of pounds of additional interest on his debts.

When Mr J complained to HMCTS, it apologised and offered him £1,000 compensation for the frustration he experienced. But it said there was no link between its delay and the additional interest Mr J incurred.

What we found

We did not uphold this case. Court staff lost an early opportunity to identify that the case was with the wrong court. Although the case was held up because of the Deputy Master's actions, HMCTS staff should have done more to hurry matters along.

However, there were no grounds for HMCTS to pay Mr J the level of compensation he was looking for and we were satisfied it had already done enough to put the matter right.

Organisation(s) we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 1004/August 2015

RPA confused payment to farmer but did not cause him financial loss

Mr N complained about how the Rural Payments Agency (RPA) had handled his payment for land management since 2007, the way it communicated with him, and how it handled his complaint.

What happened

In late 2005 Mr N bought 200 acres of land to add to the 40 acres he already owned. He decided to lease the 200 acres to a company he had, and transfer the Single Payment Scheme (SPS), a payment to farmers for land management, to the company until the end of 2007. RPA transferred the land and entitlements to the company (registered to Mr N's accountant's address) in time for the company to claim SPS for 2006.

In spring 2007 Mr N instructed a land agent to handle both his personal and company SPS claims and pay them into the same bank account. Mr N continued to receive statements and notices about payments.

In autumn 2007 Mr N's accountant wrote to RPA asking it to extend the transfer of the 200 acres and its SPS entitlements to the company indefinitely, rather than just to the end of 2007. RPA never received that letter and so, under SPS rules, the 200 acres and its SPS entitlements reverted to Mr N's personal account at the end of 2007.

In winter 2007 Mr N discovered that RPA had overpaid his personal account and underpaid the company account. Mr N phoned RPA about this but did not receive a clear response, and its letters were unclear.

Mr N said he was still unaware of the mistake when he and the company made claims for SPS in 2008. As a result Mr N only claimed for the small portion of the personal entitlements he could, and more for the company's entitlements. But RPA rejected the company's claim because it had transferred all the entitlements to Mr N's personal account. When Mr N challenged RPA about this in 2009, RPA advised Mr N to delete the 200 acres from the company's claim and add it to his own claim. He did this and RPA fully paid for both personal and company SPS claims in 2009.

But he was still missing his entitlements for the 200 acres in 2008. He appealed against this but his appeal was unsuccessful. In early 2009 Mr N discovered RPA had sent letters for him to an incorrect address and he believed this had contributed to RPA's poor handling of his 2008 claim.

What we found

We partly upheld this complaint. RPA had made overpayments to Mr N's personal account, which it subsequently correctly claimed back from Mr N against future payments. It failed to explain this which caused Mr N frustration and inconvenience. RPA also continued to send mail to an incorrect address despite telling Mr N it had resolved that problem. However, it was not RPA's fault that it did not receive the accountant's letter in 2007 extending the lease and entitlements to the company indefinitely. Mr N should have queried with RPA why it had not confirmed the indefinite transfer to his company. We did not find any evidence of other financial loss to the company or to Mr N as a result of RPA's error and poor communication.

Putting it right

RPA apologised to Mr N for the failures we found and for the impact on him. It paid Mr N £250 for the frustration and inconvenience it caused him. RPA also agreed to look at the matter again should Mr N provide evidence of financial loss resulting from its overpayments.

Organisation(s) we investigated

Rural Payments Agency (RPA)

Summary 1005/September 2015

Health and Safety Executive's inspections were not at fault

A local community action group complained that the Health and Safety Executive (HSE) did not properly investigate its complaint about health and safety breaches at a nearby building site.

What happened

A local community action group was unhappy about the condition of a nearby building site where a developer was building new homes. It was particularly worried about inadequate site security and the risk that children would get onto the site too easily. A resident reported the matter to HSE. It took some time for HSE to get involved as the developer insisted there was not an issue. HSE decided to inspect the site after the action group sent it video footage.

HSE carried out three inspections of the site, and met separately with the developer. During these visits HSE found several problems, including poor site security caused by inadequate fencing. HSE asked the developer to take action, and eventually issued legal notices to force it to make improvements.

The action group was dissatisfied with HSE's actions. It felt HSE should have carried out more detailed inspections, and taken stronger enforcement action. It believed HSE was colluding with the developer to make sure that no serious action was taken to sort out the problems. The group said local children were no longer able to play in safety and were placed in great danger by the continued health and safety breaches of the developer, supported by HSE's lack of action. It wanted a full and open inquiry into whether the developer was responsible for breaches of health and safety regulations.

What we found

We partly upheld this complaint. HSE carried out its inspections in line with both its published procedures, and with the Government's expectations of how a regulator carries out its business. HSE treated in good faith all the information that both the action group, and the developer, had given it. When the action group's evidence showed that there was a problem, HSE inspected, and took enforcement action. Although the action group had wanted HSE to take stronger action, its actions were acceptable.

However, HSE had not explained its role and responsibilities clearly to the action group, and so the group felt increasingly dissatisfied with the situation. Its frustration and unhappiness led it to suspect collusion between HSE and the housing developer.

Putting it right

HSE offered to meet the action group to discuss its role and to explain how it regulates the construction industry, and to express its regret that the action group felt dissatisfied with what had happened. We told HSE that if it could not arrange a meeting with the group, it should provide it with this information in writing instead.

Organisation(s) we investigated

Health and Safety Executive (HSE)

Summary 1006/September 2015

Allegations of bias in Home Office funding decision

Mr L complained that the Home Office unfairly denied his company funding for a project to help people from outside the European Union to integrate in the UK.

What happened

Mr L sells online resources for teaching English and wanted to help third country nationals (people from outside the European Union) who were preparing for life in the UK. In 2013 he submitted an application to the Home Office for funding for his project. He applied to the European Integration Fund, a fund to support initiatives which help third country nationals integrate into European society. His application included the need to develop software for the project. The Home Office turned down his application. It failed on, among other things, a lack of in-depth analysis of its target group.

Mr L took on board the Home Office's feedback and made a second application in early 2014, again requesting funding to develop software for the project. In his application Mr L noted that he hoped to *'learn from the experience and potentially create an effective template for deployments to other communities*'. The Home Office again refused Mr L's application, this time on the basis that there was a '*conflict of interest*' – that Mr L and his company could potentially use the software they hoped to develop through the funding for financial gain after the project had finished.

Mr L complained to the Home Office, saying he did not intend to profit from the software he was developing. The Home Office told him that it was against Fund rules for applicants to gain financially from projects. It explained to Mr L that his application had been assessed by a two-person assessment panel. The Home Office reassured Mr L that the people on the assessment panel for his second application were different from those on the first assessment panel, to avoid any unconscious bias. However, that had meant that any issues missed by the first assessment panel could be picked up by the panel assessing the second application. The Home Office commented that it would not be fair or transparent to overrule the assessment process.

Mr L complained to us that the Home Office had introduced a new criterion which it had not included in its literature and guidance, and which had only been raised in his second application. Mr L was concerned that the Home Office was biased against profit making organisations applying for such funding. He said that he had wasted a great deal of time applying for funding.

What we found

We did not uphold Mr L's complaint. European legislation and the Home Office's own guidance were clear on the 'non-profit making' requirement. And the guidance reflecting this point was available to Mr L at the time of his applications. It was reasonable for the Home Office to take this issue into account. It would have been better if the Home Office had included the not-for-profit issue in its first feedback to Mr L. But having said that, we did not think this failure was a serious fault.

We noted that Mr L clarified that he did not intend to make a profit and that he believed the Home Office should have discussed with him his comment about deployment to other communities. However, the Home Office had a two-stage assessment process, as well as a QA panel for what it called '*marginal applications*'. Mr L's second application was considered by the QA panel, which agreed with the original refusal decision. Overall, the Home Office handled Mr L's application reasonably, and we agreed that if it had approached Mr L to discuss his application, that would not have been fair to other applicants.

Organisation(s) we investigated

Home Office

Summary 1007/September 2015

UKVI did not give wrong advice but paid compensation for subsequent poor communication

Mr E, a Polish national, did not get wrong advice from UK Visas and Immigration (UKVI) about applying for residency. But UKVI's poor communication about his application did cause him stress and frustration.

What happened

Mr E is from Poland and has lived and worked in the UK since 1996. In 2013, Mr E wanted permanent residency in the UK and he phoned UKVI's helpline to find out what documents he needed for a successful application. He alleged that UKVI told him the documents he had described to it were sufficient. Mr E submitted his application on that basis, but UKVI refused it on three grounds, one of which was wrongly applied.

Mr E wrote to his MP setting out what had happened, and the MP's office asked UKVI to review its decision. UKVI did so and sent Mr E a letter by recorded delivery confirming its refusal on two valid grounds. Royal Mail confirmed this letter was never delivered. Mr E asked his MP what was happening and the MP's office asked UKVI for an explanation. UKVI replied that it had informed Mr E (the recorded delivery letter). The MP's office asked UKVI to resend its letter to Mr E. It eventually did so, but the letter did not include information about his right to appeal. It was not until several months later that Mr E finally received a letter from UKVI refusing his application on the correct grounds and with information about his appeal rights, and an apology for its errors.

What we found

We partly upheld Mr E's complaint. UKVI had given Mr E correct advice in the phone call. UKVI had recorded the call and gave us a transcript which showed that Mr E had not told UKVI what documents he had. We did find fault with UKVI's error over the grounds for refusal, and its failures to include appeal rights, promptly reply to the MP's office and make sure Mr E received its decision letter. All this caused Mr E stress and frustration.

Putting it right

UKVI apologised to Mr E and paid him £100 compensation for the stress and frustration he endured.

Organisation(s) we investigated

UK Visas and Immigration (UKVI)

Summary 1008/September 2015

Legal Aid Agency made mistakes in its consideration of application for legal aid

Mr S went to court without the benefit of legal aid. He felt that the Legal Aid Agency (LAA) had deliberately delayed considering his legal aid application in order to deny him the right to justice.

What happened

Mr S applied for legal aid to be represented in a court case. There were delays by the LAA and it also initially wrongly refused the application as it believed it was incomplete. This meant the LAA did not fully consider Mr S's application until after his case was heard in court. It then refused Mr S's application as it did not consider it had merit. Mr S's court case was unsuccessful and he was ordered to pay costs of around £2,000.

Mr S complained to the LAA. It accepted that its initial decision had been wrong, and that there was unnecessary delay in making that decision. The LAA also accepted that it delayed replying to Mr S's complaints and to his request for compensation. Mr S came to us because he was wanted compensation from the LAA.

What we found

The LAA made mistakes in Mr S's case, and there were excessive delays by the LAA in dealing with both his legal aid application and his complaint. However, we could not say for certain that Mr S would have been granted legal aid if the LAA had not made mistakes. And we could not say whether the outcome of Mr S's court case would have been any different if he had been granted legal aid, or that he would not have been ordered to pay costs. We did agree that by not having the LAA's decision in advance of the hearing, Mr S was unable to make an informed decision about the risks of pursuing his case without the benefit of legal aid.

The LAA's mistakes and delays caused Mr S distress and frustration during what was an already difficult time for him.

Putting it right

The LAA paid Mr S £350 for the loss of opportunity to make an informed decision about his court case, and £150 for the frustration and inconvenience caused by its delays and poor complaint handling.

Organisation(s) we investigated

Legal Aid Agency (LAA)

Summary 1009/September 2015

UKVI's system for accessing phone call recordings failed

Mr F claimed UK Visas and Immigration (UKVI) officers gave him wrong information and misled him during phone calls.

What happened

Mr F's wife and stepdaughter had been granted indefinite leave to remain in the UK and wished to apply for naturalisation as British citizens. Mr F phoned UKVI's helpline to confirm the criteria and documents needed. He said that the helpline officer told him that his wife and stepdaughter could submit the same documents as they did for indefinite leave to remain. If true, that was incorrect information. A week or so later, the helpline officer emailed Mr F with correct information about the criteria and documents required. Mrs F and her daughter provided documents based on what Mr F said he was told in his first phone call, and submitted applications that did not meet the required criteria.

Mr F misunderstood UKVI's letter asking for the correct documents, wrongly believing it had refused his wife's application. He then tried to appeal a decision that had not been made. UKVI did not tell Mr F he could not appeal a decision it had yet to make. Subsequently during other phone conversations some months later with UKVI officers, Mr F said that it had told him that it had granted his stepdaughter naturalisation but not his wife. Mr F said that in another call a UKVI officer told him his wife need not meet some criteria because it had '*messed up the case*'. The information Mr F alleged he was given during these calls would have been incorrect.

UKVI refused Mr F's wife and stepdaughter's applications because they did not meet the criteria or submit the correct documents. Mr F asked UKVI to reconsider its decision and it did so, but did not charge him the fee for this. Mr F complained to UKVI that he had been misadvised but was unhappy with UKVI's response to his complaint.

UKVI told us that it had recorded the conversations between Mr F and the helpline but, due to a problem with the back-up system, it could not access the recordings and could not make a transcript. UKVI did not explain how frequently the system was checked and how and when the fault was discovered.

What we found

We partly upheld this complaint.

We were unable to determine whether UKVI misled Mr F over the phone because we could not listen to the calls. UKVI could not say how and when the fault was discovered, or how frequently it checked the system. We concluded that its inability to access recordings of the calls was a failing.

UKVI had sent the correct information about naturalisation before Mr F's wife and stepdaughter submitted their applications, and so it had not misadvised Mr F. However, UKVI did not tell Mr F he had appealed a decision it had not yet made, and so subsequent communications were at cross purposes. UKVI did not address the issues in Mr F's complaint.

UKVI's failure to tell Mr F his appeal was premature and to address his complaint was an injustice.

Putting it right

UKVI apologised to Mr F and paid him £150 compensation.

Organisation(s) we investigated

UK Visas and Immigration (UKVI)

Summary 1010/September 2015

Cafcass apologised for factual errors in its report

The Children and Family Court Advisory and Support Service (Cafcass) misinterpreted safeguarding information from the police and local authority, leading it to submit inaccurate information to the court.

What happened

Mr J was involved in family court proceedings relating to contact with his two young sons. Mr J was generally unhappy with the way Cafcass handled his case and the contents of its report to the court about future contact arrangements. He felt the Cafcass officer involved was biased against him and had overlooked his evidence. He also complained that the Cafcass report was inaccurate.

What we found

We partly upheld Mr J's complaint, as many of the points he raised related to the officer's professional judgment and would be best addressed in court.

However, Cafcass' report did include some factual inaccuracies. For example, it had misinterpreted information from the local authority and attributed information to Mr J when it actually related to a different person who happened to have a similar surname to Mr J.

Cafcass also overlooked a reference on updated police record checks which confirmed that Mr J had been found not guilty of breaching a non-molestation order. As a result, its report wrongly stated that Mr J had breached the order, when he had been cleared of this offence earlier that month.

Cafcass could have handled some of Mr J's correspondence better as some letters went unanswered and some phone calls were not returned.

Putting it right

Cafcass apologised to Mr J for the factual inaccuracies in the report, and for its communication. It also wrote to the court to correct the errors in the report.

Organisation(s) we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 1011/September 2015

Criminal Injuries Compensation Authority had already offered reasonable compensation

The Criminal Injuries Compensation Authority (CICA) caused a one-month delay to a case by writing to a medical professional at an incorrect address.

What happened

Mr G applied to CICA for compensation for post-traumatic stress after witnessing a crime. CICA took over 15 months to decide his application and ultimately declined to award him compensation.

Mr G felt that CICA had delayed matters by only contacting his GP to begin with, rather than requesting records from all the relevant medical professionals. He also complained that it had written to his psychologist at the wrong address, and had refused to send him for an independent psychological assessment.

What we found

CICA acted in line with its policy when it only approached Mr G's GP. CICA can often obtain all relevant information this way without making unnecessary additional enquiries. We were satisfied that CICA had been reasonable in not sending Mr G for an independent assessment.

Although CICA took around 15 months to decide Mr G's application, it explained that post-traumatic stress cases are complex and can take longer to decide. On top of that, a significant part of the delay was caused by a third party outside of CICA's control. However, we did find that CICA had caused a one-month delay by writing to Mr G's psychologist at an incomplete address. As a result, its request was returned and had to be resent.

We did not uphold Mr G's complaint because CICA had already addressed its mistakes.

It had acknowledged the delay and paid Mr G £100 compensation. Unfortunately CICA did not offer this payment until Mr G complained to it about a separate matter. This meant Mr G was confused about what part of his complaint the payment was for. While CICA could have offered the payment earlier in the complaint process and explained the reason for it more clearly to Mr G, it had ultimately offered a reasonable remedy for the delay.

Organisation(s) we investigated

Criminal Injuries Compensation Authority (CICA)

Summary 1012/September 2015

Failure to keep information confidential led to significant distress

The Children and Family Court Advisory and Support Service (Cafcass) mishandled personal information it had previously agreed to keep confidential.

What happened

Mrs M was involved in a court case relating to contact arrangements for her children. Because Mrs M had made allegations of domestic abuse against her former partner, she asked Cafcass to keep her current whereabouts confidential. Cafcass agreed to do this. However, a report it later wrote to the court included information which was shared with Mrs M's former partner and which would have made it easy for him to trace her current address.

When Mrs M complained to Cafcass about this, it apologised for the error. However, Mrs M did not feel Cafcass' apology went far enough given the distress she had suffered as a result of its error. Mrs M also complained to Cafcass about other aspects of the report. However, Cafcass said that if she did not agree with the report, she could challenge the contents in court.

What we found

We partly upheld Mrs M's complaint.

We were pleased that Cafcass recognised its error, but agreed with Mrs M that it had not done enough to put matters right for her. Although we found no evidence that Mrs M had come to harm as a result of the information being released, she continued to live with the prospect that this may happen in future. This was an injustice to her.

Cafcass later explained to us that, in hindsight, it should not have promised to keep Mrs M's details confidential. This was because it was for the court to decide what could or could not be kept confidential. While we understood Cafcass' general point, it was not relevant in Mrs M's case, as there was no evidence the court had asked for the information to be included in Cafcass' report. As such, Cafcass should not have included this information in its report.

We did not uphold Mrs M's complaint about the other aspects of the Cafcass report. This was because we agreed with Cafcass that these were issues Mrs M should rightly challenge in court.

Putting it right

Cafcass apologised again to Mrs M and paid her £2,000 because of the distress she had suffered.

Organisation(s) we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 1013/September 2015

Legal Aid Agency gave mixed messages about the process for appealing its funding decisions

The Legal Aid Agency (LAA) caused distress and frustration to someone who was appealing its decision to refuse legal aid.

What happened

Ms H was awarded legal aid in connection with a matter in the family courts. Her legal aid certificate did not cover the costs of a final hearing, and her solicitor applied to the LAA in autumn 2014 to amend the certificate so she could be represented at a final hearing. The LAA refused Ms H's application because it considered that her case had a poor prospect of success. Ms H appealed, but the LAA still refused her application, so the matter was transferred to the Independent Funding Adjudicator (the Adjudicator) in winter 2014.

On the same day, the LAA sent two letters to Ms H. The first told Ms H that her appeal was being sent to the Adjudicator, and invited her to submit any further evidence as a matter of urgency. The other letter explained the Adjudicator's decision to refuse her appeal. The LAA explained the decision was final.

Ms H complained to the LAA and said she wanted to meet with the Adjudicator. Ms H said the LAA and the Adjudicator had overlooked key evidence in connection with her appeal. The LAA did not uphold Ms H's complaint, so she asked her MP to refer the matter to us.

What we found

We upheld some parts of Ms H's complaint. The LAA sent over 300 pages of evidence to the Adjudicator in connection with Ms H's appeal. We were satisfied from looking at the LAA's records that the Adjudicator had seen all of the information needed to make a robust decision. The Adjudicator would only meet with an individual in exceptional cases, and there was no reason to believe that it would have been necessary to meet with Ms H to consider her appeal.

Although there was no fault in the way the LAA decided Ms H's application, it was wrong for the LAA to ask her to send further evidence on the same day that it sent the Adjudicator's final decision.

Putting it right

The LAA apologised to Ms H for the distress and frustration it had caused by sending her two letters on the same day which gave mixed messages about its process.

Organisation(s) we investigated

Legal Aid Agency (LAA)

Summary 1014/September 2015

Delay in dealing with complaint about Jobcentre Plus medical examination report

Mr T complained about the accuracy of a report that was written up on a medical assessment he attended to determine his eligibility for benefits.

What happened

Mr T attended a work capability assessment - a medical assessment to determine his entitlement to Employment Support Allowance. The assessment was with Atos Healthcare - a company that used to do these assessments for Jobcentre Plus. The healthcare professional who conducted the assessment completed a medical report. Jobcentre Plus decided that Mr T did not qualify for his incapacity benefit claim to be converted to Employment Support Allowance. He appealed this decision but the original decision wasn't changed.

Mr T then complained to Jobcentre Plus and Atos Healthcare that the healthcare professional had falsified the medical report in several respects and left things out. He also said that he had not '*declined*' to do a specific movement, as stated in the report.

Mr T involved his MP, and eventually escalated his complaint to the Independent Case Examiner (ICE), an organisation that investigates complaints about Jobcentre Plus. It investigated but did not uphold his complaint. Mr T complained to us that ICE's report had not addressed all the specific questions he had asked.

What we found

We partly upheld Mr T's complaint. For the most part, ICE carried out a thorough investigation and reached reasonable conclusions. It did not, however, pick up on the fact that Atos Healthcare had taken around six months to address Mr T's complaint about the phrase '*client declined*' in the medical report. ICE's mistake caused Mr T confusion and frustration as it meant that he had to make further complaints about the same issue.

Putting it right

Jobcentre Plus apologised to Mr T for the length of time it took to address his complaint about the use of the phrase '*client declined*'. ICE apologised to Mr T for not recognising that Jobcentre Plus was at fault on this.

Organisation(s) we investigated

Jobcentre Plus

Independent Case Examiner (ICE)

Complaints about the NHS in England

Summary 1015/July 2015

GP practice missed opportunities to refer patient for cancer investigations

Mrs C complained about the standard of care her late husband, Mr C, received from the GP Practice. She said it missed several opportunities to detect her husband's kidney cancer at an early and treatable stage. She said witnessing her husband's illness and eventual death caused her considerable distress and worry.

What happened

Mr C saw his GP in summer 2012, reporting weight loss and pain when urinating. The GP conducted some blood tests, examined his chest and discovered a heart murmur. The GP then referred Mr C to a cardiologist. There was nothing at that stage to indicate suspected kidney cancer. Over the following 11 months Mr C attended multiple appointments at the GP Practice and his local hospital, reporting similar symptoms.

In spring 2013 the GP examined Mr C's abdomen and urgently referred him for further investigations for suspected gastrointestinal (stomach) cancer. The investigations were carried out at the trust and no cancer was found in the bowel or stomach. Mr C had further appointments at the GP Practice throughout summer 2013 but the GP did not take further action to investigate his ongoing weight loss and abnormal blood test results. In autumn 2013, the GP examined Mr C's abdomen and identified a large hard swelling. The GP requested a CT scan but did not indicate that it was urgent. The CT scan confirmed a diagnosis of terminal kidney cancer. Mr C passed away in spring 2014.

Mrs C said that witnessing her husband's illness and eventual death had caused her considerable distress and worry. She said his death would have been avoided had appropriate investigations been carried out sooner. Mrs C complained to the Practice but was dissatisfied with its response. She wanted an apology, service improvements and a payment.

