Parliamentary and Health Service Ombudsman

Selected summaries of investigations by the Parliamentary and Health Service Ombudsman

July to September 2014

Parliamentary
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 third in a series of quarterly digests of summaries of our investigations. The short, anonymised stories it contains illustrate the profound impact that failures in public services can have on the lives of individuals and their families. The summaries provide examples of the kind of complaints we handle and we hope they will give users of public services confidence that complaining can make a difference.

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

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

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

January 2015

Parliamentary cases

Summary 244/July 2014

Cafcass gave court damaging information about father in custody case

Mr H and his ex-partner split in acrimonious circumstances. Both made allegations about the other to the court. Two Children and Family Court Advisory and Support Service (Cafcass) officers gave the court incorrect information about Mr H and he had to go to some trouble to put the matter right.

What happened

The first Cafcass officer told the court that Mr H had admitted to an allegation that his ex-partner had made against him. Mr H had to make a number of phone calls to Cafcass before it accepted that he had not admitted it. It finally changed the document just before the next hearing.

The second Cafcass officer later told the court that Mr H was not engaging with her efforts to meet him. But this was not true. She later filed another report to the court that had some minor mistakes.

When Mr H complained to Cafcass, it accepted that it had made these mistakes and wrote to the court to say so before the court made a decision about the children's custody.

What we found

Cafcass had showed a lack of attention to detail and poor judgment. But it had admitted its mistakes and, crucially, had told the court about them so they did not affect the judge's decision in the case.

We thought, however, that there was more it could do to put the matter right.

Putting it right

Cafcass paid Mr H £500 compensation for his unnecessary distress and inconvenience.

Organisation we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 245/July 2014

Break in benefit claim due to Jobcentre Plus failings

A break in Ms K's benefit claim meant that she lost out on financial support (a job grant and in-work credit) when she returned to work.

What happened

Jobcentre Plus gave Ms K wrong information about claiming benefits when she was ill while she was claiming jobseeker's allowance. As a result, there was a break in her benefit record. This meant that when she started work, she was unable to claim financial support for the transition from receiving benefits to working in the form of a job grant and in-work credit.

Ms K complained to Jobcentre Plus and then to the Independent Case Examiner (ICE) that Jobcentre Plus had given her incorrect advice. She sought a payment to cover the job grant and in-work credit that she lost out on because of the break in her benefit record. Jobcentre Plus and ICE did not uphold her complaint.

What we found

Ms K had given Jobcentre Plus enough information for it to have advised her correctly. If Jobcentre Plus had advised Ms K correctly, she would not have had a break in her benefit claim and Jobcentre Plus would have accepted her job grant and in-work credit claim.

Jobcentre Plus's record keeping was poor. It has a data retention policy under which it destroys records after a set period. If someone has made a complaint, it should keep the records until 14 months after the complaint is closed. Jobcentre Plus did not do this.

Jobcentre Plus incorrectly told ICE that it had not received a letter from Ms K in which she had asked for advice on her benefits. However, Ms K had hand-delivered her letter to Jobcentre Plus.

We did not have any more information than ICE had when it investigated the complaint and yet we spotted Jobcentre Plus's failure to retain records and the incorrect information that it gave ICE. Consequently, ICE had failed to consider the evidence in this case properly.

Jobcentre Plus's failings were responsible for the break in Ms K's benefit record that meant she could not claim employment and support allowance. Ms K lost out on over £3,000 (for the job grant, in-work credit and employment and support allowance). This was a significant loss to her that had put her under financial strain.

Moreover, in addition to the errors already noted, Jobcentre Plus gave Ms K a poor explanation about a £100 consolatory payment that it gave her, and ICE made things worse by not considering evidence properly.

These failings added to Ms K's time, costs, confusion and frustration in seeking a resolution to her complaint and the in-work benefits that she expected but which, at the time of our investigation, some years later, she had yet to receive.

Putting it right

Jobcentre Plus paid Ms K over £3,000 in compensation plus interest for the benefits that she lost out on. It apologised to Ms K for the failings we identified and their impact.

Jobcentre Plus also paid Ms K £500 made up of £250 for its poor complaint handling and £250 for the financial strain Ms K felt when she did not receive the benefits she was entitled to.

Jobcentre Plus checked its guidance about when to retain evidence after a complaint. It used this case to remind employees about the importance of keeping evidence for complaints, and how to identify what counts as evidence.

Jobcentre Plus also checked the mechanism that prevents complaint evidence being destroyed until 14 months after the close of a complaint.

ICE paid Ms K £150 for compounding Jobcentre Plus's poor complaint handling by failing to consider properly the evidence in this case. ICE also apologised to Ms K for the failings we identified in its investigation and for their impact on Ms K.

Organisations we investigated

Jobcentre Plus

Independent Case Examiner (ICE)

Summary 246/July 2014

HM Revenue and Customs (HMRC) agreed to pay additional compensation for service failures and poor complaint handling

Mr S complained that in light of HMRC's mishandling of his Self Assessment tax returns and poor complaint handling, the £45 compensation HMRC offered him, a sum agreed as reasonable by the Adjudicator, was inadequate and should instead have been in line with the £100 penalties that had wrongly been imposed