What we found

It was not possible to determine when Mr C's kidney cancer was present and detectable. However, he should have been referred under the two-week pathway for gastrointestinal cancer when he first saw his GP in summer 2012. By the time his kidney cancer was diagnosed in 2013, there had been several missed opportunities to refer him for the appropriate investigations. This resulted in an injustice to Mrs C, which can never be put right. This missed opportunity meant that she will never know for sure whether earlier diagnosis and treatment of her husband's cancer was possible and what difference this would have made.

Putting it right

The Practice acknowledged and apologised for the failings we found. It paid Mrs C £1,500 for the impact of these failings. It also produced an action plan to show what it had learned from the complaint.

Organisation(s) we investigated

A GP practice

Location

West Yorkshire

Region

Yorkshire and the Humber

Summary 1016/July 2015

Inadequate assessment led to woman giving birth unassisted at home

Ms H complained about the care and treatment she received from the Trust during labour. She said the Trust did an inadequate assessment over the phone, which led to her giving birth unassisted at home. She said she suffered stress and had been traumatised as a result.

What happened

Ms H was under consultant-led care for her pregnancy because she was considered high risk. The plan was for her to give birth in hospital, on a consultant unit.

Ms H called the Trust's labour advice line, reporting contractions and discharge. The Trust told her it was likely this was Braxton Hicks contractions (intermittent weak contractions during pregnancy) and that she should not worry and should stay at home.

The next morning she called for advice again and the Trust invited her in for an examination. The Trust found that Ms H's discharge was the 'show' (a sign that labour had started) but insisted she was not in active labour and told her to wait at home. Ms H's husband called the advice line later that day as the contractions had become stronger and more frequent. A midwife assessed Ms H over the phone and decided that, based on her calculation of Ms H's contraction rate, Ms H was not in active labour and did not need to come to hospital. She told Ms H to wait at home, have a bath to ease the pain and call if she had any concerns or needed further advice.

Two hours later Ms H felt a change in her contractions and her husband called the advice line again. But while he was on the phone, Ms H gave birth to their baby. An ambulance was sent and Ms H and her baby were taken to hospital and checked, and both were fine. Ms H said that she and her husband were left traumatised by the experience of giving birth unassisted at home. She said the experience affected her husband's enjoyment of the birth.

What we found

Overall, we found the Trust did not handle phone assessments in line with the relevant guidance and established good practice. The fact that Ms H was under consultant care should have reinforced the need for her to come to hospital for an assessment on the consultant unit, to make sure she had the support that she needed.

The Trust's note taking and record keeping was inadequate because midwives did not record large amounts of conversations during the triage calls. There were no records of midwives asking about any medical complications or concerns in pregnancy and they did not keep Ms H's medical records up to date. This meant that when Ms H called the advice line she had to repeat the history of her previous calls so that the midwives could find any previous notes.

Putting it right

The Trust acknowledged the failings we found and apologised to Ms H. It also produced an action plan explaining how it had improved the service on the labour advice line, and its assessments and note taking to make sure there was continuity of care, to avoid a recurrence of the failings we identified.

Organisation(s) we investigated

Colchester Hospital University NHS Foundation Trust

Location

Essex

Region

East

Summary 1017/July 2015

Trust made 'Do Not Attempt Resuscitation' decision without telling patient's family

Mr and Mrs R complained about the care Mrs R's late mother, Mrs G, received. They said poor treatment and lack of communication, denied them the opportunity to be with Mrs G when she died.

What happened

Mrs G was admitted to hospital following a stroke. She had a chest infection and respiratory failure, which meant she required a mask to help her breathe. Mrs G was agitated at times and attempted to remove the mask. Mr and Mrs R gave their permission for the Trust to put mittens or gloves on Mrs G's hands to prevent her removing the mask. But the mittens were not available and so the Trust restrained Mrs G with bandages round her hands. The following morning Mrs G became distressed and the mask was removed but the staff did not remove the bandages. Mr and Mrs R received a phone call the same day advising them to attend hospital urgently. When they arrived Mrs G had already died.

Mr and Mrs R complained that when Mrs G was restrained with bandages, she was not checked frequently. They said the Trust made a 'Do Not Attempt Resuscitation' decision without informing them. They also said the timing of Mrs G's death was unclear. Mr and Mrs R said that the lack of communication with them meant they were denied the opportunity to be with Mrs G when she died. They explained that what happened had a great emotional and physical impact on Mrs R.

What we found

It was reasonable for staff to use bandaging as a restraint in the absence of an alternative, but there was a failure to document why they were being used or to review the need for these over time. There was also a failure to remove the bandages following Mrs G's death, which meant that Mrs R had been left with a lasting memory of Mrs G's hands being restrained by bandages.

The nursing staff failed to refer Mrs G to a doctor when her health deteriorated. This meant that the Trust missed the opportunity to treat Mrs G's symptoms or consider palliative care at the very end of her life. The Trust failed to tell Mr and Mrs R about Mrs G's obvious deterioration and did not discuss the 'Do Not Attempt Resuscitation' decision with them.

Putting it right

The Trust acknowledged and apologised to Mr and Mrs R for the failings we found. It paid them £1,000 in recognition of the overall impact of these failings. The Trust also produced an action plan to address the failings we had identified.

Organisation(s) we investigated

Frimley Health NHS Foundation Trust

Location

Surrey

Region

South East

Summary 1018/July 2015

Claim for retrospective continuing healthcare funding was unreasonably refused

Mrs Y's daughter, Ms P, complained that the Clinical Commissioning Group (CCG) never informed her that a continuing healthcare assessment was undertaken for Mrs Y, and so was not in a position to challenge or appeal the decision. She also complained about the CCG's handling of her complaint.

What happened

Mrs Y suffered from Alzheimer's and had lived in a care home since autumn 2008. In Late 2008, a social worker carried out a continuing healthcare needs checklist assessment to determine whether Mrs Y should be referred for full consideration of continuing healthcare, (a package of care that is funded and arranged by the NHS). The record of the checklist noted that the social worker explained to Mrs Y, in the presence of her carer, what the checklist assessment was for. The social worker also noted that Mrs Y was able to make her own decisions when she underwent the checklist assessment. The checklist assessment showed that Mrs Y was not eligible for full continuing healthcare and Mrs Y agreed with the outcome.

The social worker and care home also carried out a single assessment and community care service review and care plan for Mrs Y in spring 2010. Her family was also present at this review and were given a copy of the review document but did not raise any concerns. The review considered continuing healthcare but decided that a checklist assessment was not required because Mrs Y's needs had not changed significantly. Mrs Y died in autumn 2010.

Ms P was unhappy that the CCG did not tell her a continuing healthcare assessment was undertaken for her mother, or that she had the right to appeal the assessment, and so was not in a position to challenge or appeal the decision. She also complained about delays in the CCG responding to her retrospective request, lost records and the CCG's handling of her complaint. She wanted the CCG to assess her mother for retrospective continuing healthcare funding and to refund the amount paid to the care home between autumn 2008 and autumn 2010.

What we found

Mrs Y was considered able to make her own decisions at the time of the continuing healthcare needs checklist assessment in autumn 2008, and the outcome of the assessment was explained to her. There was therefore no requirement to inform the family and there was no official 'right' of appeal to the findings of a checklist assessment. The assessment was in accordance with the National Framework in place at the time.

The single assessment and community care service review appropriately considered whether Mrs Y might have been eligible for funding and found a checklist was not required. Mrs Y's daughter was given a copy of the review document and had the opportunity to raise concerns about the provision of care but did not.

However, we found there was an unassessed period of care from spring to autumn 2010.

Putting it right

The CCG agreed to undertake an assessment for the period spring to autumn 2010 to determine whether Mrs Y met the eligibility criteria for fully funded NHS continuing healthcare. Following that assessment, the CCG paid Mrs Y's family £1,600.

Organisation(s) we investigated

South Tees Clinical Commissioning Group (CCG)

Location

Middlesbrough

Region

North East

Summary 1019/July 2015

Failings in nursing care of older patient

Mr N complained about the nursing care and treatment his late mother, Mrs N, received in hospital and the events surrounding her death.

What happened

In early spring 2013 Mrs N was admitted to the Trust having become bed bound and suffering from a necrotic toe (death of most or all of the cells in an organ). One late morning, nursing staff were aware that Mrs N was drowsy, and they used the 'Patient at Risk' scoring system (used to recognise 'at risk' patients and to trigger early referral to doctors) to record their observations and had twice called a doctor but did not indicate it was urgent. As a result, nursing staff did not act on Mrs N's deteriorating symptoms and did not document their actions. In the afternoon Mrs N's visitor twice expressed concern about her condition, and nursing staff said they were still waiting for a doctor to arrive. However, nursing staff did not take any further observations until later that evening when the doctor came to see Mrs N.

Two days later, Mrs N's condition deteriorated and she died of hospital acquired pneumonia.

Mr N believed that his mother received poor care, which led to her death. He also expressed concerns about the Trust's complaint handling and a breach of confidentiality relating to the temporary loss of his mother's records.

What we found

Nursing staff failed to carry out adequate observations despite concerns raised by Mrs N's visitor. When nurses assessed Mrs N, they did not properly assess her condition, which in turn meant that a doctor was not called earlier that afternoon. This was followed by a failure to properly record events. In consequence there was a missed opportunity to treat Mrs N with antibiotic medication at an earlier stage.

We were unable to say whether this would have changed the outcome for Mrs N, but it is established clinical fact that early treatment is vital in these cases. Therefore, we upheld this part of the complaint about the Trust. We did not uphold concerns about complaint handling and patient confidentiality.

Putting it right

The Trust apologised to Mrs N's family and paid them £1,000 in recognition of the distress they experienced.

The Trust also put together an action plan to show it had learned from its mistakes so that they would not happen again.

Organisation(s) we investigated

The Hillingdon Hospitals NHS Foundation Trust

Location

Greater London

Region

London

Summary 1020/July2015

Failure to diagnose and operate on fractured femur caused pain

Mr T complained that the Trust did not give his late father, Mr M, adequate care and treatment when he went to A&E with pain in his left thigh. He said a catalogue of inefficiency and incompetence led to his death. Mr T also said that the actions of the Trust following his father's death caused the family further distress.

What happened

Mr M attended A&E with pain in his left femur (the bone of the thigh). The Trust conducted X-rays but didn't find any fracture. It then discharged Mr M to the short stay medical unit where he was encouraged to weight bear (try to let his leg support him). After a few days Mr M's leg broke while he was walking. He had an operation to fix his leg and was admitted to the high dependency unit. However, four days later Mr M died. The nursing staff did not call his family, so they were not there when he died.

The Trust then incorrectly listed cause of death as pneumonia but his family disputed this. Following a meeting with the medical director, the Trust changed cause of death to '*pathological* [extreme] *fracture left femur (operated)*'.

The Trust also incorrectly filled in the cremation form that it gave the funeral directors. It had stated that dangerous nails were left in Mr M's body. When the funeral directors asked the Trust to remove the nails it refused. The funeral directors then had to arrange with another hospital for the nails to be removed and the family was charged a fee for this. In fact the nails did not have to be removed.

What we found

We partly upheld this complaint. We found a number of failings by the Trust. It failed to conduct an appropriate scan in A&E and to conduct the appropriate discharge process to the short stay medical unit, which led to Mr M being incorrectly advised to keep mobile. There was also a delay in performing the operation on Mr M's leg and the Trust gave incorrect information to the funeral directors.

We could not conclude that the failings led to Mr M's death. Surgery on his leg would have been required in any event and we could not predict whether he would have recovered from this surgery. However, we concluded that Mr M suffered unnecessary pain and discomfort, and that it was likely his chances of survival would have been increased by earlier intervention and a more appropriate assessment. The events that occurred after Mr M died caused his family unnecessary stress and upset.

Putting it right

The Trust apologised and paid Mr M's family £1,500. It also produced an action plan outlining areas of improvement and lessons learned as a result of our investigation.

Organisation(s) we investigated

Luton and Dunstable Hospital NHS Foundation Trust

Location

Luton

Region

East

Summary 1021/July 2015

Hospital wrongly told patient she had miscarried

Ms E said she suffered a miscarriage because the Trust told her to stop a course of progesterone (hormone treatment) due to results of a blood test, which were later found to be incorrect. She said this caused her great distress, and had an adverse effect on her mental health.

What happened

When Ms E was in the early stages of pregnancy, the Trust prescribed progesterone to support the pregnancy due to her history of miscarriages. She had regular blood tests to monitor the pregnancy. However, one of the blood tests presented low levels of progesterone, which is used to indicate the progression of a pregnancy. The Trust told Ms E that she had miscarried and that she should stop taking the progesterone.

The hospital later discovered that the blood test results were incorrect and that it should have reviewed and re-tested them. When the hospital re-tested the results it found the expected levels of progesterone. Ms E was confirmed to have miscarried a few days later.

Ms E complained that the error had resulted in the death of her unborn child and had caused her a great deal of distress.

What we found

It was evident that the Trust had failed to re-test the blood test result and instead gave Ms E incorrect results. The Trust had acknowledged and apologised for this.

We took advice from an experienced obstetrician/gynaecologist, to help us reach a view as to whether we could directly link the error with the death of the baby. From the evidence and our adviser's comments we could not say with any level of certainty that the error caused the death. There were indications that the foetus had not developed as well as expected before the error, and Ms E would have likely miscarried anyway. However, we concluded that the error had caused Ms E a lot of distress.

Putting it right

While the Trust had apologised and taken measures to prevent the same error occurring, we did not feel it had taken any action to acknowledge the distress caused. Therefore the Trust accepted our recommendation and paid Ms E £150 in recognition of the distress caused by the error.

Organisation(s) we investigated

Cambridge University Hospitals NHS Foundation Trust

Location

Cambridgeshire

Region

East

Summary 1022/July 2015

Lack of compassion and sensitivity for couple whose baby had died

Miss K and her partner, Mr N, complained that their child's death might have been avoided if the Trust had provided appropriate care and treatment. They said there was a lack of compassion and sensitivity during labour and inadequate aftercare. They said they suffered physically and financially, and were traumatised by the whole experience.

What happened

Miss K was reaching the latter stages of her pregnancy when she started to suffer from breathlessness. She visited the maternity unit at the Trust and the midwives arranged an ultrasound scan and blood tests. Following this, doctors diagnosed a complication in the pregnancy.

Two weeks later Miss K told her midwife she was worried that the baby was not moving as much as before. The midwife did some basic checks and advised Miss K to contact the hospital if she had any further concerns. The next day she went to the hospital and told the midwife that she had felt the baby moving a lot during the night but since then the movements had reduced. The midwife could not find the baby's heartbeat and arranged for a scan. The scan confirmed that Miss K's baby had died.

Miss K did not want to stay in hospital and went home. A consultant gave her medication to help induce labour so that the baby could be delivered, and asked her to return to hospital the next morning. Miss K went back to hospital with a friend but there were no signs that labour was starting. Midwives gave Miss K further labour inducing medication and during the day gave her pain relieving medication when she was distressed and uncomfortable.

However, Miss K complained that there had been delays in midwives giving pain relief and midwives were only with her from time to time when she was in labour.

Miss K and Mr N said following their child's death, the midwives did not deal with them sensitively.

What we found

There were no failings in care up until Miss K reported reduced movements to her midwife. We found that at that point the midwife should have sent her to hospital for a scan. We were unable to establish what the scan would have shown and so we could not say that the baby would have been delivered safely at that point.

However, there was a possibility that it could have highlighted concerns that would have led doctors to deliver the baby. We said the couple were left not knowing whether their baby would have survived if appropriate action had been taken.

We also found failings during labour. Miss K was left alone on several occasions by hospital staff because they were busy elsewhere. We found that Miss K was in pain and left alone to deliver her baby and that midwives did not give her the support she needed. Staff treated Miss K and Mr N with a lack of compassion and sensitivity after the baby had died. There were several incidents where the actions of staff made the couple's distress worse.

Putting it right

The Trust accepted our recommendations and apologised for its failings. It paid the couple £3,000 in recognition of the distress caused. The Trust also produced an action plan to make sure that it had learned from the complaint.

Organisation(s) we investigated

Chesterfield Royal Hospital NHS Foundation Trust

Location

Derbyshire

Region

East Midlands

Summary 1023/July 2015

GP practice wrongly removed patient from patient list without warning

The GP Practice did not handle Mr S's repeat prescriptions well and unreasonably removed him from its patient list, following a phone conversation.

What happened

Mr S had a medication review at his GP Practice. A few days later, the reception manager told Mr S that he could not have a six months' prescription for one of his medications and had only been given one month's supply until his next medication review. Over a week later, Mrs S called the Practice to check if her husband's prescriptions were ready to collect, but the Practice said they were not.

Mr S then called the Practice about his prescriptions. His behaviour in the telephone conversation was perceived by the Practice manager to be aggressive, and he was notified in writing on the same day that he would be removed from the patient list.

Mr S complained to the Practice about its handling of his prescriptions and his removal as a patient. The Practice responded saying it would have reverted to the six-month prescription the next time Mr S ordered his medication and that this was in line with its prescription policy. With regard to Mr S's removal, the Practice explained the decision had been taken under its zero tolerance policy. However, it acknowledged that it would have been better if the phone call had been transferred to the practice manager. Mr S remained dissatisfied with the Practice's responses.

He wanted an apology, revisions to the Practice's relevant polices or procedures and staff to receive training on empathy and customer service.

What we found

We partly upheld this complaint. We obtained all the relevant medical records, correspondence and also an audio recording of the phone conversation. We sought advice from one of our GP advisers who confirmed that while matters may not have been explained to Mr S in the clearest way, the Practice's handling of his prescriptions had been appropriate.

We listened to the audio recording and did not consider Mr S's behaviour to warrant immediate removal from the Practice. We felt that, at worst, he should have had a warning about his behaviour. The Practice had not followed contractual regulations by removing him immediately without warning.

Putting it right

The Practice accepted our recommendations and apologised to Mr S and paid him £250 in recognition of the impact of the failing, and for not following contractual regulations.

Organisation(s) we investigated

A GP practice

Location

Blackpool

Region

North West

Summary 1024/July 2015

Trust put administrative failings right

The Trust gave Mr T inadequate care and treatment for his obsessive compulsive disorder (OCD). His psychiatrist also failed to respond to information his mother, Mrs T sent to her. Mrs T said the stress of the experience affected her and her family, and denied her son having a more fulfilling life.

What happened

Mr T had a history of interactions with local mental health services. He had been diagnosed as having OCD and mixed anxiety and depressive disorder. He first had private treatment but later saw NHS staff at the Trust and tried different types of therapy. Mrs T was unhappy with the care that staff at the Trust were giving to her son, Mr T. When his symptoms seemed to be getting worse, Mrs T did not feel that his psychiatrist did enough to help him get better. She believed Mr T needed additional therapy. She later found that the psychiatrist had failed to write up a summary of a review appointment she and her son had attended. This was sent to her son's GP over a year after the event and she felt that it did not show how concerned his family had been at the time.

Mrs T complained that there was a lack of care when the psychiatrist failed to respond to the information she sent her. She wanted the Trust to recognise and apologise for its errors and the impact they had on her family.

What we found

We did not uphold this complaint. The psychiatrist and her colleagues cared for Mr T in line with the relevant guidelines. We were critical that the psychiatrist did not make a record of the review appointment until much later and also that she failed to answer letters from Mrs T. However, we noted that the Trust had already accepted these failings, apologised for them and taken action to try to make sure they were not repeated.

Organisation(s) we investigated

South Essex Partnership University NHS Foundation Trust

Location

Essex

Region

East

Summary 1025/July 2015

Trust provided appropriate support to patient and his wife as carer

Mr and Mrs A said the Trust failed to give Mr A adequate support for his mental health, and also did not support Mrs A as his carer. As a result they said their health had been affected and they had suffered financially.

What happened

Mr A had a number of conditions that affected his mental health and stopped him from being able to work. He had been known to mental health services since 2005. Mrs A was his full time carer, although she found this incredibly challenging.

Mr A received psychological support for his mental health and in autumn 2013 he started to see a psychiatrist. His last therapy session was in summer 2014. However, Mrs A became concerned that the discharge from this service caused real deterioration in her husband's health, so much so that she described it as a '*crisis*'. Some days after being discharged, a mental health social worker assessed Mr A again and referred him to another scheme for his mental health. He then attended various support groups.

In summer 2014, a mental health social worker assessed both Mr and Mrs A's needs. The social worker recorded that Mrs A was no longer able to provide the same level of care for her husband and plans were put in place for Mr A to get funding for some hours of support from another carer. The social worker recorded that she would monitor and review this. Mrs A also received a carer's assessment, and both have a continued relationship with the Trust and social services.

What we found

We did not uphold this complaint. We found that Mr A received appropriate psychological support and input over a two-year period. There was also evidence that sufficient out-of-hours and crisis support was provided. Mr A did become unwell after being discharged from therapy in summer 2014 but we found that his discharge was planned and appropriate.

Overall we were satisfied that Mrs A's needs as a carer were also appropriately assessed.

Organisation(s) we investigated

Oxleas NHS Foundation Trust

Location

Kent

Region

South East

Summary 1026/July 2015

Decision to discharge a patient from hospital was appropriate

Mr H said doctors at the Trust did not treat his father, Mr J, appropriately when he was a patient there. Mr H said that poor assessment and inappropriate discharge arrangements contributed to his father's death. He said that if his father had remained in an acute hospital he might not have died.

What happened

Mr J went to a community hospital because of a chest infection. Staff there thought his condition was so severe that they sent him to the Trust. After less than 24 hours doctors felt that his condition was stable enough for him to return to the community hospital and they discharged him.

However, nurses at the community hospital noted that the level of oxygen in Mr J's blood was low and arranged for him to return to the Trust. Doctors assessed him and moved him to the medical assessment unit. A doctor met members of Mr J's family to explain that his health was deteriorating because of pneumonia and respiratory failure. The doctor explained that, because of his medical history, there would be no attempts to resuscitate if he collapsed. In the following days Mr J's health worsened and he died.

Mr H complained that his father might not have died if he had stayed at the Trust.

What we found

We did not uphold this complaint. We found that doctors at the Trust followed the appropriate standards when they assessed Mr J and decided that he was fit to be discharged.

Organisation(s) we investigated

Doncaster and Bassetlaw Hospitals NHS Foundation Trust

Location

Doncaster

Region

Yorkshire and the Humber

Summary 1027/July 2015

Trust's poor communication led to delays in physiotherapy

Ms B had treatment for a road traffic accident injury. But she suffered ongoing pain and delays in arranging follow-up appointments and physiotherapy, due to poor communication and co-ordination of services.

What happened

Ms B had a road traffic accident and had an operation. When she was discharged the Trust did not arrange follow-up appointments as planned until she chased them up herself. Then a planned scan was cancelled with no explanation. The Trust gave Ms B an appointment for physiotherapy, which was cancelled because the physiotherapist was off sick. The start date for physiotherapy was changed several times and eventually Ms B was discharged from the physiotherapy service without having received any physiotherapy and without her consent.

The Trust's record keeping was also poor and this directly impacted on Ms B's experience at every part of her patient journey.

Ms B complained that she was frustrated, upset and inconvenienced by the time she had spent sorting out the errors. She said the attitude of a member of staff in the physiotherapy department was poor. She wanted an acknowledgement of failings and service improvements for everyone.

What we found

The Trust had not properly acknowledged or explained what had gone wrong. We found that the processes for arranging physiotherapy and the attitude of a member of staff in the physiotherapy department had been poor.

We also found that the record keeping in every department dealing with Ms B had been inadequate.

Putting it right

The Trust agreed to apologise to Ms B, to carry out an analysis of what had gone wrong and to draw up an action plan to put this right. The Trust agreed to share this action plan with the Care Quality Commission, who monitor performance.

Organisation(s) we investigated

North Middlesex University Hospital NHS Trust

Location

Greater London

Region

London

Summary 1028/July 2015

Mental health assessment did not identify key risk factors

When a mental health nurse assessed Mrs G, she failed to properly record that she planned to take an overdose the next day. Mrs G took an overdose for which she needed emergency treatment in hospital.

What happened

In spring 2014 Mrs G's counsellor referred her to the Trust's Crisis Resolution Team (CRT). She was assessed the next day by a community psychiatric nurse (CPN) working as part of the CRT. Mrs G said she reported having a '*stockpile*' of medication and '*overwhelming*' thoughts of suicide as she was planning to take an overdose the next day. Although Mrs G's husband pointed out that intervention from the Home Treatment Team (HTT) had been beneficial in the past, based on the assessment that day, the CPN decided it would not be helpful on that occasion.

The following day Mrs G took an overdose and needed emergency treatment at hospital. Mrs G complained to the Trust saying that intervention from the HTT would have prevented her from taking an overdose.

The Trust investigated and explained to Mrs G why she had not been referred to the HTT. The Trust acknowledged that although the CPN felt Mr and Mrs G had understood and agreed with their assessment, this was clearly not the case. They apologised for 'any misunderstanding' and said the CPN's manager would speak to the CPN. Mrs G and her husband met the Trust in summer 2014 but felt that this didn't resolve their concerns. Mrs G was told that the Trust would contact her again after the meeting but when she had heard nothing further she asked us to investigate her complaint.

What we found

We decided it was more likely than not that Mrs G did inform the CPN she had a stockpile of medication, and that she intended to take an overdose the next day. We saw adequate evidence in the assessment that Mrs G reported she had stored up her medication although we were unable to say why there was no record of her informing the CPN of her intentions. We found this was crucial information that should have been documented.

If this information had been clearly recorded, then it was likely that the assessment would have reached an outcome that was consistent with the outcome of Mrs G's previous assessments, that she needed referral to the HTT.

Mrs G said there would have been a different outcome if she had been referred to the HTT. We could not say for certain that Mrs G would not have taken an overdose even if she had been offered intervention from the HTT. However, we accepted that it was less likely that she would have felt the need to take this course of action and that she would have been reassured that the support she wanted was available to her on the day she most needed it.

Putting it right

The Trust apologised to Mrs G and provided her with the written reassurance that she could request a review by the on-call psychiatrist if she was unhappy with the outcome of any future assessments.

Organisation(s) we investigated

Leicestershire Partnership NHS Trust

Location

Leicester

Region

East Midlands

Summary 1029/July 2015

Patient left without appropriate treatment for over 11 hours

Mr W's sister complained that her brother was left for a long time without treatment after being admitted to hospital. She said his sudden death left her distraught.

What happened

Mr W who was in his sixties suffered from chronic obstructive pulmonary disease. An ambulance took Mr W into hospital after his mother had found him collapsed and cyanotic (blue skin colour as a result of low levels of oxygen). When he arrived in A&E, the Trust inserted a tube into his trachea to help him breathe. The plan was to remove the breathing tube when his blood carbon dioxide (CO2) level had returned to normal.

The Trust removed the tube and admitted Mr W to the hospital's acute assessment unit (AAU). Mr W's family was told that he was being left to pass away peacefully.

Mr W was then given a tight-fitting mask to help with breathing and his condition improved to the extent that he was discharged home four days later. Sadly Mr W died of a heart attack just over one month after his discharge from hospital.

Mr W's sister complained that her brother was treated with a lack of dignity which was very distressing for the family.

What we found

We upheld this complaint. The Trusts' decision to remove Mr W's breathing tube was wrong, as his blood CO2 level had not recovered to a sufficient extent. We also found that he should have been admitted to the intensive treatment unit rather than the AAU at that time. We found that the decision to remove the breathing tube led to an 11-hour period during which Mr W was in a state of considerable agitation and distress because he was left without the appropriate treatment. This in turn caused distress to Mr W's sister and other members of the family who were present.

However, we found that Mr W's death could not be attributed to the poor care that he received from the Trust.

Putting it right

The Trust acknowledged and apologised for the failings in the treatment given to Mr W. It paid his sister £500 in recognition of the distress she experienced as a result of these failings. The Trust also prepared an action plan to show what it had learned from the complaints.

Organisation(s) we investigated

The Mid Yorkshire Hospitals NHS Trust

Location

West Yorkshire

Region

Yorkshire and the Humber

Summary 1030/July 2015

Trust's poor communication with vulnerable patient caused unnecessary stress

A Trust failed to communicate adequately with Ms K and her son, Mr P, while they were waiting for an urgent psychiatric assessment. She wanted the Trust to take steps to make sure it didn't happen again.

What happened

Mr P had a history of low mood and went to his GP feeling low and agitated. The GP prescribed him diazepam for ten days but Mr P took all the diazepam in two doses. Mr P went to see his GP again and said he had suicidal thoughts. The GP referred him for an urgent assessment.

Mr P went to the Trust with his mother, Ms K, for the assessment and they were told to wait in the A&E department of a nearby mental health trust (which was not part of this investigation). They regularly asked when they were likely to be seen, but the A&E staff could not get hold of the psychiatrist who was performing the assessment. Ms K thought that they may have been forgotten. After around three hours of waiting, Ms K's son could not cope waiting any longer and they left without the assessment being done.

Ms K complained that she found it upsetting that they were not updated regularly while waiting and worrying that someone as vulnerable as her son was, may not receive the urgent care they need. She wanted the psychiatrist involved to know exactly what she and her son went through that night, and for the Trust to take steps to make sure it did not happen again.

What we found

The Trust failed to communicate with Ms K and her son, which led to them walking out without the assessment being done. The Trust was separate to the mental health trust, where Ms K and her son were told to wait, and it did not have any policies or procedures in place to keep people who were waiting updated.

We found that it was not good practice to leave vulnerable people waiting with no idea when they would be seen. We concluded that the two Trusts should agree a procedure between them for keeping patients updated.

Putting it right

The Trust wrote to Ms K and explained how it had improved communication with vulnerable people while waiting in A&E for psychiatric assessments.

Organisation(s) we investigated

Sussex Partnership NHS Foundation Trust

Location

Sussex

Region

South East

Summary 1031/July 2015

GP practice did not arrange any follow-up to review blood test results

The GP Practice failed to provide continuity of care and treatment to a patient who had breathlessness. She was later diagnosed with cancer.

What happened

Mrs A went to see her GP about various issues, including breathlessness. After a physical examination, the GP could not find the cause of her breathlessness but ordered blood tests. The GP left the Practice a few days after the consultation with Mrs A, without arranging any follow up to review the results. Although the Practice transferred Mrs A's care to another GP, there was a delay in reviewing her blood test results. The blood test results came back normal but it was over a month later, when Mrs A visited the Practice with similar symptoms, that it referred her for a chest X-ray at the local hospital. Following this, doctors there diagnosed Mrs A with cancer.

Mrs A complained that the Practice took too long to refer her for an X-ray to investigate her breathlessness. She said that there was a lack of continuity when her GP left the Practice. Mrs A said that if the Practice had referred her to hospital sooner, she could have received treatment for her cancer to stop it from spreading.

What we found

We partly upheld Mrs A's complaint. We found that the Practice referred Mrs A for a chest X-ray in line with the applicable standards. It was highly unlikely that further investigations taken before her second visit to the GP would have made any difference to her prognosis. However, the failure by the first GP to put a plan in place to review the results of the blood tests with Mrs A and for the Practice to implement that plan would have worried Mrs A. Once she did the tests, she was in the dark about what happened next. The GP should have explained to Mrs A the need to follow up the consultation, even if the tests came back normal, as she was still suffering with breathlessness.

The GP should have organised a follow-up consultation with the person taking over from her to review the blood test results, even if they came back normal.

Putting it right

The Practice apologised to Mrs A for the distress she experienced at not knowing what was happening with her test results and for the lack of continuity in her care.

Organisation(s) we investigated

A GP practice

Location

Buckinghamshire

Region

South East

Summary 1032/July 2015

Staff didn't do enough to address bullying and abuse on a mental health ward

Ms C said that staff did not do enough to address issues of bullying and abuse from other patients and that this led to deterioration in her mental health.

What happened

In spring 2013 Ms C raised concerns with staff about how other patients on her ward had made inappropriate and offensive comments to her.

Staff at Partnerships in Care (PIC – which provides independent specialist services for people with mental illness and other conditions) acknowledged that bullying and abusive behaviour had become a problem on the ward. They discussed Ms C's concerns at a team meeting and spoke with the individuals involved. PIC also implemented a new programme called 'Living Together' to address issues of discontent between patients and improve the environment on the ward.

At the beginning of summer 2013 Ms C agreed to be separated from the other patients by spending her days on another ward but returning in the evening to sleep. She was later transferred to another hospital. However, her mental health subsequently deteriorated and she had to return to PIC.

Ms C complained that staff did not do enough to address her concerns about bullying and abusive behaviour on the ward. She said that this caused her mental health to deteriorate.

What we found

We partly upheld Ms C's complaint. PIC failed to do enough to address issues of bullying and abuse and to protect Ms C and the other patients.

We could understand how Ms C would have felt distressed by the bullying and abusive behaviour on her ward. However, she was clinically stable enough to manage at another hospital in the months after she experienced the bullying and abusive behaviour. She remained on the low secure unit at the other hospital until early 2014 when her condition deteriorated and she was transferred back to PIC. Taking into account that Ms C's condition was stable enough for her to be transferred to a low secure unit in summer 2013 and the length of time between her transfer and her subsequent deterioration, we could not say that her experience at PIC led to a deterioration in her mental health.

Putting it right

We were reassured that PIC had apologised and improved its service in light of Ms C's concerns and we did not recommend any further action be taken.

Organisation(s) we investigated

Partnerships in Care Limited

Region

East Midlands

Summary 1033/July 2015

GP practice's poor communication caused inconvenience

Mr M's GP Practice did not explain to him that it had stopped medication for his psoriasis. Mr M felt that his treatment had been undermined and that his condition deteriorated as a result.

What happened

Mr M had a long history of psoriasis. He had a repeat prescription of medication, including a type of soothing ointment. Mr M gave his repeat prescription request to a pharmacy. When he went to collect his medication, he was told that the soothing ointment had been refused by his GP Practice. He contacted the Practice and found out his GP had denied the ointment because his prescribing history indicated use of a similar product and therefore he should have continued with that. But Mr M had not been informed of this. However, after some discussion, the practice nurse gave Mr M a prescription for the ointment.

Mr M complained that the Practice failed to tell him that it would no longer be issuing items on his prescription. He wanted an independent review of the Practice's actions.

What we found

The GP made a clinical decision not to provide medication. This was not a failing. However, Mr M should have been informed of the decision by a member of staff at the Practice, if not the GP himself. We found the poor communication represented a failing on behalf of the Practice.

Putting it right

The Practice apologised to Mr M for its poor communication.

Organisation(s) we investigated

A GP Practice

Location

East Sussex

Region

South East

Summary 1034/July 2015

Unreasonable delay in treating broken arm

The Trust failed to recognise the severity of Mr S's condition after he fell off his motorbike, and he suffered an unreasonable wait for surgery.

What happened

Mr S fell from his motorcycle and was taken to A&E at the Trust with a suspected broken arm. The Trust referred him to a fracture clinic but it took 18 days before he had corrective surgery.

Mrs S complained about several aspects of her husband's care, particularly the delay in surgery. Mr S wanted to know if his arm would have healed sooner if he had been seen and operated on earlier. He also wanted a payment for the pain and distress caused by the delay.

What we found

We partly upheld this complaint. The Trust reasonably addressed concerns about Mr S's general care but we found that there was an unreasonable delay until he received surgery for his injury. The Trust explained the measures put in place to avoid something like this happening again but did not reasonably address the consequences of that delay for Mr S.

Putting it right

The Trust apologised for the delay in surgery and paid Mr S £350 in recognition of the additional pain and distress he suffered as a result of that delay.

Organisation(s) we investigated

Colchester Hospital University NHS Foundation Trust

Location

Essex

Region

East

Summary 1035/July 2015

Trust inadequately assessed patient at risk of falls

Mrs J complained about several aspects of her medical and nursing care while an inpatient at the Trust. In particular, she said she was dropped while on an inappropriate ward and that her leg was then set in a way that made it difficult for her to retain her independence.

What happened

Mrs J has multiple sclerosis (MS) and is paraplegic (paralysis of the legs and lower body). She had a seizure and was found unconscious. She was admitted to the Trust's emergency admissions unit and the next day was transferred to the short stay unit. For the first few days Mrs J refused most treatment and was confused, agitated and aggressive, which was not her usual behaviour. She fell from her bed (she said she must have been dropped because she could not move her legs). She refused examination. Her condition gradually improved and she was discharged after nine days.

At a follow up appointment, a surgeon identified that Mrs J had two fractures (at her knee and ankle) and Mrs J felt these had happened during her fall. Her leg was set bent (with the knee flexed) and she said this made it very hard for her to retain her former independence.

Mrs J complained that as a result of the poor care she received, her quality of life had been affected. She wanted service improvements as a result of her complaint.

What we found

We found no evidence that Mrs J had been dropped. However, we found that her risk of falls had not been adequately assessed and that adequate nursing plans had not been put in place.

We found it was possible that Mrs J's fall had caused her fractures but that it was appropriate for her leg to be set in a bent position. If it had been set with the knee extended (straight), this would have made it difficult for her to move in a wheelchair. We therefore, partly upheld this complaint.

Putting it right

The Trust wrote to Mrs J and acknowledged the lack of risk assessment and apologised for it. It also told us and Mrs J how it was going to make improvements in those areas.

Organisation(s) we investigated

North Tees and Hartlepool NHS Foundation Trust

Location

County Durham

Region

North West

Summary 1036/July 2015

Trust provided reasonable medical care but not nursing care

When Mr P underwent gall bladder surgery, the aftercare he received was reasonable medically, but the nursing care fell short. As a result, he experienced unnecessary pain and frustration.

What happened

Mr P had his gall bladder removed at the Trust in autumn 2013 and was discharged. He continued to have pain and went to the Trust's surgical admissions unit a few days later, where he was vomiting with pain. Despite this, the nurses did not give him any pain relief and he was sent home. His pain continued and he had various tests, which did not identify the problem.

Later, Mr P was diagnosed with an infection and taken back to the Trust where he was given antibiotics and his wound was drained and cleaned. When Mr P's problems continued, he was readmitted to the Trust with a possible hernia. Eventually, in early 2014, Mr P underwent exploratory surgery, where a small lump of fat was removed from the original surgery site. This resolved his problems.

Mr P complained that there was a lack of communication from the Trust, he was treated inadequately by staff, he was misdiagnosed and the Trust failed to recognise an infection that had developed. Mr P said that as a result of this, he was put through unnecessary pain and frustration.

What we found

We partly upheld this complaint. There were no failings in the clinical care Mr P received.

However, we found that there were failings in the nursing care. This care was not in line with recognised quality standards and established good practice, and resulted in Mr P experiencing unnecessary pain and frustration.

Putting it right

The Trust apologised for what went wrong, and also put a plan in place to learn lessons from the failings to make sure they didn't happen again.

Organisation(s) we investigated

Portsmouth Hospitals NHS Trust

Location

Hampshire

Region

South East

Summary 1037/July 2015

GP practice did not appropriately treat or manage patient's pain

The GP Practice and the Trust did not give Mr H appropriate treatment and pain relief for his right toe. He also complained that they both delayed diagnosing him with a bone infection and that, as a result, those failings led to the avoidable partial amputation of his toe.

What happened

Mr H visited the GP Practice and Trust on 11 occasions in 2013 with pain in his toe that became more severe as time went on. Eventually, following an X-ray, the Trust diagnosed that Mr H had a bone infection. Mr H then had to have an operation to have part of his right toe amputated.

Mr H complained that if the Practice and the Trust had diagnosed and treated him appropriately, by providing him with an X-ray earlier, the partial amputation of his right toe could have been avoided. He said he experienced severe pain which hindered his mobility. He said he also suffered a financial loss as he became dependent on help from other people for his daily needs and needed to take taxis regularly.

What we found

We partly upheld Mr H's complaint about the Practice. We found it got a number of things wrong. It did not appropriately manage Mr H's pain, did not appropriately treat him on two occasions, and prescribed antibiotics at a lower dose than recommended and without seeing him. However, we found it referred him to the Trust appropriately. We did not find that these shortcomings led to a delay in Mr H being diagnosed with a bone infection or that it contributed to the partial amputation of his toe.

We did not uphold Mr H's complaint about the Trust as we found no service failure in its care and treatment.

Putting it right

The Practice apologised to Mr H and gave him a full written acknowledgement of the errors that we had identified. It also paid him £1,500 for the injustice he suffered.

Organisation(s) we investigated

A GP practice

Lincolnshire Community Health Services NHS Trust

Location

Lincolnshire

Region

East Midlands

Summary 1038/July 2015

Trust had already apologised for delays and poor cleanliness

Ms S complained about several incidents that happened while she was an inpatient at the Trust. These included delays and poor cleanliness.

What happened

Ms S went to hospital (part of the Trust) because of a persistent headache. She had various tests and was discharged the next day when doctors diagnosed a possible viral illness.

Ms S complained about delays in admitting her to a ward (she waited on a trolley for 11 hours), communication, staff attitude and cleanliness. The Trust recognised that there were some failings in care and apologised to Ms S at a meeting about these problems.

Ms S remained dissatisfied with the Trust's response and brought her complaint to us.

What we found

We did not uphold Ms S's complaint. Although there were failings in relation to delays and cleanliness, we did not find these had any significant impact on Ms S. We were satisfied that the Trust had already taken appropriate action to respond to her complaint.

Organisation(s) we investigated

London North West Healthcare NHS Trust

Location

Greater London

Region

London

Summary 1039/July 2015

Failings in care and support for a boy with autism

Staff at the Trust failed to carry out appropriate assessments for Mrs N's son, who was later diagnosed as having autism.

What happened

Mrs N was concerned about aspects of her son's behaviour at an early age. She saw her GP, who referred her son to a community child health clinic for an assessment about Asperger's syndrome.

The clinic put Mrs N's son on a waiting list to see a paediatrician at the Trust. The paediatrician arranged for various assessments to be carried out from different people, including the school, to consider possible autistic spectrum disorder or attention deficit hyperactivity disorder. The paediatrician expected that it would take four months to properly assess Mrs N's son. However, the full assessment took place 29 months after the first referral. Following this, Mrs N's son was found to have an autistic spectrum disorder and dyslexia.

Mrs N complained to the Trust that the delay in diagnosis meant her son missed out on earlier intervention and left him without the support he needed. Mrs N said the whole experience had been stressful and upsetting and the poor handling of her complaint added to her distress. She was unhappy with the Trust's response and came to us.

What we found

The Trust's care and treatment fell below the required standard. We found that doctors should have assessed Mrs N's son sooner. They did not give enough weight to Mrs N's concerns and should have been clear about who was co-ordinating care.

We also found that the Trust did not deal with Mrs N's complaint promptly and sensitively and that it did not recognise its failings.

We did not find that there was any impact on the longterm health of Mrs N's son, but we found that the failings led to his mother being distressed and worried. This was compounded by poor complaint handling.

Putting it right

The Trust apologised for its failings and the injustice to Mrs N. It also paid Mrs N £1,000 and produced an action plan to show that it had learned from the complaint.

Organisation(s) we investigated

Alder Hey Children's NHS Foundation Trust

Location

Merseyside

Region

North West

Summary 1040/July 2015

Patient's death not linked to medication change

Mrs W complained that the GP Practice caused problems for her late husband, Mr W, when it increased his blood pressure medication. She believed he never fully recovered from this.

What happened

Mr W had a history of high blood pressure and bipolar disorder. He took regular medication to treat his illness. When the GP saw Mr W in early 2010, his blood pressure was high and his bipolar disorder was stable. So the GP increased his blood pressure medication. When Mr W reported symptoms, he received treatment promptly. He went to hospital, where his physical illness was treated, and he was seen by mental health specialists. His condition appeared to be stable by the end of 2010. However, by summer 2012 his mental health had deteriorated. He died in autumn 2012.

Mrs W complained to the Practice about her husband's care. She believed that he had never fully recovered from his illness in 2010. She said that Mr W's GP had caused the problem by increasing his blood pressure medication in early 2010. The GP said that Mr W had been taking blood pressure medication for a long time, and there were several factors which could have caused his illness. She remained dissatisfied with the Practice's response, and complained to us.

What we found

We partly upheld this complaint. We found it was appropriate for the GP to increase Mr W's blood pressure medication. However, he should have arranged prompt blood tests to check that Mr W was not suffering a reaction to the increase. But the delay in arranging blood tests did not lead to Mr W's death.

Putting it right

The Practice acknowledged the delay in arranging blood tests following the increase in Mr W's blood pressure medication. It apologised to Mrs W for the distress she had experienced due to not knowing whether her husband could have been treated differently if it had done so.

Organisation(s) we investigated

A GP practice

Location

Merseyside

Region

North West

Summary 1041/July 2015

Failings in nursing care

Mr R received appropriate clinical care but his family were distressed by failings in nursing care. They also claimed that Mr R was a victim of abuse, neglect and discrimination and that this contributed to his death.

What happened

Mr R was admitted to the Trust through its emergency department having been referred by his GP with a number of symptoms, including possible congestive cardiac failure. After just over two weeks, Mr R died in hospital with the cause recorded as pneumonia.

During numerous meetings with the Trust, Mr R's family complained about the care and treatment he received. They said Mr R received poor nursing care in terms of cleanliness, personal care and medication. They also suggested that Mr R experienced abuse, neglect and discrimination which contributed to his death.

The family also complained about the Trust's handling of their complaints.

What we found

We partly upheld this complaint. The clinical care Mr R received was reasonable and the Trust had properly responded to the issues raised by Mr R's family.

There were failings, however, in the nursing care. The Trust had already acknowledged a number of these failings, apologised for them and explained the action it was taking to put things right. But there were several other failings in nursing care that the Trust had acknowledged but not addressed.

We did not find evidence to support the concerns expressed about Mr R being subject to abuse, neglect or discrimination.

Putting it right

The Trust apologised for not showing how it would address some of the nursing failings that had been identified. It also prepared an action plan to address those issues and shared it with the family.

Organisation(s) we investigated

Great Western Hospitals NHS Foundation Trust

Location

Swindon

Region

South West England

Summary 1042/July 2015

Clinical failing but appropriate safeguarding

The Trust's urological department discharged Miss E without full investigations. She disagreed with this decision. Due to inappropriate contact with its consultant urology surgeon, the Trust banned Miss E from the urology department and asked her to visit a neighbouring Trust for treatment.

What happened

Miss E had a history of urological (related to the urinary system) and other symptoms that had been investigated by the Trust. Contrary to Miss E's wishes, the Trust discharged her from its urology department because it believed further treatment was not warranted. It referred Miss E back to her GP on the basis that no urological cause for her symptoms could be found. Miss E disagreed with this decision but, before this could be resolved, the Trust banned her from the urology department and asked her to seek any further treatment at a neighbouring Trust.

The Trust's decision to exclude Miss E from its urology department was as a result of concerns that she had made inappropriate advances to its consultant urology surgeon.

Miss E complained to the Trust about the ban and that she felt humiliated that the Trust had discriminated against her due to her disabilities. The Trust responded saying that it was felt that Miss E did not require review by the urology team. It also appeared that the professional and therapeutic relationship between her and the urology team had irrevocably broken down because of her inappropriate communication to a member of the team.

In view of that, its suggestion was that a referral to a neighbouring Trust would be appropriate, if she or her GP felt further urological investigations were required in the future. Miss E remained unhappy with the response and came to us.

What we found

We partly upheld this complaint. The initial decision that further investigation of Miss E's urological symptoms was not warranted was flawed. We saw that there were a number of possible abnormalities in the investigations carried out and that there were some treatment options that could have been of benefit to Miss E. We felt that it was unreasonable for the Trust to have referred Miss E back to her GP on the basis that no urological cause for her symptoms could be found. This was a failing.

However, we considered that given the nature of Miss E's later contact it was reasonable to stop her seeing the consultant urology surgeon. The Trust tried to arrange some appointments with another consultant but Miss E was unwilling on each occasion. Before further arrangements could be made, the contact concerns escalated, leaving the Trust with little option but to decline to see Miss E at all. We found this was appropriate.

Putting it right

The Trust apologised to Miss E for referring her back to her GP having failed to recognise that she could have been offered further investigation and/or treatment. It also paid Miss E £250 in recognition of the distress she experienced from the Trust's failure to carry out further urological investigation and treatment.

Organisation(s) we investigated

East Sussex Healthcare NHS Trust

Location

East Sussex

Region

South East

Summary 1043/July 2015

Trust gave appropriate care but communication with family was poor

Ms B's family complained that the Trust failed to give her adequate care and treatment when her mental health declined. They said this led to her avoidable death. They also complained about the Trust's poor communication and complaint handling.

What happened

Ms B had a medical history of schizotypal personality disorder and moderate depression, as well as high blood pressure and cholesterol. During 2011 she was admitted to the Trust for short periods three times, once because of an overdose of blood pressure medication, and twice because she was suffering from stress.

Ms B did not engage with the services on offer during her admissions, or after discharge. When she did not attend an appointment, the Trust wrote to her inviting her to make contact at any time. Ms B was found dead in her flat in summer 2011. She had been dead for several weeks. The Coroner's inquest in autumn 2011 recorded that it was not possible to identify the cause of death because of the time that had elapsed before she had been found.

Ms B's family complained that the Trust did not give her adequate care and treatment. They believed her death could have been avoided. They also said the Trust failed to listen to them when they tried to give Ms B's clinicians information about her, and this caused them great anxiety and distress.

The Trust responded and explained that, because Ms B had declined to give permission for her family to be involved, her clinician was limited as to what discussions he could have had with them. The Trust apologised because it should have called the family back to explain this. The Trust said that Ms B had been given a reasonable standard of care, both psychologically and physically. The family were not satisfied and complained to us.

What we found

We partly upheld this complaint. We found the care received by Ms B by the Trust was in line with recognised quality standards and established good practice, and there were no failings.

However, there were failings in the way the Trust treated Ms B's family when they tried to give information about her to her clinicians. There were also failings in the way their complaint was handled. These failings caused the family great anxiety and distress.

Putting it right

The Trust acknowledged the failings and apologised for them. It also prepared an action plan to make sure it had learned from the failings so that they didn't happen again.

Organisation(s) we investigated

East London NHS Foundation Trust

Location

Greater London

Region

London

Summary 1044/July 2014

Appropriate gynaecological care but poor record keeping

Mrs P complained about the gynaecological care and treatment, which she believed led to pain over a significant period of time and her bladder problems.

What happened

Mrs P had a history of heavy periods. The Trust investigated to rule out any underlying problems, and a coil was fitted to help. Mrs P returned to the hospital a few days after because she was in pain. The coil was removed but Mrs P was unhappy about the process surrounding the coil. A few months later Mrs P went on to have endometrial ablation (surgical treatment for women who have heavy periods) as the next step. Again, she experienced pain following it. She said the machine used in the procedure broke, and she was sent home with empty painkiller boxes. The Trust later identified that the procedure had burst a hole in her bladder.

There were more investigations and Mrs P then had a hysterectomy. Following the hysterectomy, Mrs P returned to hospital with further pain, and concerns about wound management. She was admitted, and later discharged.

Mrs P complained about her gynaecological care throughout this time, but explained that she believed her ongoing urinary infection stemmed from her hysterectomy. She had also complained about the lack of records from some periods of her care.

What we found

We partly upheld this complaint. There were no failings in the care and treatment provided to Mrs P. We did not find evidence of the machine breaking or Mrs P being given empty painkiller boxes. However, we found failings in the record keeping as records of visits were not available.

Putting it right

We asked the Trust to conduct a review of record keeping arrangements and produce an action plan to make sure the failings we identified did not happen again.

Organisation(s) we investigated

Barking, Havering and Redbridge University Hospitals NHS Trust

Location

Greater London

Region

London

Summary 1045/July 2015

Trust's poor monitoring caused traumatic experience for woman following childbirth

Mrs N claimed that the Trust's failings when she was giving birth led to her permanent disability with no control over her bowel movements. She complained specifically about the delays in admitting her to theatre following the birth and receiving blood.

What happened

Mrs N went to the Trust to have her first child. The birth was difficult because her baby's shoulder got stuck, and so Mrs N had to have an incision (an episiotomy) to allow her baby to be born. The incision led to blood loss but staff repaired it. A consultant obstetrician inspected the repair and, following that, noticed a third degree tear that needed to be repaired in theatre. However, there was a delay as the only theatre was dealing with an emergency case. In the meantime, Mrs N was given antibiotics and was later taken to theatre. Mrs N suffered more blood loss during the procedure. She was transferred to the high dependency unit and was later discharged.

Mrs N complained that she suffered from bowel incontinence as a result of what happened and that, although she was later referred to specialists at the Trust, she has not been able to regain control of her bowel. She's now left with a lifetime disability. She said she was highly dependent on the help and support of family and friends and that a second pregnancy would be very difficult and could put her and the baby at considerable risk. She was also unable to work and lost her previously active lifestyle.

What we found

We partly upheld the complaint. We found that there was service failure but that this did not lead to the claimed injustice.

Following the birth of her baby, Mrs N was not adequately monitored, managed and treated. However, we did not consider that the delays she experienced could be linked to the outcome of incontinence. Our view was that this was more likely to be associated with straining when giving birth, leading to pudendal nerve neuropathy (damage to nerve located in the pelvis). Mrs N was recorded as straining for two hours and the recommended maximum is three hours.

Putting it right

The Trust told us that it had developed a standard operating procedure that addresses how postnatal women who require further treatment in theatre should be managed while awaiting transfer. This was to make sure that there were improvements in postnatal management, monitoring and recording.

Organisation(s) we investigated

Royal Surrey County NHS Foundation Trust

Location

Surrey

Region

South East

Summary 1046/July 2015

Earlier diagnosis and treatment could have decreased patient's chances of developing painful ulcers

Mrs T complained that the Trust delayed giving her late mother, Mrs K, the correct medical attention and failed to manage her pain.

What happened

Mrs K was in her nineties and suffered with osteoarthritis (a condition that affects the joints) but she was well and had a good quality of life. To help with her mobility, Mrs K had injections in her knee every six months.

Mrs K went to A&E with pain in her knee. However, after an examination, she was discharged and told to come back if the pain got worse. She did go back the next day and investigations found that she had an infection and she was admitted to hospital.

The infection was treated but Mrs K did not respond to the antibiotics. The Trust discovered that she had developed gastric ulcers. She was treated for these and was placed on the Liverpool Care Pathway (a way of caring for patients who are in the final days or hours of life) the day before her death. However, not all of the medication suggested by the palliative care team was started before she died.

Mrs T believed that her mother died in agonising pain as a result of the care she received from the Trust. She said her mother died two weeks after getting a routine injection in her knee.

What we found

The examination performed in A&E when Mrs K first went there was not thorough enough as there were signs of infection. Mrs K should have been admitted to hospital then for treatment. However, when she was admitted the next day, the treatment she had was appropriate.

We also found that the Trust should have given Mrs K another medication alongside the non-steroidal anti-inflammatory drugs, to decrease her chances of developing the painful ulcers.

We found that her pain relief was appropriately monitored and she was given appropriate amounts of pain relief. We did not find a delay in placing Mrs K on the Liverpool Care Pathway.

We found that the Trust should have undertaken a serious untoward incident investigation into the fact that an infection was contracted following a routine injection. This should have looked into the aseptic procedures used to see whether the Trust was at fault. This was not done and that was a significant failing.

We could not conclude that Mrs K's death could have been avoided, but the infection could have been diagnosed and treated earlier and her chances of developing painful ulcers could have been decreased. As a result her family will never know whether earlier diagnosis would have saved Mrs K, which was a significant failing.

Putting it right

The Trust apologised to Mrs T and paid her £1,000 in recognition of the impact of the failings on her. It also reviewed its serious untoward incident investigations policy and identified lessons learned from our investigation.

Organisation(s) we investigated

Blackpool Teaching Hospitals NHS Foundation Trust

Location

Blackpool

Region

North West

Summary 1047/August 2015

Trust failed to act on another Trust's diagnosis of possible pancreatic cancer

Mrs W complained that her husband died because the Trust failed to treat his suspected pancreatic cancer despite another Trust's diagnosis. Mrs W also complained about how the Trust handled her complaint.

What happened

Mr W was diagnosed with suspected pancreatic cancer by Trust A in late 2011 and was referred to Trust B for treatment. Trust B conducted its own tests, but did not treat Mr W for the suspected cancer. Mr W continued having tests in early 2012, and at the end of a two-month period Trust B confirmed that Mr W had pancreatic cancer. The Trust said that it intended to operate in approximately two weeks' time but unfortunately, by then, Mr W was too jaundiced to have the operation. The next month, when his jaundice had improved, Mr W was too frail to have the operation. The Trust referred him for chemotherapy but it was too late to treat him, and he died in summer 2012.

Mrs W complained to Trust B that it had delayed treating her husband despite the diagnosis from Trust A. She was unhappy with the Trust's response and the way that it had handled her complaint and so she complained to us.

What we found

We partly upheld Mrs W's complaint. Trust B had ruled out Trust A's earlier suggestion of possible pancreatic cancer and instead concentrated on changes in the body and another part of the pancreas. It failed to act quickly enough on Mr W's symptoms. However, the outcome might have been the same even if Trust B had been quicker with Mr W's investigations.

While Trust B had apologised for its delay in dealing with Mrs W's complaint, we found that some of the information it gave her was confusing and contradictory. We therefore also partly upheld this aspect of Mrs W's complaint.

Putting it right

Trust B apologised for the failings we identified and the impact those failings had on Mrs W. It also paid Mrs W £1,500 in recognition that its failings denied Mr W the opportunity to be given the best chance of survival, and for the delay in providing a reasonable response to Mrs W's complaint.

It also completed an action plan that set out what it had learned from the failings.

Organisation(s) we investigated

King's College Hospital NHS Foundation Trust

Location

Greater London

Region

London

Summary 1048/August 2015

GP practice missed opportunity to prevent patient from having a fatal pulmonary embolism

When Mrs H, in her early fifties, saw her GPs with pain and swelling in her leg, they failed to carry out sufficient investigations to identify or rule out a deep vein thrombosis (DVT). Mrs H died of a pulmonary embolism (a blood clot in the lung) shortly afterwards.

What happened

Mrs H went to the Practice in summer 2012 with pain and swelling in her left leg. The first GP warned her of the possibility of a DVT and prescribed painkillers. Mrs H was still in pain and returned to the Practice a few days later. She saw a second GP who thought she might have a cyst behind her knee, and prescribed more painkillers.

Mrs H remained unwell and was admitted to hospital nine days later. The following morning she had a pulmonary embolism and died.

Her husband, Mr H, complained to us.

What we found

We found that, having considered the possibility of a DVT, the two GPs did not carry out enough tests to either diagnose or rule this out. This meant there were two missed opportunities to arrange urgent care and follow up, which very likely would have avoided Mrs H having her fatal pulmonary embolism.

Putting it right

Following our investigation the Practice apologised to Mr H and paid him £15,000. It put a plan in place to learn lessons from what happened to avoid the same thing happening again.

In October 2015 the Practice followed up on our investigation and told us that staff are now doing more D-dimer tests (one of the tests for DVT) as a result of their raised awareness of this issue. The Practice reported that it had found DVT in patients where it had not expected to.

Organisation(s) we investigated

A GP practice

Location

Cheshire

Region

North West

Summary 1049/August 2015

Unreasonable withdrawal of treatment

Mr V's treatment was stopped when the Trust said funding was withdrawn.

What happened

For several years, Mr V had been receiving orthopaedic treatment at a number of clinics in Essex for an ongoing problem. The consultant overseeing his care was transferred to a hospital controlled by a Trust in Kent, and Mr V followed him for treatment at that hospital. Although Mr V lived in Essex, and the hospital was outside its normal catchment area, his local commissioning service in Essex, firstly a primary care trust (PCT), then a clinical commissioning group (CCG), continued to pay for his treatment.

Mr V was happy with the treatment he received at the hospital, but at the end of 2013, after around a year, the Kent Trust told Mr V that, as his symptoms had eased for the time being, there would be a natural break in his treatment. It said that as a result of this, the CCG in Essex had withdrawn funding for his treatment and Mr V would need to get any further treatment closer to home.

Mr V thought that the decision to withdraw both his treatment and financial support was both unfair and unreasonable. He also felt it contravened the spirit of the NHS Constitution for England which says patients are able to make informed choices about their healthcare.

What we found

We upheld Mr V's complaint. Mr V's local CCG never withdrew funding, and we are unsure why the Kent Trust wanted to discharge him. Furthermore, having taken clinical advice, we were not convinced by the Trust's opinion that he had reached a natural break in his treatment. We could therefore see no viable reason why his treatment at the Trust was terminated.

Putting it right

The Kent Trust apologised to Mr V and issued an appointment for his continued treatment at its hospital.

Organisation(s) we investigated

East Kent Hospitals University NHS Foundation Trust

Location

Kent

Region

South East

Summary 1050/August 2015

Dental practice failed to refer patient for unresolved bad breath

Mr J had to pay for private treatment because the Dental Practice failed to adequately assess or treat a wisdom tooth that was causing him bad breath.

What happened

Mr J went to his doctor at the beginning of 2013 with bad breath. He said this made him feel anxious and stressed when talking to people.

The doctor examined him and referred him to the dentist. Mr J went to the dentist about five months later saying that he believed the odour in his mouth was caused by an impacted wisdom tooth. The dentist examined the tooth but found no evidence to suggest this was the case, but did find an overhang from a filling (where filling juts out from a tooth) which could have trapped food and harboured bacteria. The dentist treated this, applied sealant, scaled and polished his teeth and gave him advice on oral hygiene.

Mr J returned to the Dental Practice three months later, still complaining of bad breath. A second dentist examined him but also did not find any evidence that the wisdom tooth was the cause of this. The second dentist did not remove the tooth as there was no clinical reason to do so.

Mr J went back to the Practice early the next year to have a fractured tooth repaired, and was still concerned about his bad breath. He went to a private practice shortly afterwards and had his impacted wisdom tooth removed. He said that the offensive odour disappeared after this.

What we found

We partly upheld this case. The Dental Practice was right not to remove Mr J's wisdom tooth as there was no evidence that it caused the bad breath. This was in line with National Institute for Health and Care Excellence guidelines which state that the evidence for removing a tooth is dental decay where the tooth cannot be restored, tooth fracture or an abscess, and these were not present in this case. However, the Practice should have referred him to an NHS specialist in the light of his continuing problems with bad breath. Because the Practice did not do this, Mr J had to pay for treatment privately.

Putting it right

The Practice apologised to Mr J, reimbursed him £475 for the cost of his private treatment and paid him £200 for the injustice this caused him. The Practice wrote to us and to Mr J to explain what it had learned from the complaint, and how it now refers patients to a specialist when symptoms continue and no cause can be found.

Organisation(s) we investigated

A dental practice

Location

Birmingham

Region

West Midlands

Summary 1051/August 2015

Gender reassignment operation delayed because of poor communication

Poor communication between surgeons led to delay of several months for transgender patient's operation, causing him additional anxiety.

What happened

Mr S, who was born a female, identified throughout his life as a male. He had begun the gender reassignment process, and the next step in the process involved the removal of his female reproduction organs. As Mr S was anxious to have the operation as soon as possible, for personal as well as medical reasons, his GP referred him to a private hospital run by BMI Healthcare to have this carried out on the NHS. The GP chose this hospital specifically because the consultant gynaecologist was able to carry out the procedure laparoscopically (through keyhole surgery), and also to reduce the waiting time for surgery.

The hospital then had to change the consultant surgeon, and when Mr S saw a second consultant surgeon, they only had a brief discussion about the operation.

Mr S found out that the second surgeon was not able to carry out the procedure by keyhole surgery, and that the surgeon would have to make an open incision to perform Mr S's operation. The surgeon agreed to see if he could find another surgeon who could do the procedure by keyhole surgery, but did not get back to Mr S on this.

As Mr S was keen to proceed with the gender reassignment process (which had begun three years previously), and was worried about delays to the operation, he agreed to let the second surgeon do the operation. On the day of the operation, when the surgeon went to get Mr S's consent for the procedure, it became clear that he would not be able to fully remove all of Mr S's female reproductive system, and so the operation was cancelled.

Mr S went on to have the full procedure done elsewhere some months later. However, he said he had to put his life on hold while waiting for the operation and the full process to be completed, and this caused him additional anxiety.

What we found

We partly upheld the complaint. There was poor communication between the first surgeon, the second surgeon and Mr S, and not all the specific details that Mr S discussed with them were recorded in his notes. This meant that when the operation was due to take place, it became clear that Mr S expected some specific procedures would be done which the second surgeon did not have the competency to do. Mr S had also made attempts to contact the second surgeon between his consultation with him and the day of the operation, but this was unsuccessful.

We found failings in communication between both surgeons and the patient, and we did not think that the hospital had taken adequate steps to make sure that these failings did not recur.

Putting it right

The hospital wrote to Mr S to apologise for the failings we identified, and improved the communication issues we highlighted.

Organisation(s) we investigated

BMI Healthcare

Location

Greater London

Region

London

Summary 1052/August 2015

Decision to discharge patient may have contributed to his death

The Trust discharged Mr H after he went to A&E with chest pain, and he died two days later. His son complained to the Trust but was not happy with its response.

What happened

Mr H went to A&E in autumn 2013 with chest pains and shortness of breath. Following assessment, the doctor discharged him with a referral to the Trust's outpatient Rapid Access Chest Pain Clinic. Mr H died at home two days later.

One month later, and again in spring 2014, Mr H's son complained to the Trust. He raised concerns about the decision to discharge his father and asked for details of his assessment, diagnosis and treatment.

In its responses, the Trust gave an account of what had happened in A&E, including the examination and tests that it carried out. This included a troponin test (a test that measures proteins in the blood which are released when the heart muscle has been damaged).

The Trust acknowledged that it would have been more appropriate to admit Mr H to hospital, and refer him to the medical team for further investigation into the cause of his chest pain. The Trust explained the actions it had subsequently taken to address its failing.

Mr H's son was dissatisfied with the Trust's responses and asked us to investigate his complaint.

What we found

The doctor who assessed Mr H in A&E should have sought a senior doctor to sign off his findings, in line with National Institute for Health and Care Excellence guidance. Although Mr H's initial troponin test was normal, the doctor should have repeated this test, in line with European Society of Cardiology (ESC) guidance, when he suspected Mr H was suffering from acute coronary syndrome (ACS). This did not happen.

While we cannot know whether Mr H would still have died if he had been admitted to hospital, there was a missed opportunity for him to have a second troponin test. Although we do not know what the outcome of this test would have been, it may have given information about protein levels which, if acted upon, could have increased his chances of survival.

Putting it right

Following our investigation the Trust acknowledged and apologised for its failings with regard to its decision to discharge Mr H. It paid Mr H's son £1,000 for the distress it had caused him by not repeating the troponin test, and for the uncertainty of not knowing whether the outcome could have been different for his father.

The Trust also prepared an action plan to make sure medical staff follow the Trust's policy for managing patients with suspected ACS in line with NHS Emergency Medicine Quality Indicators.

Organisation(s) we investigated

Lewisham and Greenwich NHS Trust

Location

Greater London

Region

London

Summary 1053/August 2015

Poor nursing care in the community

District nurses failed to treat an ulcer on an older woman's leg, or notice that she had developed another one on her other leg.

What happened

Mr B complained to the Trust on behalf of his mother Mrs B, who was in her eighties, about the district nursing care she received over a two-month period in autumn 2013, for an ulcer on her leg.

Mr B said that he was concerned the nurses did not care for his mother properly. He also said they did not notice or treat an ulcer that had developed on her other leg during this time.

He complained to the Trust and said it did not fully recognise the pain and suffering his mother experienced. The Trust said that it had made improvements to the service as a result of his complaint, but Mr B was still unhappy about his mother's care. Mrs B died early the next year.

Mr B said the Trust continued not to recognise the anguish both he and his mother experienced as a result of its poor care and treatment, so he brought the complaint to us.

What we found

When Mr B complained to the Trust it held a local resolution meeting and admitted to many failings. These included the way Mrs B's care was co-ordinated, that procedures were not followed, and that it had not identified the complexity of Mrs B's needs. It apologised for these failings and put action plans in place so that it could learn from these mistakes.

However, we identified more significant failings in basic nursing care that it had not previously addressed: in wound care management, pain assessment, record keeping, and communication with Mr B and his mother. Therefore, the improvements the Trust had made had not gone far enough.

The Trust's lack of good record keeping left Mr B without clear explanations for what happened, and its lack of communication caused Mr B and his mother unnecessary worry, reducing their confidence in the district nursing team.

Putting it right

The Trust acknowledged the failings we found, apologised to Mr B, and paid him £500 in recognition of the anguish and distress these events had caused him and his mother.

The Trust produced an action plan to make sure that it learned from the failings in basic nursing care. This included a review of its own wound assessment policy with a reference to national guidance. It also prepared an action plan to improve its record keeping. The Trust did this work as well as the improvements it had already made following Mr B's original complaint.

Organisation(s) we investigated

North East London NHS Foundation Trust

Location

Greater London

Region

London

Summary 1054/August 2015

Surgeon operated on breast unnecessarily

Ms A expected to have an operation to remove a cluster of painful cysts from her breast, but the surgeon did a different, unnecessary operation.

What happened

Ms A went into hospital to have painful cysts removed from her breast. An ultrasound scan highlighted the specific area of cysts to be removed and showed the rest of the breast tissue was normal.

Before the operation, the anaesthetist drew a circle around the area and Ms A consented to the procedure. When Ms A woke from the operation, the surgeon had operated on a different area of her breast and had not touched the cluster of cysts. She was unable to ask the surgeon about this as he left the hospital after the operation, and did not return to explain what had happened.

Ms A was left with a scar on her breast and spent the two weeks before her clinic appointment not knowing whether the surgeon had found a cancerous lump. At that appointment the surgeon was unable to explain to Ms A why it was necessary to operate in a different area of her breast, and why he had removed a different lump that he had found. This was very distressing for Ms A as she'll never know exactly what happened or why.

Ms A had to have another operation three weeks later to remove the cysts, and is now left with two scars on her breast. She said this has significantly affected her self-confidence and body image, leaving her with lasting emotional and physical damage.

What we found

Ms A had an unnecessary operation on her breast and the Trust had not recognised that was the case. The Trust said that a surgeon could take action if they found something during the procedure that they felt could be life threatening. But this explanation was not relevant in this case because the operation was not necessary.

Also, the surgeon had not explained to Ms A what had happened immediately after the surgery, and he should have done so.

Putting it right

Following our investigation the Trust wrote to Ms A. It said it recognised that the surgery was not necessary and apologised for the upset and distress she suffered, and continues to suffer, because of this. The Trust also paid Ms A £3,000 in recognition of the upset and uncertainty, and the permanent scar she now has.

The Trust prepared an action plan to set out what it had learned from the failings, how it would avoid a recurrence of the same failings, and how it would monitor staff's compliance with these actions.

We also recommended the Trust contact the surgeon, who has since retired and lives abroad, to ask for a personal apology and explanation.

Organisation(s) we investigated

Barking, Havering and Redbridge University Hospitals NHS Trust

Location

Essex

Region

East

Summary 1055/August 2015

42-week wait for knee replacement surgery

Mrs F was on a waiting list for a knee replacement. But instead of having her surgery within 18 weeks, as set out in the *NHS Constitution*, Mrs F waited for 42 weeks for her operation and was in pain during this time.

What happened

Mrs F's GP referred her for knee replacement surgery in summer 2012. The Trust assessed her and put her on the waiting list one month later. She went for another assessment and expected surgery later that year, but heard nothing from the Trust. Despite following this up several times with the orthopaedic team and the Patient Advice and Liaison Service team, she was still not admitted for surgery. The Trust sent her a letter saying delays were partly due to a backlog of operations from the previous winter.

Mrs F told us that during this time she experienced pain and frustration, and that she also developed ankle swelling for which she needed treatment.

The Trust eventually admitted Mrs F in early summer 2013, but postponed her operation because of her high blood pressure. While the decision to postpone the operation was good practice from a clinical point of view, by that point Mrs F had already been waiting 42 weeks. The Trust arranged for her GP to treat her blood pressure, and Mrs F had the surgery three months later.

What we found

The *NHS Constitution* says: '*You have the legal right to start your NHS consultant-led treatment within a maximum of 18 weeks from referral, unless you choose to wait longer or it is clinically appropriate that you wait longer*'.

This did not happen in Mrs F's case. There were failings by the Trust as there was a significant delay in arranging Mrs F's operation and poor communication with her over what was happening with her treatment. The Trust's explanation that '*winter pressures*' were the cause of the delay was unacceptable because Mrs F was not referred until July, long after the previous winter's pressures would have tailed off.

These failings caused Mrs F unnecessary frustration and anxiety while waiting for surgery, and prolonged her pain for a significant period of time. However, we did not find that the delay caused Mrs F's later ankle swelling.

Putting it right

The Trust apologised to Mrs F and paid her £1,000 in recognition of the failings we found. It also produced an action plan to improve waiting times and communication with patients.

Organisation(s) we investigated

James Paget University Hospitals NHS Foundation Trust

Location

Norfolk

Region

East

Summary 1056/August 2015

Specialist cancer care may have helped with pain

Miss J thought her mother was dying, and so felt her hospital treatment was unnecessary and that she should have been given palliative care.

What happened

Mrs W was in her late forties when she was diagnosed with a large bladder cancer. She went into hospital in winter 2013 for invasive treatment to enable her to have chemotherapy. The chemotherapy would shrink the cancer so that doctors could remove it. Mrs W had the treatment but became more unwell, and did not go on to have the chemotherapy and surgery. She died just over two weeks later.

Miss J, her daughter, complained to the Trust about her mother's treatment. She said that hospital staff should have known Mrs W was dying and given her palliative care. She said that if her mother had known that the invasive treatment was not going to help cure her, she would not have wanted to go through with it. Miss J also said that staff did not give her mother enough pain relief for the cancer, particularly towards the end of her life.

Miss J said that failings in Mrs W's care meant that she died in an undignified way, which caused the family a lot of distress.

The Trust acknowledged some failings in Mrs W's care but said that overall it believed her care was appropriate. Miss W was unhappy with this, and so she came to us.

What we found

Although Mrs W was seriously ill when she went into hospital, it was not clear that she was dying. The Trust's plan to treat her was appropriate, but it should have arranged for specialist cancer services to be involved in her care. Those services could have helped Mrs W and her family understand and cope with what was happening. Also Mrs W's pain relief fell below an adequate standard.

The Trust has since taken action to improve the care it gives patients like Mrs W who are seriously ill and may not recover.

Putting it right

The Trust apologised to Miss W and acknowledged that Mrs W's care fell below an acceptable standard. It paid Miss J £250 in recognition of her distress at seeing her mother in avoidable pain.

Organisation(s) we investigated

Worcestershire Acute Hospitals NHS Trust

Location

Worcestershire

Region

West Midlands

Summary 1057/August 2015

Trust failed to take action when it suspected sepsis

Staff suspected Mrs P had sepsis but did not diagnose and treat this until she went to intensive care.

What happened

Mrs P was readmitted to hospital as an emergency after minor orthopaedic surgery. She deteriorated, and after various medical investigations in A&E, doctors found that she had possibly developed sepsis but they failed to escalate their concerns to more senior staff.

The next morning doctors in A&E conducted their morning review and should have realised Mrs P was very ill. There were signs of sepsis, but the consultant failed to note this or act on it. Mrs P deteriorated during the day and 12 hours later doctors suspected she had sepsis and transferred her to intensive care. She was then diagnosed with severe sepsis and began antibiotic treatment. Despite this, she suffered cardiac arrests and died.

Mr P complained to the Trust as he believed his wife's life could have been saved. He raised several issues, including that Mrs P was inappropriately discharged after her orthopaedic surgery and this led to her emergency readmission.

The Trust conducted a Serious Untoward Incident (SUI) investigation and found many shortfalls. It said doctors failed to escalate concerns about Mrs P's condition to senior colleagues when she was in A&E, the consultant in A&E did not act on signs of sepsis and start treatment, and there was poor communication between staff.

It shared its action plan and recommendations with Mr P but he was not satisfied with the thoroughness of the answers he received, and came to us.

What we found

We partly upheld this complaint. The Trust had already carried out a thorough SUI investigation with senior clinical staff and agreed it had failed to escalate concerns about possible sepsis, or to appreciate the severity of Mrs P's condition. We agreed that the Trust had identified the main shortfalls, but we found the actions the Trust had taken to prevent a recurrence centred mainly on nursing staff rather than the doctors, including the consultant. We therefore recommended the Trust address this with the doctors, and take further action to reinforce what it had learned from its SUI.

We did not uphold Mr P's complaint that his wife had been inappropriately discharged.

We concluded that the Trust had the opportunity to treat the sepsis but did not do so. This caused Mr P distress, as there remained the possibility that there could have been a better outcome for Mrs P if doctors had treated the sepsis earlier, but we could not say that Mrs P's life could have been saved.

Putting it right

The Trust discussed the case in a clinical governance meeting and raised our findings in the consultant's appraisal process.

Organisation(s) we investigated

Brighton and Sussex University Hospitals NHS Trust

Location

Brighton & Hove

Region

South East

Summary 1058/August 2015

Patient's blood clot missed in A&E

The Trust should have done further tests to check for a blood clot on Mrs N's lung before discharging her.

What happened

Mrs N went to her local A&E department because she was feeling unwell. A doctor examined her and said she could go home. She remained unwell, and saw another doctor privately who diagnosed her with a pulmonary embolism (a blood clot in the lung) a week later. Mrs N was distressed that the Trust had left her without treatment for a potentially serious problem.

Mrs N complained to the Trust. It accepted that it should have carried out further tests to check whether she had a clot, and also sent her statements from the doctors involved in her care. Mrs N was unhappy with the Trust's explanations and the time it took to respond to her complaint, so she came to us.

What we found

We partly upheld this case. The Trust should have done further tests to look for a blood clot before discharging Mrs N. It was appropriate for the Trust to acknowledge that, but it had not explained what it had done to stop something similar from happening again.

The Trust took too long to respond to Mrs N's complaint and the doctors' statements that it sent to her were contradictory. It should have clarified which statement it considered accurate.

However, the doctor who saw Mrs N in A&E told her to come back to hospital if she was still unwell. If she had done so, we thought that the Trust would most likely have found her clot then.

Putting it right

The Trust paid Mrs N £100 in recognition of the avoidable distress she experienced, and apologised for the shortcomings in its handling of the complaint. It also produced an action plan to show how it would stop something similar from happening again.

Organisation(s) we investigated

Dartford and Gravesham NHS Trust

Location

Kent

Region

South East

Summary 1059/August 2015

Hospital missed opportunities to save man's sight

Mr G went to the Trust's emergency Eye Clinic with complications after an eye operation. He had treatment but lost the sight in his eye and is now registered as severely sight impaired.

What happened

Mr G had eye surgery in autumn 2014. A few days later he suffered eye pain that got worse and was violently sick. He went to the Eye Clinic for an emergency appointment.

An ophthalmologist treated Mr G with medication to reduce the pressure in his eye. The ophthalmologist discharged him although there was no evidence that the treatment had worked, and referred him for an outpatient appointment six days later with the consultant who did the surgery.

The consultant reviewed him and found Mr G's eye pressure was still high, but much lower than it had been when the ophthalmologist had seen him. The consultant prescribed more medication and arranged to review Mr G in four days' time.

Mr G's eye pressure reduced slightly but was still higher than it should have been, so the consultant referred him to a glaucoma specialist. The specialist treated him with laser surgery, but this was not successful and Mr G lost the sight in his eye.

Mr G complained that he did not receive appropriate treatment for his symptoms and that this led to the loss of his sight.

What we found

There were significant failings in the ophthalmologist's management of Mr G's severely raised eye pressure. He should have given Mr G more aggressive treatment with intravenous medication, and should not have been discharged until his eye pressure had reduced. We also found that the ophthalmologist should have arranged an early review of Mr G's condition within two days of his discharge. These failings meant opportunities to save Mr G's sight were missed.

Putting it right

The Trust apologised to Mr G for its failings, paid him £5,000 and explained what actions it would take to prevent this happening again.

Organisation(s) we investigated

Ipswich Hospital NHS Trust

Location

Suffolk

Region

East

Summary 1060/August 2015

Possible missed opportunity to prevent suicide

Miss J was admitted to the Trust following her third suicide attempt. But the Trust failed to manage the risks to her health appropriately and Miss J took her own life a few days later.

What happened

Miss J had a history of depression and took an overdose in autumn 2012. She was briefly admitted to the Trust but as she preferred to be cared for by her family she was discharged home under the care of the Crisis and Home Treatment Team (the Crisis Team), and other agencies.

Miss J remained unwell and took a second overdose just over three weeks later. She was again discharged under the care of the Crisis Team. When Miss J deteriorated a few days later she was readmitted and then allowed home on leave a short while later with medication.

A few days afterwards, Miss J made a further suicide attempt. She was admitted to hospital, and assessed as having significant suicidal intent. The Trust reassessed her risk of self-harm as 'low' a few days later and discharged her. Two days later she went missing from home and her mother tried to call the Crisis Team to raise the alarm but nobody answered the phone. Miss J's son found her body the same day; she had hanged herself.

Her sister Mrs K said the Trust did not adequately manage the risks to her sister's health, provide adequate medicine, or enough contact with the family. She believed her sister's suicide might have been avoided if she had received the right level of care. She said the whole family, especially Miss J's son, had been totally devastated by Miss J's death.

What we found

We partly upheld this case. The medication the Trust gave Miss J was in line with recognised quality standards and established good practice and there were no failings. However, the Trust's risk assessments and the way it managed Miss J's care were not reasonable. This meant there were missed opportunities to give her appropriate care and treatment that could have reduced her risk of committing suicide. As a result her family will never know whether appropriate care and treatment might have saved her life.

The family also did not have appropriate access to the Crisis Team. We acknowledged that even if the Crisis Team had answered the phone this would not have prevented the sad events that followed. However, it could have alleviated some of the distress Miss J's sister and mother felt at that time and offered them some support.

Putting it right

The Trust apologised to the family and paid them £2,500 in recognition of the distress caused. It also put a plan in place to learn lessons from its failings and to make sure they do not happen again.

Organisation(s) we investigated

Dorset Healthcare University NHS Foundation Trust

Location

Dorset

Region

South West

Summary 1061/August 2015

Poor root canal treatment caused pain

Mr D said his Dental Practice inadequately completed a root canal procedure and did not give him antibiotics for an infection. He said that he lost two teeth because of this.

What happened

Mr D went to the Dental Practice for a routine check-up. An X-ray revealed an infection in a tooth and the dentist completed root canal treatment. Mr D said that the next day his face was swollen and he had fluid coming out of his mouth. He said he went to hospital and staff prescribed him antibiotics. Mr D complained to the Practice as he said the infection lasted for five months and did not clear up until he had the adjoining tooth removed. Shortly afterwards he also had to have the original tooth out. He said the Practice should have prescribed antibiotics before or at the same time as doing the root canal treatment.

What we found

We partly upheld this complaint. There were failings in the root canal procedure, and the Practice did not advise Mr D of the pros, cons and risks of the treatment. We did not find failings in the Practice's decision not to prescribe antibiotics, but we saw that as a result of the failings in the root canal procedure Mr D suffered pain.

We did not link the loss of the tooth treated and the tooth next to it, to the care and treatment Mr D received. The root canal treatment might have failed to save the tooth anyway, and we did not find the loss of the other tooth was due to any failings on the part of the dentist.

Putting it right

The Practice apologised to Mr D and offered to pay him £250.

Organisation(s) we investigated

A dental practice

Location

Hampshire

Region

South East

Summary 1062/August 2015

Missed opportunities to treat two-year-old child

Doctors missed several opportunities to treat a child before his cardiac arrest and gave him the wrong dose of a controlled antibiotic.

What happened

Mr A's two year old son, C, had Down's Syndrome and suffered from leukaemia. He was admitted to hospital for treatment and had the first of four planned courses of chemotherapy. After this, doctors were keen to operate on C to see if the chemotherapy had worked. But the operation was delayed because of C's repeated infections. Eventually a doctor decided C was fit enough to have an anaesthetic and the operation took place in summer 2012.

C deteriorated over the next three hours and suffered a cardiac arrest (when the heart malfunctions and suddenly stops beating). After this, doctors treated him in intensive care for several weeks and gave him controlled antibiotics. A specialist pharmacy unit prepared the antibiotics, but prepared two doses at five times the dose prescribed. Doctors injected C with the antibiotics and this affected his kidney function, but he recovered from this over time. Doctors could not continue with C's planned chemotherapy course because of his cardiac arrest and damage to his heart.

C died at home in spring 2013. Mr A said he and his wife suffered unnecessary distress because of the Trust's failure to prevent C's cardiac arrest. They believe that because of this C could not continue with chemotherapy and this reduced his chances of recovery. Mr A was also angry about his son being given too much controlled antibiotic.

What we found

We partly upheld this case. The doctor who assessed C did not consider all the facts when he decided that C was fit enough for an anaesthetic. Specifically, he missed that C had been ill during the previous 12 hours. After the operation, nurses monitored him, but they did not escalate concerns to more senior staff when he began to deteriorate. This meant doctors missed several opportunities to treat him.

When doctors did treat him, they gave C opiate medication and shortly afterwards he had a cardiac arrest.

We could not say that the cardiac arrest was avoidable, as it was possible C already had cardiac damage that caused the arrest, but a respiratory cause related to the anaesthetic and made worse by opiates was also possible.

Mr A would never know if adequate assessment, or prompt response to C's deterioration, could have prevented his son's cardiac arrest. However, the subsequent decision to suspend his chemotherapy was correct, given the heart damage that C had suffered.

The Trust had fully accepted that doctors had given C overdoses of antibiotic and investigated the causes of this before Mr A complained to us. It put together a robust action plan to prevent the same thing happening again, which we found was adequate and sufficient.

Putting it right

The Trust acknowledged and apologised for its failings. We recommended it pay Mr A £5,000 and prepare an action plan to make sure that staff learned from the complaint.

Organisation(s) we investigated

Great Ormond Street Hospital for Children NHS Foundation Trust

Location

Greater London

Region

London

Summary 1063/August 2015

Dental practice did not tell patient why it stopped treating him

Mr F wanted a specialist procedure done at the Dental Practice but the dentists said it could not be done. The Practice eventually decided to stop treating him, but did not tell him why.

What happened

Mr F said that his Dental Practice refused to carry out a specialist dental procedure, which he believed should have been done under the NHS. He said that when he raised concerns about this, the Practice without giving him any warning, decided to stop treating him completely. He said he was both shocked and distressed by this.

Mr F said that as a result of being denied any dental treatment, both his oral health and his general health deteriorated which caused him significant pain and discomfort. Mr F also said that when he complained to his local primary care trust (PCT), it supported the Practice.

What we found

We partly upheld this complaint. The dentists at the Practice did not have the necessary skills or equipment to carry out the specialist treatment. Also Mr F could not have the work done under the NHS, as it could only be done privately. Dentists said they explained this to him but he refused to accept their explanations. They gave him options for NHS treatment instead of the specialist treatment, but he refused this. Initially the dentists continued to treat him for other procedures but they eventually concluded that, from their perspective, the relationship with Mr F had broken down.

After discussing the situation with the PCT, the Practice decided to stop treating Mr F. However, due to some confusion over who would communicate this to him, the Practice did not tell Mr F about this decision.

Although Mr F's care and treatment was appropriate, the Practice failed to inform him that it was going to stop treating him, and so we upheld this part of the complaint.

We found no failings in the PCT's response to Mr F's complaint, as the specialist treatment was not available under the NHS. The PCT (now the Area Team) also adequately handled Mr F's complaint and so we did not uphold his complaint about the PCT.

Putting it right

Following our investigation, the Practice wrote to Mr F and apologised for its failure to inform him about the decision to stop treating him.

Organisation(s) we investigated

A dental practice

Surrey and Sussex Area Team

Location

Surrey

Region

South East

Summary 1064/August 2015

Nursing home did not tell son about his mother's discharge from hospital

Mrs W was discharged back to a nursing home after being in hospital but staff at the home did not tell her son until about four hours after she had arrived. She died soon afterwards.

What happened

Mrs W was in her late eighties and had lived in the nursing home since spring 2010. She had severe vascular dementia and needed help with eating and drinking at all times. Doctors prescribed her a sedative to help with her agitated behaviour but this left her drowsy and unable to swallow. Mrs W's son, Mr W, said he raised concerns that staff did not supervise his mother properly at mealtimes, particularly given her drowsiness. He said staff did not listen or act on his concerns about this.

In spring 2012 Mrs W developed aspiration pneumonia (inflammation of the lungs that can be caused by breathing in particles of food) and was taken to hospital. She was discharged back to the nursing home five days later but it wasn't until four hours after she arrived that staff told Mr W this. Mrs W's condition deteriorated and she died about one hour later.

Mr W believed that his mother's death could have been avoided if the nursing home had listened and acted upon his concerns about her swallowing difficulties. He said that he was greatly upset and distressed by her death, and that staff did not tell him as soon as she returned from hospital, so that he could have been with her when she died.

What we found

We partly upheld this case. There was insufficient evidence that nursing home staff gave Mrs W sedatives inappropriately. We did not find that staff failed to act on Mr W's concerns about his mother's swallowing difficulties or to monitor Mrs W properly while she ate.

However, staff should have told Mr W that his mother had returned to the nursing home after her discharge from hospital. This failure meant Mr W suffered unnecessary distress.

Putting it right

The nursing home acknowledged its failing and apologised to Mr W for the distress he experienced.

Organisation(s) we investigated

A nursing home

Location

Cambridgeshire

Region

East

Summary 1065/August 2015

Hospital unfairly detained man under the *Mental Capacity Act*

A hospital held Mr M for 24 hours until a psychiatrist could see him, when it should have assessed him immediately.

What happened

Mr M was admitted to hospital with a medical problem. He had no history of psychiatric illness. Soon after admission Mr M began to behave unusually and staff were concerned for his welfare. Four days later, he got dressed and left the ward, telling staff that he intended to walk home (a distance of ten miles). Staff followed him as he left the hospital and the hospital grounds. Mr M's doctor decided that Mr M should be brought back to the ward until he could be assessed by a psychiatrist. Staff called the police and hospital security staff to help with this, and Mr M was detained on the ward overnight. The next day a psychiatrist assessed him, declared him medically fit and discharged him home soon afterwards.

Mr M complained that his detention was unfair and that he was not told what was happening. He also complained about the way he was restrained when he attempted to leave the hospital, and said that he sustained injuries as a result of this. He said staff delayed assessing these injuries, and also took away his emergency medicine when he was eventually discharged.

What we found

It was not unreasonable that Mr M was brought back to the hospital when he attempted to leave. However, his mental capacity should have been assessed immediately, and a senior medical doctor on the ward could have done this.

Instead clinical staff decided to detain Mr M under the *Mental Capacity Act* until he could be assessed by a psychiatrist, which took 24 hours. This delay in assessing Mr M's mental capacity, and his detention under the *Mental Capacity Act,* was a failure in service.

There was no evidence to support Mr M's other complaints.

Putting it right

The Trust apologised to Mr M and told us and Mr M what it had learned from the failure we found. It reinforced the need for all staff to make clear mental capacity assessments in health records, and gave them mandatory training on the *Mental Capacity Act* and the *Deprivation of Liberty Safeguards*.

Mr M wanted to insert a statement into his hospital records to say that he disagreed with the Trust's version of his complaints, and the Trust agreed to this.

Organisation(s) we investigated

Gloucestershire Hospitals NHS Foundation Trust

Location

Gloucestershire

Region

South West

Summary 1066/August 2015

Trust did not follow guidance for investigating hip pain

Trust failed to follow guidance for one aspect of its care and treatment of a lady who fell and sustained fractures to her wrist and pelvis.

What happened

Mrs R fell and went to A&E. Staff X-rayed her shoulder and wrist and discharged her with painkillers. The radiologist, looked at the X-rays, saw a small wrist fracture and emailed A&E promptly with the result. A&E did not contact Mrs R as it should have done and so did not follow up on the wrist fracture.

Mrs R returned the next week as she had a pain in her groin. Staff X-rayed her pelvis and hip, but did not find any fractures. At the same time the doctor noticed the previous X-rays of her wrist and treated it with a plaster cast and painkillers.

About three months later she still had pain in her hip and her GP referred her to another hospital for a second opinion. Doctors diagnosed a pelvic fracture. Mrs R was advised to keep mobile and manage any pain with painkillers, as this was the only treatment.

Mrs R had physiotherapy care for wrist and shoulder pain from the Trust but said she was discharged inappropriately. She complained to the Trust about this, and about the missed diagnoses of the wrist and pelvic fractures. Although the Trust apologised to her, she was not satisfied as she believed she had suffered '*life time damage*' to her wrist.

What we found

We partly upheld this case. We found that the Trust acted in line with established good practice when treating Mrs P's wrist, which had a slight fracture, and in her physiotherapy care. We did not consider it a failing for the Trust to have missed the pelvic fracture, as it was extremely difficult to see, but it should have followed the guidance on investigating hip pain by carrying out a scan. Mrs R had probably experienced some additional pain, as well as anxiety about the cause, but her treatment would have been the same in any event.

Putting it right

The Trust apologised to Mrs R for failing to make further investigations into her hip pain and for the anxiety and distress this caused her. It agreed to learn from the case and show how it would follow relevant guidance on fractures.

Organisation(s) we investigated

Sandwell and West Birmingham Hospitals NHS Trust

Location

West Midlands

Region

West Midlands

Summary 1067/August 2015

Poor nursing care for a disabled man

Staff did not carry out required assessments and risk planning, and senior nursing staff failed to identify serious incidents on two occasions.

What happened

Mr S is profoundly disabled and carers help him at home with 24 hour support and care. In 2013 he was admitted to hospital with a chest infection. His carers went with him to hospital to help with his routine care.

Mr S's health deteriorated while he was in hospital. He said that this was due to the poor medical treatment he received and the errors and oversights in his nursing care. He said there was poor communication with the nurses, a risk of pressure sores, and staff kept inaccurate records. Mr S eventually recovered and was discharged home.

Mr S complained to the Trust and received a response within three months. He raised a number of other issues in relation to the Trust's response and it was 11 months before the Trust addressed these points. He said these delays were avoidable, and complained to us.

What we found

We partly upheld this complaint. The medical care that Mr S received conformed to national standards, and the deterioration in his health in hospital could not be blamed on any acts or omissions on the part of doctors.

However, there were a number of shortcomings in Mr S's nursing care. Because nurses were content to allow Mr S's carers to provide his care, they failed to do the necessary assessment and risk planning. This was an integral part of their role and was particularly important as Mr S was disabled.

There were discrepancies in some of the nursing records. Fortunately, this did not have serious implications for Mr S although it was immensely frustrating for his carers.

Senior nursing staff failed to flag up two serious incidents that were similar in nature and compromised Mr S's safety. If staff had noted the first one, the second one may have been prevented.

The delays during the complaints process were excessive and avoidable.

Putting it right

The Trust acknowledged its failings and apologised to Mr S. It put together an action plan to show that it had learned from its mistakes so that they would not happen again.

Organisation(s) we investigated

University Hospital Southampton NHS Foundation Trust

Location

Southampton

Region

South of England

Summary 1068/August 2015

Failure to follow *Mental Health Act* code of practice

Doctors did not assess whether Mr B had the capacity to make decisions for himself, so he did not have information about taking a drug with side effects.

What happened

Mr B became ill while staying with his mother in a different part of the country, and was admitted to hospital to have his appendix removed. Doctors discharged him on antibiotics and soon after this he experienced prolonged insomnia and increasing agitation.

Eight days after his discharge, in extreme agitation, he was taken back to the Hospital, diagnosed with an acute psychotic episode and sectioned under the *Mental Health Act*. He had never had any previous mental health problems.

The Hospital then transferred him several hundred miles to a mental health trust near his own home, under escort by a private security firm. When he arrived, doctors assessed him but could not find any clear physical cause for the episode. They prescribed him Olanzapine (an anti-psychotic medication) and discharged him. He had to inform the Driver and Vehicle Licencing Authority (DVLA) about the psychotic episode, and his full licence was withdrawn.

Mr B gradually stopped taking Olanzapine several months later and had very unpleasant withdrawal symptoms, including acute insomnia.

Mr B complained to us that he had suffered an allergic reaction to the medication after his appendix operation and said the Hospital failed to pick up on this. He said the allergic reaction had caused the psychotic episode which had led to his driver's licence being withdrawn. He said the Hospital told him he had been transferred to the Mental Health Trust by police escort and the Mental Health Trust did not tell him about the side effects of Olanzapine.

What we found

We partly upheld this complaint. The treatment Mr B received from the Hospital had been appropriate and when he complained, its response was largely reasonable. However, it had wrongly told him that he had been transferred to the Mental Health Trust under police escort, when it had been by a private security firm.

The Mental Health Trust acted in line with good practice in trying to reach a diagnosis about his psychotic episode, but doctors could not find what caused it. Antibiotic-related psychotic episodes are rare and we did not think it was unreasonable that the Hospital had not reported this as a possible adverse drug reaction.

However, the Mental Health Trust did not assess whether Mr B had the capacity to make decisions for himself at the time it prescribed Olanzapine. This was a breach of the *Mental Health Act* code of practice and caused Mr B distress. If this had been done, doctors would have given him information about the drug's possible withdrawal symptoms, and he could have decided whether he wanted to take it. However, we did not think that the Mental Health Trust would have been able to predict the severity of the withdrawal symptoms he subsequently experienced.

We thought the Mental Health Trust communicated appropriately with the DVLA when it asked for information about renewing Mr B's licence, and although there had been some delays in issuing and renewing his yearly licence, these were not the fault of the Trust.

Putting it right

The Hospital apologised for wrongly informing Mr B that he had been transported to the Mental Health Trust under police escort.

The Mental Health Trust apologised for failing to adhere to the *Mental Health Act* code of practice. It produced an action plan to make sure it learned from these events, and added a written note to his medical records incorporating Mr B's views on the cause of his psychotic episode.

Organisation(s) we investigated

University Hospital of South Manchester NHS Foundation Trust (the Hospital)

Sussex Partnership NHS Foundation Trust (the Mental Health Trust)

Location

Greater Manchester and West Sussex

Region

North West and South East

Summary 1069/August 2015

13-hour wait in A&E before transfer to medical unit

Hospital took too long to transfer patient from A&E to the acute medical unit. Staff then moved him to a ward but didn't tell his family.

What happened

Mr L went to A&E and staff decided he should be admitted to an acute medical unit. However, it was a 13-hour wait before he was transferred. Mr L was also concerned about the overcrowding and lack of cleanliness in A&E.

After moving him to the acute medical unit, staff then moved Mr L to a medical ward at midnight, but did not tell his family. Mr L and his family said because of this they had lost confidence in the hospital.

What we found

We partly upheld this complaint. Although the Trust had a plan to manage waiting times it did not effectively put it into place. This meant that it did not take steps to reduce the overcrowding in A&E when Mr L was there.

As Mr L was moved to a ward at midnight, it was reasonable that nurses on the unit did not tell the family at the time. It is not clear from the records whether nurses on the acute medical unit told their colleagues on the ward that the family needed to be contacted, or whether nurses on the ward just assumed the family had been told. In any event, the family were not told of the transfer.

This was a failing. When staff transfer a patient to another ward, it is established good practice and national guidance to include non-clinical information, such as communication with family, along with clinical information.

Putting it right

Following our investigation the Trust conducted regular inspections of A&E to make sure standards of cleanliness were being met.

It also produced action plans to make sure its plans and procedures for managing waiting times and overcrowding in A&E were put in place, and that non-medical information as well as medical information is transferred with the patient if they are moved to another ward.

Organisation(s) we investigated

University Hospitals of North Midlands NHS Trust

Location

Stoke-on-Trent

Region

West Midlands

Summary 1070/August 2015

Trust did not communicate well with carer, which caused unnecessary distress

There were failings in the way nursing staff communicated with a stroke patient's carer, and they did not give her appropriate information about her rights.

What happened

Mr A was admitted to hospital following a stroke. While he was in hospital, staff left a letter for Mr A inviting his family to meet the stroke specialist nurse. Mrs G, his partner and full time carer, said she did not receive this letter so no one could take up this offer. However, it was clearly recorded in the notes that it was left with Mr A. This was the ward procedure at the time.

Mrs G was entitled to a carer's badge, but staff did not tell her about this. She also experienced problems when she tried to arrange an appointment with a consultant to discuss Mr A's condition. Mr A died in hospital shortly afterwards.

Mrs G complained to the Trust about Mr A's care as well as how she was treated. But she was not happy with its response so she came to us.

What we found

We partly upheld this complaint. There were no failings in the care the Trust provided to Mr A. However, staff did not give Mrs G information about her rights as a carer, including that she was allowed to visit 24 hours a day, and entitled to hospital accommodation and reduced priced parking. This meant that Mrs G could not be with Mr A as much as she would have liked.

The letter informing Mr A's family about the stroke team was not passed on, which meant Mrs G did not know who to speak to about Mr A's care.

After Mrs G complained to the Trust it identified some changes it should make but it had not put these into action, particularly about how it could improve the way patients make appointments with consultants.

The Trust had already accepted its failings and taken reasonable steps to improve the service for carers. However, although it had received other complaints about providing information about contacting the stroke team, it had still not come up with a solution to the problem.

Putting it right

The Trust agreed to give relatives details of the stroke team when appropriate, and to offer meetings with the consultant within a set time frame.

Organisation(s) we investigated

Gloucestershire Hospitals NHS Foundation Trust

Location

Gloucestershire

Region

South West

Summary 1071/August 2015

Dentist gave inappropriate treatment at patient's request

Mr J insisted on a certain kind of temporary treatment for his tooth and the dentist went ahead with it, although she should have refused to do this and treated Mr J correctly.

What happened

Mr J had a cracked tooth. He went to a dental hospital for emergency treatment and a dentist put in a temporary filling. He made an appointment to see his own dentist but had to cancel several appointments. When he went to the Dental Practice he asked the dentist to top up the temporary filling with a permanent one. The dentist was reluctant to do so, but went ahead because Mr J insisted.

The same day, the Dental Practice wrote to Mr J saying it had removed him from its list of patients due to a perceived breakdown in the patient/dentist relationship, and Mr J's failure to attend appointments. Mr J later had pain in the tooth and had it taken out at a dental hospital.

Mr J complained about his removal from the Practice's list and about the care and treatment he received from the dentist.

He said he had been left without a dentist for some time, suffered pain, and lost the tooth.

What we found

We partly upheld this case. The Practice had removed Mr J appropriately and followed correct procedures. There was a breakdown in the patient/dentist relationship, and Mr J had cancelled a number of previous appointments.

However, the dentist should have X-rayed the tooth, removed the temporary filling, and replaced it with a permanent filling. If the dentist was reluctant to carry out the treatment Mr J wanted, she should have refused to treat him rather than carry out inappropriate treatment. There was therefore a failing in the care and treatment the dentist provided for Mr J. While we could link the lack of care and treatment to the pain Mr J subsequently experienced, we could not directly link it to the need for extracting the tooth.

Putting it right

The Practice apologised to Mr J and paid him £250 for the pain he experienced.

Organisation(s) we investigated

A dental practice

Location

Greater Manchester

Region

North West

Summary 1072/August 2015

GP practice gave poor standard of blood-thinning treatment

Staff took too long to get the dose of a blood-thinning medicine right, and should have discussed Mrs R's care with senior staff.

What happened

Mrs R was treated in hospital for a blood clot in her lung. Doctors gave her warfarin, a medicine to thin her blood and prevent another clot from forming. After her discharge, Mrs R's blood was not thin enough which meant there was a risk she might suffer further clots. She continued to receive warfarin from her GP Practice and doctors slowly increased her dose to thin her blood. It took around five weeks for Mrs R's blood to reach the target set by the doctors in hospital.

Mrs R complained to us about the Practice. She said that the GP she saw did not properly arrange diagnosis and treatment of her symptoms. She said that the Practice did not give her the right blood-thinning treatment after she was discharged from hospital. Mrs R said that she had suffered distress, frustration and inconvenience because of failings in her care, and that the Practice did not handle her complaint well.

What we found

We partly upheld Mrs R's complaint. The Practice took too long to get Mrs R's dose of warfarin right. The staff treating her should have discussed her care with more senior staff to decide how to treat her effectively.

We did not find that Mrs R suffered serious health problems because of what the Practice had done, but it was clear that she had been worried and upset while her treatment was not having the required effect.

Putting it right

The Practice had already taken appropriate action to improve how it manages patients' blood-thinning treatment. It apologised to Mrs R for the upset she had experienced as a result of the failing in her care, and acknowledged that the treatment was poor.

Organisation(s) we investigated

A GP practice

Location

Kent

Region

South East

Summary 1073/August 2015

Trust diagnosed Alzheimer's disease in reasonable time

The time taken to assess, diagnose and give medication to a patient with Alzheimer's disease was appropriate and delays could not be attributed to Trust.

What happened

Mrs T's GP first referred her to the Memory Clinic (which is run by the Trust and helps people with dementia), in spring 2011. The Clinic offered her an appointment shortly after, but Mr T, acting on his wife's behalf, declined this.

Her GP referred Mrs T to the Clinic again four months later. A consultant psychiatrist saw her after two weeks and carried out an initial assessment of her condition. His first impression was that she had mild dementia caused by vascular (blood vessel) changes and Alzheimer's disease. He asked for an MRI (magnetic resonance imaging) scan of Mrs T's brain as well as blood tests, and an ECG (electrocardiogram, a test that measures the electrical activity of the heart). The plan was to review her once these investigations had been completed.

Unfortunately, due to ongoing issues with her lungs, Mrs T was not able to have the MRI scan. When the consultant knew this in autumn 2011 he asked for a CT (computerised tomography) scan of her head instead. Staff did this a few weeks later.

Shortly afterwards, Mr T contacted the Trust to ask for an appointment with the consultant. The consultant offered Mr and Mrs T an appointment for a week later, to discuss the results of Mrs T's investigations and her ongoing care. However, Mr T declined this appointment as he said he had lost confidence in the consultant.

Mrs T's GP subsequently contacted the Trust to ask for a second opinion. The Trust turned down this request as it said it would complicate matters for another clinician to become involved at that stage, as the consultant had not even provided a diagnosis.

The consultant psychiatrist saw Mrs T early the next year and confirmed a diagnosis of dementia caused by vascular changes and Alzheimer's disease, and he prescribed her rivastigmine, an anti-dementia medication. Mrs T passed away one week after the appointment.

Six months later, in summer 2012, Mr T complained to the Trust about how long it had taken to diagnose his wife's Alzheimer's disease and begin her medication. He did not believe that she received appropriate care and he said that as a result of this he had to see her suffer. He also complained that the consultant ignored his requests for support, guidance and a second opinion about his wife's condition. He said that he was left feeling frustrated and '*out on his own*'.

Mr T and the Trust corresponded until summer 2014, but Mr T was unhappy with the Trust's responses and came to us.

What we found

We did not uphold this complaint. The Trust had not failed in the time it took to assess, diagnose and give Mrs T medication. Her care and treatment was reasonable and in line with established good practice.

About six months passed from Mrs T first seeing the consultant to receiving a diagnosis and medication. While there were some delays during this time, these could not reasonably be attributed to the Trust. Delays occurred because of matters outside its control, or by Mr and Mrs T's lack of engagement.

The Trust had given a good reason for not offering Mr and Mrs T a second opinion, and gave them support and guidance.

Organisation(s) we investigated

North Essex Partnership University NHS Foundation Trust

Location

Essex

Region

East

Summary 1074/September 2015

Trust did not meet woman's nutritional needs

Ms Q complained that the Trust did not give her mother, Mrs U, enough food and drink during several hospital admissions; discharged her from hospital when she was unfit; and put her on the Liverpool Care Pathway (a way of managing her care at the end of her life) without telling her family. Ms Q also complained about the way the Trust communicated with her.

What happened

Mrs U was admitted to hospital three times in four months with diarrhoea and vomiting. In hospital her food and fluid intake decreased and she lost weight. Mrs U became increasingly unwell and on her third admission she developed an infection. Mrs U died during her third admission.

What we found

We upheld some parts of Ms Q's complaint. The Trust did not properly assess Mrs U's nutritional needs and it did not consider other feeding methods. It also discharged her from hospital when she was not fit to be discharged, and discussions with Mrs U and her family about end of life care were poor.

We were unable to reach a conclusion about the way the Trust had communicated with Ms Q.

Putting it right

The Trust apologised to Ms Q and produced an action plan which demonstrated the changes it had made as a result of her complaint.

Organisation(s) we investigated

Lewisham and Greenwich NHS Trust

Location

Greater London

Region

London

Summary 1075/September 2015

Lack of patient observations and poor record keeping

Mrs K complained about the care and treatment given to her daughter, Mrs Y, who died three days after having a caesarean section.

What happened

Mrs Y went to hospital for a planned caesarean section. There were no issues with the caesarean and she gave birth to a healthy baby boy. Mrs Y was recovering well in hospital but three days after giving birth she was found unconscious in her chair. She died despite attempts to resuscitate her. A pathologist initially reported the cause of Mrs Y's death as postpartum sepsis. The Trust felt there was not enough evidence to identify sepsis. It commissioned a second pathologist's report which put the cause of death as cardiac arrest.

Mrs K complained that her daughter's consultant had not been present and that three or four different midwives had been assigned to her within the first few hours. Mrs K also complained that the Trust had not monitored her daughter appropriately after the birth and that its resuscitation procedures were not effective. She also raised concerns about the Trust's record keeping. Mrs K said she believed her daughter's death could have been avoided if she had received appropriate care and treatment.

What we found

The Trust failed to monitor Mrs Y in line with local and national guidelines. Although she was not observed as often as she should have been, the observations that staff did take were normal, and there was nothing to indicate any problems with her recovery. We saw no suggestion that Mrs Y's observations would have been anything but normal even if they had been recorded more frequently, and so it is likely her care and treatment would have been the same had the service failure not happened.

The standard of the Trust's record keeping was poor and it did not keep clear and accurate records. We found no fault with the attempts to resuscitate Mrs Y.

Mrs Y did not receive the standard of care she should have done and knowing this has caused Mrs K great distress and anxiety. However, we did not find Mrs Y died because of failings by the Trust, and for that reason we partly upheld Mrs K's complaint.

Putting it right

The Trust wrote to Mrs K to acknowledge the service failure and to apologise for the distress this caused her and her family. It also drew up plans to prevent the same mistakes happening again and explained these changes to Mrs K.

Organisation(s) we investigated

East Lancashire Hospitals NHS Trust

Location

Blackburn with Darwen

Region

North West

Summary 1076/September 2015

Patient left in pain after hip operation

Mr F complained about the care and treatment he received after his hip replacement surgery.

What happened

Mr F had a hip replacement operation. He complained of increasing pain in his thigh and buttock throughout the following night and asked for pain relief. This continued into the morning and Mr F's thigh became very swollen. He repeatedly asked nurses to arrange for a doctor to see him, and when he thought his concerns were not being taken seriously he phoned a colleague at a local hospital for help. The colleague then contacted the surgeon who had operated on Mr F. As the surgeon was working elsewhere, he asked an anaesthetist to arrange for another surgeon to review Mr F. The Matron saw Mr F at midday, and she asked the second surgeon to review him. After the review Mr F was taken back to theatre and a large haematoma (a clot of blood within tissues) was removed.

Mr F complained that staff had not recognised that he was developing compartment syndrome (a painful and potentially serious condition caused by bleeding or swelling in an enclosed bundle of muscle). He complained that the Matron lacked empathy and had stopped him seeing a doctor. He also complained that the hospital had not investigated his concerns robustly: staff had given inconsistent accounts and it had not got a written response from the doctor treating him.

What we found

We upheld some parts of Mr F's complaint.

Nurses did not manage Mr F's post-operative care in line with applicable standards. In particular, staff didn't examine his wound when they should; they didn't monitor the effectiveness of his pain relief; and they missed opportunities to arrange for a doctor to review Mr F and his medication. While we did not find that Mr F had suffered nerve damage as a result of these failings, he was in pain for longer than he would otherwise have been and clearly suffered anxiety and distress.

We found no fault with the Matron's behaviour towards him, nor with the way the hospital looked into his complaint.

Putting it right

The hospital apologised to Mr F for the distress it had caused him. It also drew up plans aimed at preventing the same mistakes happening again.

Organisation(s) we investigated

Ramsay Healthcare UK

Location

Lancashire

Region

North West

Summary 1077/September 2015

Fatal blood clot could have been prevented

An older woman died of a preventable pulmonary embolism (a blood clot in the artery from the heart to the lungs), but she would have died from a heart attack even if the embolism had not developed.

What happened

Mrs B was elderly, had arthritis, osteoporosis and a degenerative spine condition. She had developed a blood clot after breaking her ankle.

Four years later, Mrs B fell downstairs. She broke two bones in her neck and doctors also suspected a broken bone in her foot. She was given a neck collar and an Aircast boot to support and immobilise the injured areas. She was told to keep mobile, and physiotherapy helped with that. She was admitted to an orthopaedic ward.

Mrs B was at high risk of developing blood clots because of her age, weight and medical history. Doctors decided not to give her blood thinning medicine due to the risk of bleeding into the neck fracture, which could have been fatal. Instead, they prescribed tight-fitting stockings to help prevent the formation of blood clots in leg veins.

Just over two weeks after being admitted, Mrs B collapsed. Attempts to resuscitate her failed. Mrs B's family had been expecting her imminent discharge to a residential care home, so this came as a great shock. The main cause of Mrs B's death was a pulmonary embolism which had come from a clot in a leg vein. She had also suffered a heart attack.

Mrs B's son, Mr S, complained to the Trust about his mother's care and treatment, communication, access to the consultant and discharge arrangements. He said his mother's death could have been prevented. The Trust gave written responses and two meetings were held. An inquest also took place. Mr S was not satisfied with the Trust's responses and its handling of his complaint. He wanted to know what had happened to his mother and he wanted the Trust to learn lessons and make improvements.

What we found

We upheld some parts of this complaint.

The Trust did not adequately manage Mrs B's risk of developing an embolism. She would probably not have developed one if she had been managed in line with national guidelines. Clinicians should have reassessed her when the risk of bleeding into the spinal fracture had reduced and they should have given her an anticoagulant (blood thinning medicine). Mrs B's ability to move about was very restricted due to pain, the collar and boot, and her pre-existing conditions. The tight-fitting stockings and very limited movement were not enough to prevent clots forming.

Doctors did not prescribe two drugs that Mrs B took regularly at home and did not document any reasons for this. One drug was aspirin, which Mrs B took to reduce the risk of heart attack and stroke. We found that it was more likely than not that she would still have had a heart attack even if she had been taking these drugs in hospital. In other words, she would have died of the heart attack, even if the embolism had not happened.

The Trust did not adequately explain the clinical situation and plan of care to Mrs B and Mr S, and the records did not show a reasonable level of supervision from senior doctors. Nurses responded appropriately to Mrs B's deterioration in the days before she died. There were no failings in physiotherapy or discharge planning, apart from a lack of senior review to confirm that Mrs B was medically fit to be discharged.

We found failings in complaint handling. In particular the Trust should have clarified with Mr S at the beginning all the issues he wanted its investigation to cover.

Putting it right

The Trust acknowledged and apologised for its failings and for the impact they had. The Trust agreed to share our investigation report with the healthcare professionals involved in Mrs B's care and with the complaint handlers so that lessons could be learned. It also agreed to identify whether the arrangements in place for consultant orthopaedic follow up of patients and supervision of junior doctors were robust.

Organisation(s) we investigated

Southend University Hospital NHS Foundation Trust

Location

Essex

Region

East

Summary 1078/September 2015

Trust failed to give appropriate pressure area care and did not communicate woman's deterioration to her family

Mrs D complained about several aspects of her mothers care and treatment following surgery to repair a rectal prolapse (when part of the rectum protrudes through the anus). Mrs D said she believed poor care and treatment had led to her mother's avoidable death, and that poor communication denied the family the chance to prepare themselves for her death.

What happened

Mrs C, in her early seventies, was admitted to hospital for surgery to repair a rectal prolapse. Her condition significantly deteriorated after surgery and she died nearly three weeks later. Her daughter, Mrs D, complained to the Trust about many aspects of her care and treatment. She said surgery had been delayed and no information had been given about its risks; the dose of anaesthetic was miscalculated, causing pain; the surgery caused bleeding and kidney failure, and doctors continued to give blood thinning medication even though she developed a bleed. Mrs D also said that the Trust should have transferred Mrs C to a High Dependency Unit after surgery; staff did not act when her condition deteriorated; staff should have moved her to intensive care earlier; she was moved to several different wards; she developed severe bruising on her arm; she received poor hydration, pressure area care and personal hygiene care; and staff did not communicate her deterioration to her family.

What we found

Our investigation established that Mrs C's care and treatment was generally in line with relevant standards and established good practice except in the pressure area care it gave her. There was no documented evidence that staff discussed Mrs C's condition or deterioration with her family until just before her admission to intensive care. Better communication earlier on would have given the family an opportunity to better prepare themselves for the possibility that Mrs C might not survive.

Although we did not find that Mrs C's death was avoidable, both she and Mrs D had suffered an injustice because of service failures. We therefore partly upheld Mrs D's complaint.

Putting it right

The Trust wrote to Mrs D to acknowledge its poor communication and poor pressure area care and apologised for the impact this had. It also explained how it would improve communication and pressure area care in future.

Organisation(s) we investigated

Stockport NHS Foundation Trust

Location

Greater Manchester

Region

North West

Summary 1079/September 2015

Failure to provide appropriate care for a cancer patient who suffered a major fit and died

Mr A, who was in his late seventies and in good health, was on holiday abroad with his wife. He developed abdominal pains and they decided to come home.

What happened

Mr A was admitted to the Trust. He had a CT scan, which showed a tumour obstructing the bowel, and evidence that the cancer had spread to other organs. Neither he nor his family were told of his diagnosis before he had an urgent colostomy procedure to deal with the blockage in the bowel.

Mr A suffered a major fit some hours after he came out of theatre, which had to be controlled with sedatives. Doctors decided he should not be admitted to intensive care because of his advanced cancer. They suspected that the fit may have been caused by a spread of cancer to the brain, but a CT scan showed no evidence of this. Mr A remained on the ward and doctors did not review the 'Do Not Resuscitate' decision they had made earlier.

Mr A's family then pushed for him to be moved to intensive care and doctors agreed. While the family were waiting for Mr A to be transferred, he was given an injection to reverse the sedation. Shortly afterwards, his oxygen levels began to fall rapidly. He was rushed to intensive care but doctors were unable to resuscitate him and he died.

What we found

The Trust failed to attend to Mr A quickly enough after his fit. Once staff had sedated him, they did not monitor him closely enough or provide active care. Staff should have transferred him to a High Dependency Unit rather than kept him on the ward. When the CT brain scan came back clear, doctors should have actively tried to identify the reason for Mr A's fit, and also reviewed the Do Not Resuscitate decision. A junior doctor administered the injection to reverse the sedation without adequate supervision. The Trust also failed to communicate appropriately with Mr A's family about his diagnosis and his deterioration. It did not carry out a robust complaint investigation and discontinued a Serious Incident Investigation without following up on the areas of concern it had initially identified.

We could not say whether Mr A would have recovered from this episode with the right care, and it was not clear what had caused the fit. However, the Trust's failings deprived Mr A of the opportunity of a better outcome, which might have been possible if it had properly managed his care.

Putting it right

The Trust apologised to Mr A's wife and paid her £5,000 in recognition of the distress its failings had caused her. It also drew up an action plan to address the learning points from our investigation and gave an update on its work to restructure its complaints procedures.

Organisation(s) we investigated

Barts Health NHS Trust

Location

Greater London

Region

London

Summary 1080/September 2015

Doctors could not have predicted that a woman with ovarian cancer would die as quickly as she did

Ms L complained that her mother, Mrs K, was not diagnosed sooner with ovarian cancer by her GP and doctors, and that subsequent hospital care, including pain relief, was poor. Ms L also complained that doctors overestimated how much time her mother had left to live and consequently did not urge Ms L to return home from her holiday sooner. Ms L said the Trust took too long to answer her complaint.

What happened

Mrs K had abdominal pain with alternating bouts of diarrhoea and constipation. She had several tests and examinations over a period of two years. She eventually became so unwell that she was admitted to hospital and she was diagnosed with ovarian cancer. Ms L was abroad on holiday at this time, but doctors told her there was no need to change her flights and come home sooner. However, Mrs K died sooner than doctors expected and Ms L did not arrive in time to say goodbye to her mother.

What we found

We partly upheld Ms L's complaint.

We found no fault with the GP's actions. As for the Trust, it could not have diagnosed Mrs K's cancer sooner, nor predicted she would have died as soon as she did. We did find failings in the way the Trust recorded the effectiveness of the pain relief Mrs K received.

Some aspects of the Trust's complaint handling were not up to standard. It did not investigate Ms L's complaint thoroughly and it did not always keep her informed if it was going to miss a deadline.

Putting it right

The Trust apologised for the failings we identified and took steps to put things right for the future. We acknowledged that, since the time of the events complained about, the Trust had significantly improved its complaint handling.

Organisation(s) we investigated

Leeds Teaching Hospitals NHS Trust

A GP practice

Location

West Yorkshire

Region

Yorkshire and the Humber

Summary 1081/September 2015

Failings in care did not change the outcome for a patient with diabetes

Mr P is diabetic. He complained about poor care and treatment during several hospital admissions, which he believed resulted in the need for further amputation surgery.

What happened

During his first admission Mr P's right big toe had to be amputated because of reduced blood supply. Several days after being discharged he was readmitted and needed further surgery to remove infected tissue. A review a week later found that Mr P had developed more infection and more tissue needed to be removed and additional toes amputated.

What we found

We upheld some parts of Mr P's complaint. The Trust should have continued to give him antibiotics at the time of his first discharge, which might have helped to prevent his infection spreading. The Trust should have arranged for Mr P to have an angiogram sooner than it did, and monitored him more closely during the third admission. However, these failings did not change the overall outcome for Mr P.

Putting it right

The Trust apologised to Mr P and produced an action plan to show what it had learned from this case.

Organisation(s) we investigated

Warrington and Halton Hospitals NHS Foundation Trust

Location

Warrington

Region

North West

Summary 1082/September 2015

Shortfalls in Trust's discharge processes

Ms R complained about the care her late mother, Mrs F, received from the Trust before she died. She felt that her mother's death was avoidable.

What happened

Mrs F had a history of ulcerative colitis (inflammation of the colon and rectum), osteoporosis and heart disease. Several months after a routine colonoscopy, she was admitted to hospital with abdominal pain. An emergency operation was carried out to remove part of the colon. Once Mrs F had recovered she was discharged. According to Ms R, staff told her mother to leave the ward within an hour and sent her home without a care package and medication. Mrs F was readmitted to hospital three more times over the next six months and died during the last admission.

Ms R raised several complaints about her mother's initial colonoscopy and about her subsequent admissions to hospital. She felt her mother's death could have been avoided.

What we found

We upheld some parts of Ms R's complaint. Generally Mrs F received appropriate care. However, there were faults in three areas. Mrs F's care needs at home were not considered when she was discharged from her first admission to hospital. Staff did not give her adequate pain relief when she was discharged from hospital on the third occasion. A doctor failed to change the gloves worn between examining Mrs F's stoma site and wound dressing.

We did not find that these failings in any way contributed to Mrs F's death.

Putting it right

The Trust drew up an action plan to address the failings we had identified.

Organisation(s) we investigated

Portsmouth Hospitals NHS Trust

Location

Portsmouth

Region

South East

Summary 1083/September 2015

Faults in nursing, communication and complaint handling

Mrs E complained about a surgical procedure that resulted in a prolonged hospital stay. She also raised concerns about nursing care and the way the Trust communicated with her, as well as its complaint handling.

What happened

Mrs E had surgery to investigate her symptoms of jaundice. She understood it would be a routine procedure and that she would be allowed home the same day. Mrs E's liver duct was perforated during the procedure. She developed an infection and became very ill, and was transferred to intensive care. She remained in hospital for a month.

Mrs E complained to the Trust about what happened. She attended a meeting with the chief executive, but no minutes were taken, and she did not receive any written response to the complaint. She later attended a meeting with the Trust's medical director which addressed some of the issues in her complaint.

What we found

We upheld some parts of Mrs E's complaint.

The procedure which Mrs E had carries a significant risk of complications, including perforations. The Trust told Mrs E about this risk before her surgery. Based on her clinical records, we could not say if the perforation had been caused by a mistake by the surgeon. As perforation is a recognised complication, we did not uphold this part of the complaint.

Doctors did not communicate clearly with Mrs E about the complications she experienced. We also found failings in nursing care relating to poor communication, medication and blood tests.

We were concerned about the way the Trust handled Mrs E's complaint. Six months after she complained, the Trust arranged a meeting for Mrs E with the chief executive. However not all of her clinical records were available at the meeting and no minutes were taken. Mrs E and her advocate continued to ask the Trust for a full response but heard nothing. A meeting with the Trust's medical director took place over 18 months after her original complaint. The passage of time meant that the Trust could not answer Mrs E's complaint as fully as it should have done.

Mrs E went through an extremely unpleasant and difficult time during her admission, made worse by the Trust's poor complaint handling.

Putting it right

The Trust apologised to Mrs E, paid her £250 compensation and produced an action plan to address failings in nursing, communication and complaint handling.

Organisation(s) we investigated

Pennine Acute Hospitals NHS Trust

Location

Greater Manchester

Region

North West

Summary 1084/September 2015

Patient with cancer was inappropriately given a laxative for over a month

Mr H received some poor care and treatment, including being given Senna (a laxative) when he had diarrhoea. His wife complained about poor nursing care and a lack of documentation about the care given.

What happened

Mr H had prostate cancer and other conditions for which he was treated while an inpatient in hospital for ten months. During that time staff gave him a laxative for 38 days despite his wife raising concerns with staff about his diarrhoea. She also raised concerns about poor nursing care, including nutrition and personal hygiene. Mr H died soon after he was discharged. Mrs H said that her husband would have survived if he had had better care and treatment.

What we found

We partly upheld Mrs H's complaint.

Prescribing Senna to a patient with diarrhoea for over five weeks was a serious clinical failing. We could not say for sure that Senna could have worsened Mr H's condition, but the uncertainty was an injustice to Mrs H. We also found that nursing care was either not adequate, or had not been adequately recorded in the notes.

Putting it right

The Trust apologised to Mrs H. In line with our recommendations, it agreed to audit the remedial actions it had earlier said it would take to address the drug error. It also took steps to improve its record keeping and to make sure that patients receive appropriate personal care, nutrition and hydration.

Organisation(s) we investigated

Barts Health NHS Trust

Location

Greater London

Region

London

Summary 1085/September 2015

Trust failed to follow policy after patient fell out of bed

Mr D's wife complained about the care her husband received after a fall at home. She believed her husband died as a direct result of the poor care he received in hospital. She was extremely distressed by the possibility that his death could have been avoided.

What happened

Mr D had a fall at home. He sustained a severe head injury and was admitted to intensive care.

Mr D was later transferred to a ward. While on the ward he fell out of bed when staff were changing his bedding. His condition deteriorated and he died later the same day.

What we found

We partly upheld this complaint.

No vital signs observations were carried out after Mr D's transfer from intensive care to the ward. The Trust did not follow the correct protocol when handling Mr D during the bedding change, and then failed to follow its own falls policy after he fell out of bed. In addition Mr D was left alone for a period of time during which he should have had one-to-one care.

We did not see any evidence that these failings resulted in Mr D's death or that his death was avoidable.

Putting it right

The Trust acknowledged and apologised to Mrs D for its failings. At our recommendation it produced plans to make sure observations are carried out and recorded in line with national guidelines.

Organisation(s) we investigated

County Durham and Darlington NHS Foundation Trust

Location

County Durham

Region

North East

Summary 1086/September 2015

Trust failed to adequately manage child's pain after appendix operation

Mr B complained that his daughter's appendectomy procedure was delayed. He also said that after the operation there had been a delay giving her a catheter, and that her pain was not appropriately managed. Mr B said that the Trust's complaint handling was poor.

What happened

Mr B's daughter, H, was taken to A&E in winter 2013 reporting episodes of vomiting, diarrhoea and abdominal pain over the previous three days. H was given antibiotics for two days, but when her condition deteriorated a decision was taken to remove her appendix.

H experienced significant pain and discomfort after the operation. She was treated at the hospital for two more days before being transferred to another trust.

In December 2013 Mr B complained to the Trust about H's treatment and received a response in February 2014. Mr B put some follow-up questions to the Trust in May 2014. The Trust responded in October saying that it had no more information or explanations to give him.

What we found

We upheld parts of Mr B's complaint. We found no evidence of failings by the Trust in its treatment of H's appendicitis. The treatment was in line with established medical practice. We did, however, find failings in pain management.

The Trust failed to answer the further questions Mr B raised in May 2014 and its response was delayed. This caused considerable frustration to Mr B.

Putting it right

The Trust apologised to Mr B and H for the failings we identified. It paid £500 to H to recognise the pain she experienced as a result of its failings. It also paid £250 to Mr B for the frustration its poor complaint handling had caused. The Trust drew up plans to prevent these failings recurring.

Organisation(s) we investigated

Hillingdon Hospitals NHS Foundation Trust

Location

Greater London

Region

London

Summary 1087/September 2015

Lengthy wait for response to complaint about delayed operation

Mrs S complained about the care she received after two operations, and that planned surgery was cancelled twice.

What happened

In November 2013 Mrs S had surgery to remove part of her colon. She was left with a temporary stoma (where the small intestine is diverted through an opening in the abdomen). She spent several days in hospital recovering before being discharged home.

Mrs S's second operation, to reverse (close up) the stoma, was scheduled for late January 2014 but was cancelled. The Trust explained this was due to a shortage of nursing staff, which resulted in the temporary closure of two wards and the cancellation of all planned surgery for patients needing inpatient care.

Mrs S's surgery was rearranged at another hospital. But the surgeon was taken ill on the day and her surgery was cancelled again. Mrs S finally had her surgery in February.

Mrs S complained that she was not given appropriate pain relief after both operations and her intravenous fluids were left to run dry after the first operation. She also complained that the operation to close up the stoma had been cancelled twice. She later complained that her wound dressings were not attended to appropriately after the second operation, she was not given appropriate pain relief and she was given codeine and tramadol together. She was also unhappy about the time the Trust took to reply to her complaint.

What we found

We partly upheld Mrs S's complaint.

There were unavoidable reasons for cancelling Mrs S's reversal surgery. This was unfortunate and upsetting for her but waiting until February 2014 for surgery had no negative impact on her clinical condition.

The care and treatment the Trust gave Mrs S during her two admissions was satisfactory. Staff did give her tramadol and codeine at the same time, which was not in line with established good practice. However, this would not have led to a significant detrimental effect on Mrs S's condition or caused any longterm side effects.

As for the Trust's handling of Mrs S's complaint, it took around seven months to reply. This was unreasonably long and caused Mrs S some frustration.

Putting it right

The Trust had already apologised to Mrs S for the delay replying to her complaint. It told Mrs S about the steps it planned to take to make sure that it responds to complaints in good time.

Organisation(s) we investigated

University Hospitals of North Midlands NHS Trust

Location

Staffordshire

Region

West Midlands

Summary 1088/September 2015

Doctors did not treat heart attack patient appropriately

Mr R was admitted to hospital with a heart attack. His partner complained about the treatment that hospital staff gave him.

What happened

Mr R was taken to hospital by ambulance and doctors diagnosed that he had had a small to moderate heart attack. He remained in hospital for several hours before doctors identified that his health was worsening and arranged to transfer him to the local cardiac centre. Mr R died at the cardiac centre shortly after he arrived.

What we found

We upheld this complaint. Mr R had actually suffered a large heart attack followed by a cardiogenic shock. He was clinically unstable and needed urgent specialist treatment, but doctors at the hospital did not identify this. Mr R's transfer should have happened more quickly. These failings fell significantly short of established good practice.

While Mr R might have had a slightly better chance of living longer if the failings had not happened, we could not say for sure that he would have survived his illness. But, even if there was only a small chance of survival, perhaps only for one or two days, Mr R was denied even that opportunity. His partner will never know whether treatment would have extended his life. This uncertainty is a source of continuing distress to his partner.

Putting it right

The Trust acknowledged and apologised for its failings. It also put plans in place to learn from what had happened.

Organisation(s) we investigated

Northern Devon Healthcare NHS Trust

Location

Devon

Region

South West

Summary 1089/September 2015

Missed opportunities to diagnose leukaemia sooner

Mr F's son complained about the care his late father received at the Trust. He said the Trust had not diagnosed and treated his father's leukaemia at the earliest opportunity. He said the delay deprived the family of the opportunity to make Mr F's last days more comfortable and they were unaware of how much he was suffering.

What happened

Mr F, who was in his late seventies, was seen in an outpatient clinic in summer. Blood test results showed some abnormalities but the results were not referred to a doctor for a clinical opinion, nor were they seen or acted on by the doctor overseeing Mr F's care. In autumn, Mr F was back in hospital after he had a fall at home. Further blood tests showed that his haemoglobin level was low and his white blood cell count was raised. He was diagnosed with a urinary tract infection and discharged home.

Shortly after this Mr F become generally unwell and confused and was readmitted to hospital. Staff initially suspected that he was suffering from sepsis and treated him with antibiotics. His haemoglobin level was again low and he was given a red blood cell transfusion. Mr F was reviewed by a haematologist, who confirmed that he had leukaemia. His condition deteriorated over the following days until he died.

What we found

Staff missed two opportunities to diagnose Mr F's condition. Had staff reviewed and investigated the summer blood test results, he would have been diagnosed with myelodysplastic syndrome (a blood disorder that reduces the number of healthy blood cells). A diagnosis of acute myeloid leukaemia could have also been made in light of the autumn blood test results. This was not diagnosed until later in the month after Mr F had become very unwell. Overall, Mr F's care was not in line with established good practice and the missed opportunities to diagnose his condition sooner were failings.

Mr F had a number of medical conditions and was generally in poor health as a result. Although it is unlikely that an earlier diagnosis would have improved his prognosis, it would have led to offers of supportive care. This would have included transfusion of blood and platelets as required and attempts to treat any infections he developed. Mr F would also have been offered palliative care services, depending on what was available in the area.

We could understand why Mr F's family felt, and will likely continue to feel, distressed that opportunities were lost to make Mr F's last weeks and days more comfortable. Similarly, his family also suffered additional distress because they were not aware of how seriously unwell Mr F was or how poor his prognosis was until the days before he died.

The Trust wrongly sent its final response to Mr F's son's complaint to Mr F's last known address, which by this time had been sold. The Trust dealt with this issue in a reasonable way by apologising to Mr F's son and highlighting the error internally as a data breach. However, we could not see that the Trust had done anything to stop this happening again.

Putting it right

The Trust paid £1,000 to Mr F's son, and prepared an action plan to prevent the failings we identified from happening again.

Organisation(s) we investigated

Colchester Hospital University NHS Foundation Trust

Location

Essex

Region

East

Summary 1090/September 2015

Ambulance trust staff caused avoidable pain and distress to elderly fall victim

Ambulance trust staff did not adequately assess an elderly man who had fallen, and failed to give him any pain relief. He was later found to have broken his back.

What happened

Mr T had osteoporosis, arthritis and a history of falls. In summer 2013, he fell forwards while using his Zimmer frame at home and could not get up. An emergency medical technician (someone who is trained to provide emergency treatment but is not qualified to paramedic level) arrived in a rapid response vehicle in response to the 999 call. He assessed Mr T and asked for an ambulance to take him to hospital. The service was very busy and the ambulance dispatched to Mr T was then diverted to another call. A solo paramedic arrived in a car, and the technician and the paramedic helped Mr T up from the floor and sat him on a chair. When an ambulance arrived, the crew transferred Mr T using a carry chair and put him on a stretcher.

Investigations at hospital later showed that Mr T had an unstable fracture of his lower spine with spinal cord compression – he had broken his back. He died in hospital the following month.

Mr T's son, Mr W, complained that his father had been in extreme pain throughout and that staff who had attended the scene had done nothing about it. He said staff should have suspected spinal injury and taken precautions (such as using a spinal board and neck collar) before moving and transporting his father.

Mr W was unhappy that the technician told his father he would have to wait for the ambulance as there were people worse off than him. He was also concerned with the route the ambulance took to the hospital which he said had many speed bumps that added to his father's pain.

Mr W was dissatisfied with the Ambulance Trust's two responses to his complaint and he complained to us.

What we found

Staff did not adequately assess Mr T for spinal injury before moving him into a sitting position. The paramedic, as the more senior clinician, should have taken charge and checked that it was appropriate to move Mr T.

Staff failed to adequately assess Mr T's pain and to offer any pain relief during the 1 hour and 40 minutes he spent in their care, even though they documented that he was complaining of back pain. These actions were not in line with relevant guidelines for pain management.

We could not say from the available evidence if there were failings in relation to the route taken to hospital. The technician's comment, as reported by Mr T's son, did not explain in a sensitive way the delay in the ambulance getting there, but we had no objective way of determining exactly what the technician said and how he said it.

Overall, we found failings in assessment and pain management. We partly upheld the complaint because the Trust had not fully acknowledged some of the failings in care and had not done enough to put things right.

Putting it right

The Trust gave feedback to the technician and said a manager would assess his practice. The Trust also gave feedback to the ambulance crew about pain relief and the need to continue assessing the patient. These actions were reasonable.

In line with our recommendations, the Trust shared our report with the staff involved so lessons could be learned, and considered what action to take in relation to the paramedic. The Trust also wrote to Mr W to acknowledge the failings in care and to explain what further action it would take. It paid £250 to Mr W in recognition of the impact of its failings in care.

Organisation(s) we investigated

East of England Ambulance Service NHS Trust

Location

Cambridgeshire

Region

East

Summary 1091/September 2015

Woman with broken arm was given no painkillers in A&E

Miss T complained that when she went A&E with a broken arm, she was not given any pain relief and that doctors failed to notice a wound on her elbow which subsequently became infected. She also complained she was not given pain relief when she went A&E again the following week.

What happened

Miss T went to the Trust's A&E at after falling off a motorbike. She had injured her shoulder and an X-ray showed she had fractured her right arm. Staff placed her arm in a sling and made an appointment for her to see the fracture clinic in a few days.

The following week, Miss T went back to A&E because her right elbow had become infected. The wound was cleaned and she was prescribed seven days' antibiotics and advised to see her GP in a few days.

Miss T's fracture did not heal as planned and she had an operation to mend it.

What we found

The Trust failed to give Miss T painkillers on two separate visits to A&E, and did not spot her elbow wound, which became infected.

These failings caused pain, discomfort and distress for Miss T.

However, they did not lead to any significant delay in her having surgery or to a poorer outcome. For this reason, we partly upheld Miss T's complaint.

Putting it right

The Trust paid Miss T £500 in recognition of the impact the failings had on her. It also told her what it had done to make sure it gives timely pain relief to people in A&E.

Organisation(s) we investigated

Basildon and Thurrock University Hospitals NHS Foundation Trust

Location

Essex

Region

East

Summary 1092/September 2015

Trust did not arrange a CT scan after an elderly patient fell in hospital

Mrs L died shortly after a fall in hospital so her daughter, Mrs K, asked us to investigate her complaint.

What happened

Mrs L was admitted to hospital after falling at home. During the early part of her admission, staff gave her medication that she had taken previously but had stopped taking because it made her confused. Mrs K became concerned about her mother's confusion and it was only when she asked that she discovered that her mother had been given the medication. It was stopped and Mrs L improved again.

After a week in hospital Mrs L was found on the floor at the end of her bed, apparently having tried to climb over the bed rails to get out. She was seen by a doctor and monitored throughout the day. Later that evening her condition deteriorated. Nurses called Mrs K and told them that, although they had initially planned to perform a CT scan, there was by then little point. Mrs L died a few hours later.

A post mortem identified a bleed on Mrs L's brain. The report said it was more likely that the bleed had caused her fall, rather than the fall causing the bleed.

Mrs K complained to the Trust. It accepted it had used bedrails for Mrs L, when it should not have done so. It also accepted it was a mistake to have given Mrs L the medication, adding that it had given her another medication in error too.

Mrs K complained to us because she wanted apologies, an independent review of her mother's care, service improvements and a payment.

What we found

We partly upheld Mrs K's complaint. The Trust had appropriately addressed Mrs K's complaint about the use of bedrails in her mother's care, but we identified other failings in her mother's medical management.

The Trust should have logged the wrongly given medication as clinical incidents. The first medication may have caused Mrs L's confusion, but did not delay her discharge from hospital. The second medication may have contributed to the bleed on her brain.

As the Trust did not perform a CT scan when Mrs L was first admitted to hospital after her fall at home (a significant failing in itself), we could not say if there was a bleed on her brain before she fell in hospital. Because of this and the post mortem result we could not say that the fall had caused Mrs L's death.

Putting it right

The Trust acknowledged the failings we identified and apologised to Mrs K for their impact on her mother's treatment. It drew up plans to review when clinical incidents are reported and when CT scans should be taken.

Organisation(s) we investigated

University Hospitals of Morecambe Bay NHS Foundation Trust

Location

Cumbria

Region

North West

Summary 1093/September 2015

Hospital's mistakes did not have significant impact on patient's care

Mrs J fell ill while on holiday and was taken to hospital. She told staff that she had a cyst (a type of tumour that is not usually cancerous) on one of her ovaries, which might be causing the problem.

What happened

Mrs J had a scan of her abdomen, but it did not show the cause of her symptoms. The Trust gave her painkillers and, as her condition seemed to be improving, it discharged her. It said she could follow up her treatment closer to home. Mrs J returned home. Further investigations showed that the cyst on her ovary had twisted and that she needed an operation.

Mrs J complained to the Trust. She said it should not have discharged her when it did not know what the problem was. The Trust said it had carried out appropriate investigations and Mrs J seemed well enough to go home for any further treatment.

What we found

Mrs J's symptoms and history suggested that the cyst on her ovary was a likely cause of her illness. When the scan of her abdomen did not show anything, the Trust should have investigated further. In particular it should have arranged for Mrs J to see a gynaecologist. The Trust's response to Mrs J's complaint also seemed to maintain, unreasonably, that she did not have a cyst.

If the Trust had diagnosed Mrs J appropriately, it might still have been reasonable to refer her to a hospital nearer her home for the operation she needed. Mrs J's care was much as it would have been if the Trust had done this. We partly upheld Mrs J's complaint on the grounds. Although the Trust made mistakes, these had not significantly affected the care she received. For this reason, we partly upheld Mrs J's complaint.

Putting it right

The Trust acknowledged that it had given Mrs J a poor standard of care, and that she did have a cyst, which had caused her illness. It apologised to her for the distress and frustration she experienced as a result of its failings.

Organisation(s) we investigated

Plymouth Hospitals NHS Trust

Location

Plymouth

Region

South West

Summary 1094/September 2015

Patient with mental health problems not involved in discussions about her care

Miss T complained that she was unfairly discharged from mental health services.

What happened

Miss T has chronic anorexia nervosa and a long history of mental health problems. A team of professionals at the Trust felt that it had tried every possible treatment and she had shown no signs of recovery. It discharged Miss T into the care of her GP and arranged some short-term psychotherapy sessions. Miss T complained to us that she did not receive the treatment she needed and had been left unsupported.

What we found

We upheld some parts of Miss T's complaint. Trust staff discharged Miss T in line with established good practice. However, she was denied the opportunity to be involved in discussions about her care. The fact that she felt excluded led to her feeling upset and distressed. She would not have suffered this injustice if the Trust had involved her in discussions.

Putting it right

The Trust acknowledged its failings and apologised. It also explained how it would address the failings we had identified.

Organisation(s) we investigated

Surrey and Borders Partnership NHS Foundation Trust

Location

Surrey

Region

South East

Summary 1095/September 2015

Poor nursing care for elderly man and poor communication with his family

Mrs G complained about the care and treatment her late uncle, Mr E, received towards the end of his life, including when part of his leg was amputated.

What happened

Mr E was an elderly man with a number of medical conditions including diabetes and vascular disease. Towards the end of the year, Mr E had a colonoscopy after which he was discharged home. A few weeks later he had a heart attack and was in hospital for several weeks. He underwent a coronary artery bypass and was discharged home in the spring following rehabilitation. A week later Mr E was readmitted to hospital with vomiting, diarrhoea and dehydration. He was reviewed and discharged home again. A few days later he had a severe haemorrhage and was taken to hospital where he was diagnosed with bowel cancer. A decision was made that no active treatment would be given for the cancer because Mr E was so unwell.

Mr E's existing foot problems got worse in hospital and his family raised concerns about his foot pain, given his diabetes.

Mr E was discharged home with a referral to palliative support and therapy. He was seen at a foot clinic and by his GP with increasing foot pain. Mr E fell at home the next month and was taken to hospital. His leg was amputated to the knee because of severe infection. Mr E developed fluid on his lungs and was vomiting and finding it hard to breath. He was given antibiotics and oxygen. His condition continued to deteriorate and he died the following month.

What we found

We upheld some parts of Mrs G's complaint. There were no failings in Mr E's clinical care and treatment, including the care and treatment of his foot and amputation, and his end of life care.

There were, however, instances of poor basic nursing care around hygiene, fluids, nutrition and community nursing foot care, some of which the Trust had already acknowledged. The Trust had also acknowledged it had communicated poorly with the family about what was happening with Mr E's care and about his deterioration. Mr E was deaf on his right side. Although this fact was noted in numerous clinical records, we saw no evidence of any care planning in response to this.

It is highly unlikely that the outcome for Mr E would have been any different had these failings not occurred, but clearly they still caused considerable distress.

Putting it right

The Trust wrote to Mrs G to acknowledge its failings, apologised for the distress caused, and paid her £500. It also produced an action plan which described how it would prevent the same issues happening again.

Organisation(s) we investigated

Homerton University Hospital NHS Foundation Trust

Location

Greater London

Region

London

Summary 1096/September 2015

No failings found in care of premature baby

Ms C raised concerns about the care and treatment given to her baby, J, who was born prematurely.

What happened

Ms C was admitted to hospital when she was 30 weeks pregnant because she had started to bleed. In hospital it was noted there was intrauterine growth restriction (poor growth of a baby while in the mother's womb) and Ms C had high blood pressure. She had an emergency caesarean section and her son was born. Because he was premature, her son, J, was admitted to the Special Care Baby Unit. After a couple of weeks, J had low levels of oxygen in his blood (desaturations) and prolonged periods of not breathing. He was transferred to a different trust for surgical review and ongoing care, but, sadly, he died there a few weeks later.

Ms C complained about the care and treatment given to J at both Trusts. Her concerns included that J was misdiagnosed; he was given blood transfusions with the wrong blood type; placed onto his back when he vomited and choked; and he was signed up to a clinical study that staff did not explain properly.

What we found

We found that the tests and investigations at both Trusts were appropriate and well-timed. J received appropriate treatment and we saw no evidence that he was misdiagnosed. The decision to transfer J to a different trust for a surgical review was the right thing to do and was timely. While there, J vomited because he was so ill and he was placed on his back. This was appropriate as he needed to have a tube inserted through his mouth to allow suction.

With regard to the trial J was part of, the Trust got appropriate consent from Ms C and gave her information about the reasons for the trial and how J's involvement could be stopped. Ms C signed to confirm she received and understood the information. We included further explanations in our report to reassure Ms C that no harm would have been caused to J due to the trial.

We found no evidence that J was given the wrong type of blood when he received blood transfusions.

We did not uphold the complaint, but provided some further explanations to help Ms C understand the care given to her son.

Organisation(s) we investigated

Croydon Health Services NHS Trust

St George's University Hospitals Foundation Trust

Location

Greater London

Region

London

Summary 1097/September 2015

District nurses failed to provide reasonable care and support

When Mr V was in the final days of his life, the Trust's district nurses failed to provide reasonable care and support to him and his wife.

What happened

Mr V was terminally ill with cancer and wanted to die at home. His GP referred him to the District Nurse Service for support with this, but the Service overlooked the referral. When Mr V deteriorated quickly on a Sunday evening, his wife, Mrs V, phoned the Service several times, but got no answer and could only leave messages on an answer machine.

District nurses came the following day and agreed to fasttrack a referral for carers to come quickly. But there was some confusion and that did not happen as planned. The district nurses declined Mrs V's request that they phone the GP from her home to seek authorisation to increase the dosage of pain relief in Mr V's syringe driver. They did not explain that they needed written authorisation to do this. They also declined to fit an incontinence pad on Mr V, saying the carers would do this. It was only when Mrs Vs daughter contacted their MP for help that everything was put correctly in place.

The carers then provided what Mrs V described as '*superb*' care until Mr V died the next day.

What we found

The care provided by the Trust was not in line with recognised quality standards and established good practice. Mrs V was given wrong information about who would provide the carers, which caused confusion and anxiety when she tried to follow up the referral. The Trust failed to explain to Mrs V the situation over the medication for the syringe driver. This caused needless anxiety, distress and suffering to her and her husband. Mrs V described herself as feeling '*abandoned and out of her depth*'.

Putting it right

The Trust acknowledged and apologised for its failings. It also put a plan in place to prevent these things happening again.

Organisation(s) we investigated

Blackpool Teaching Hospitals NHS Foundation Trust

Location

Blackpool

Region

North West

Summary 1098/September 2015

Trust mismanaged warfarin medication

Mr R complained that mismanagement of his warfarin medication had resulted in him suffering two strokes.

What happened

Mr R was taking warfarin for atrial fibrillation (irregular and abnormally fast heart rate). Trust staff advised Mr R to stop taking warfarin for seven days ahead of an endoscopy. He did as advised, and suffered a stroke nine days later.

Mr R's INR (international normalised ratio – a measurement of how long blood takes to form a clot) continued to be monitored following this episode. Two years later his INR was found to be outside the normal range. His warfarin medication was changed to correct this and he continued to be monitored. Nevertheless, Mr R's INR level remained outside the normal range and he suffered a further stroke.

Mr R said that because of the strokes he can no longer work, drive or go fishing. His life has been turned upside down. He is now registered disabled and walks with a stick.

What we found

The Trust was wrong to tell Mr R to stop taking warfarin before his endoscopy. It should also have reviewed him more frequently when his INR was found to be low, and prescribed a different anticoagulant for him until his INR was in the normal range.

Mr R was at a high risk of stroke and failings by the Trust put him at an increased risk of this happening. However, because he was already at high risk because of his condition, we could not say that the mismanagement of his warfarin caused him to suffer either stroke.

Putting it right

The Trust had already apologised for advising Mr R to stop taking warfarin, and had taken steps to stop this happening again. In line with our recommendations, the Trust apologised to Mr R for the impact caused by mismanaging his warfarin when his INR was low and paid him £1,500 to recognise that opportunities were missed to reduce his risk of suffering a stroke. It also agreed to draw up plans to address this failing.

Organisation(s) we investigated

Sandwell and West Birmingham Hospitals NHS Trust

Location

West Midlands

Region

West Midlands

Summary 1099/September 2015

Poor complaint handling contributed to concerns that something had gone wrong

A trust delayed responding to a complainant's concerns and gave mixed messages about whether an investigation was ongoing or not. This led to fears of a cover up.

What happened

Mrs Y was admitted to hospital with end stage heart failure. A decision was made that she should not be resuscitated in the event of a heart attack.

One week later, Mrs Y's condition worsened and she was given a 5ml dose of morphine. This slowed down Mrs Y's breathing and, despite attempts to reverse the effects of the morphine, she never regained consciousness. Mrs Y died later that day from heart and kidney failure.

Mrs Y's daughter, Mrs G, complained that the family had not agreed with the decision not to resuscitate her mother; that a heart monitor was not used; and that an incorrect dose of morphine led to her mother's death. She also complained about the attitude of staff on the ward.

What we found

We partly upheld this complaint. The Trust gave Mrs Y appropriate care and treatment. The dose of morphine it gave her was a standard dose and slowing down breathing is a known side effect. The reason for giving Mrs Y morphine should have been noted in the records, but it was still appropriate to provide it as she was dying and in discomfort.

There were, however, faults in the way the Trust dealt with Mrs G's complaint. It did not follow up on actions that were agreed, particularly in relation to a member of staff's attitude, or inform Mrs G of the actions it had taken. It delayed responding to her and wrongly told her that its investigation into her concerns was ongoing, when in fact it had closed her case.

Putting it right

The Trust acknowledged and apologised for the failings in its complaint handling and took action to address these.

Organisation(s) we investigated

North Middlesex University Hospital NHS Trust

Location

Greater London

Region

London

Summary 1100/September 2015

Failings in nursing care and delayed diagnosis

Mrs F experienced poor standards in some aspects of her nursing care. A clinical diagnosis was delayed because facts were not thoroughly considered.

What happened

Mrs F went to A&E with unsteadiness, tingling and numbness in her feet. She left before tests were completed but was soon admitted to the Trust as an emergency with similar symptoms. Doctors suspected that Mrs F might be suffering from Guillain-Barre Syndrome (a rare and serious condition of the peripheral nervous system).

The next day in hospital Mrs F developed a pressure sore. A scan then revealed a lump on Mrs F's spine and she was discharged to another trust for treatment.

The complaint to us was about the standard of care, the lack of an earlier diagnosis and the pressure sore. Mrs F's daughter said that the failings had led to a tumour paralysing Mrs F from the waist down.

What we found

We upheld parts of this complaint. The Trust failed to follow national guidance on carrying out physical observations. Mrs F's nutritional care was poor but her pressure sore was properly managed. Given her age, history and symptoms, clinicians should have considered the possibility sooner that the cause of Mrs F's partial paralysis was a lump on her spine.

Putting it right

The Trust apologised for the nursing failings and developed an action plan to avoid a recurrence. It also asked the clinicians involved to reflect on the decisions made at the time and whether they might reasonably have also considered the possibility that Mrs F was suffering from a lump causing pressure on her spine.

Organisation(s) we investigated

Dorset County Hospital NHS Foundation Trust

Location

Dorset

Region

South West

Summary 1101/September 2015

An avoidable deep vein thrombosis, complications from a bunion operation and a question of consenting to risk

Ms P lived alone and was housebound and unable to drive for a year after a routine bunion operation led to a deep vein thrombosis (DVT), and the need for further operations.

What happened

Ms P had a bunion operation. She told the Trust before the operation that she had previously suffered from a DVT, but the Trust did not give her anticoagulant medication to prevent a DVT.

12 days after the operation, Ms P's calf started swelling and her foot was very painful to the touch. She was diagnosed with DVT and given medication to reduce the body's ability to form blood clots.

Six months later, Ms P needed a second operation after a screw in her foot – inserted during the bunion operation - had fractured. Almost three years later she had a third operation to remove the screw remnant.

Ms P's recovery was long, and she was in pain and immobile. She lost out on almost a year's part-time earnings and she had to pay for physiotherapy, massage and home help. Ms P also said that the Trust had failed to explain the risks of a prolonged, painful and immobile period of recovery from the bunion operation, and about the possible need for further surgery.

What we found

We partly upheld this complaint. The prolonged pain that Ms P experienced was related to the bunion surgery rather than the DVT. The consent form inadequately described the risks of surgery and the procedure for getting consent was not in line with national guidance. However, taking account of Ms P's evidence, we considered on the balance of probabilities that she would have gone ahead with the operation even if she had known the risks.

Putting it right

We saw that the Trust had already given Ms P a payment to cover the cost of private therapies, two months' lost earnings and a token amount to cover the cost and inconvenience of hospital visits. It acknowledged and apologised to Ms P for not giving her an anticoagulant, given her history of a DVT.

As a result of our investigation, the Trust paid Ms P £320 to cover a further month's lost earnings (the effects of a DVT last, on average, three months rather than two). It also agreed to consider reviewing its consent forms and procedures.

Organisation(s) we investigated

Brighton and Sussex University Hospitals NHS Trust

Location

East Sussex

Region

South

Summary 1102/September 2015

GP practice gave wrong advice on how to escalate a complaint about it

Mrs A complained about the GP Practice's failure to diagnose and treat her urinary tract infection (UTI) in a reasonable time, and about the attitude of her GP. She also complained about the accuracy of her medical records, about the Practice's complaint handling and its failure to learn from her complaint.

What happened

Mrs A began to suffer discomfort passing urine about a week after gynaecological surgery. She saw her GP who initially did not prescribe antibiotics. Her symptoms got worse and so Mrs A went back to her GP, who this time prescribed her a five day course of antibiotics. She was so uncomfortable during this consultation that she could not sit down.

Mrs A had a phone consultation with her GP a few days later, when she reported some improvement. The GP extended her course of antibiotics by five days as she was about to go on holiday to France.

While on holiday, Mrs A saw a doctor who prescribed a different antibiotic. Her symptoms gradually improved throughout the following weeks.

Mrs A complained to the Practice about the care and treatment she had received, and about what she described as the GP's uncaring attitude. She wasn't happy with the Practice's response to her complaint and contacted the primary care trust (PCT), who indicated it would investigate her concerns. However, it passed the complaint back to the Practice, which gave a further response.

In line with the PCT's governance processes for reported concerns about a doctor, a Clinical Governance Review Panel reviewed the case. Mrs A said she was not involved in this process.

What we found

We upheld some parts of Mrs A's complaint.

The Practice's care and treatment was appropriate. With regard to the GP's attitude, the Practice had already apologised to Mrs A about communication issues that arose during the consultations, and the GP confirmed that she had undertaken training modules on communication. The Practice undertook an educational session with a consultant urologist and carried out a Significant Event Analysis to identify lessons to be learned.

The Practice's clinical records for Mrs A did not adequately document the relevant clinical findings, the decisions made and the information it had given her. We upheld this aspect of the complaint.

With regard to complaint handling the Practice provided a reasonable response to Mrs A in good time. It did wrongly advise her that the next stage of the complaint process would be to contact the PCT, but we have checked that its current complaints leaflet correctly informs patients of their right to bring the complaint to us.

The PCT incorrectly gave Mrs A the impression that it would investigate her complaint. It should have advised her that, as the Practice had already responded to the complaint, it could not deal with it and she could either bring her complaint to us or ask for further clarification from the Practice. The PCT should also have informed Mrs A of the outcome of the Clinical Governance Review Panel.

Putting it right

The Practice apologised to Mrs A for its poor record keeping. The Practice and the GP agreed to put together an action plan to show how they would improve their record keeping, and the GP agreed. The GP agreed to discuss this issue in her appraisal.

The PCT ceased to exist in April 2013, so we could not make recommendations in relation to its failings. However we shared our findings with NHS England.

Organisation(s) we investigated

A GP practice

Location

Dorset

Region

South

Summary 1103/September 2015

Practice did not properly monitor prescription of a controlled drug

Mr J was over-prescribed a controlled drug by his GP Practice. When the Practice was made aware of this, the GP declined to issue another prescription on that day. Mr J complained that he suffered withdrawal symptoms as a result.

What happened

Mr J went to a pharmacy for a repeat prescription of the medication he was taking for back pain. The pharmacy advised the GP Practice that Mr J was being over-prescribed and Mr J was called into the Practice for an appointment with a GP the same day. A difficult consultation followed and the GP declined to prescribe more medication that same day. Mr J complained he had been left without medication and without a proper withdrawal plan. He said this had caused extreme withdrawal symptoms.

What we found

The Practice did not properly monitor its prescribing. However, we found no fault with the decision not to give Mr J a further prescription on the day of the consultation. As Mr J had not told the Practice about his withdrawal symptoms, he had not given it an opportunity to provide help or support, or to devise a withdrawal plan for him. For that reason we partly upheld the complaint.

Putting it right

The Practice apologised to Mr J and made improvements to the prescribing of controlled substances.

Organisation(s) we investigated

A GP practice

Location

Essex

Region

East

Summary 1104/September 2015

Trust gave good clinical care to cancer patient, but poor record keeping left family with unanswered questions

Mr P complained that his wife was not given appropriate treatment following breast cancer in 2009. The cancer returned in 2014 and spread to her lungs. Mrs P died and Mr P felt if his wife had been given appropriate treatment in 2009, and if the cancer had been diagnosed sooner in 2014, his wife may have survived or had lived longer.

What happened

Mrs P had a mastectomy in 2009. The Trust offered her follow-up hormonal treatment and chemotherapy to reduce the chances of the cancer returning. Mrs P declined the further treatment as she wished to have children and the treatment would delay her ability to do this.

Mrs P was diagnosed with cancer of her other breast in 2012. This was successfully treated. As this was a different type of cancer, follow-up treatment would not have been beneficial.

In 2014, Mrs P attended hospital with difficulty breathing. She had fluid on her lungs. She was diagnosed with cancer which was most likely to be linked to her breast cancer in 2009 returning. Unfortunately Mrs P was too ill to start chemotherapy at that time and she died the following month.

What we found

We partly upheld this complaint. The Trust offered Mrs P appropriate follow-up treatment after her mastectomy in 2009. It was recorded that she declined treatment as she was keen to become pregnant as soon as possible. The records were not detailed enough to establish whether a full discussion took place with Mrs P about the consequences of not having the follow-up treatment. On the balance of probabilities, we considered a discussion did take place: it would have been difficult to discuss the treatment options with Mrs P without reference to why this was recommended or what the consequences would be if she did not have treatment.

However, the lack of records left Mr P not knowing exactly what was discussed or whether his wife had all the information she needed to make an informed decision to decline further treatment. This caused him considerable distress.

We found no failings in the clinical care provided to Mrs P in 2009, 2012 or 2014. Her treatment was timely and appropriate.

Putting it right

The Trust acknowledged the failings we identified and apologised to Mr P for the impact these had on him. It also took steps to learn from this complaint and improve its service.

Organisation(s) we investigated

Ashford and St Peter's Hospitals NHS Foundation Trust

Location

Surrey

Region

South East

Summary 1105/September 2015

Failings led to nerve damage following a biopsy

Mrs R complained that a biopsy was not done correctly. She also complained that the risks of the procedure were not properly explained to her.

What happened

Mrs R had a biopsy. Following the procedure she suffered swelling, pain and bruising. These issues were resolved but she was left with numbness in her lip and a dull ache in this area. She now has permanent nerve damage.

What we found

The Trust had already accepted that the biopsy was not done correctly and had taken action to stop this happening again. It had also accepted that it had not fully informed Mrs R about the risks of the procedure. These failings left Mrs R with permanent nerve damage.

Although the Trust had apologised to her for the mistake with the biopsy and the shortfalls in communication, we did not think the Trust had done enough to remedy the injustice to Mrs R. The Trust had not considered making a payment to Mrs R when it should have done so. We therefore upheld this complaint.

Putting it right

At our request the Trust paid Mrs R £4,000 in recognition of the impact of the failings on her.

It also developed an action plan setting out what it would do to prevent a recurrence.

Organisation(s) we investigated

Cambridge University Hospitals NHS Foundation Trust

Location

Cambridgeshire

Region

East

Parliamentary and Health Service Ombudsman

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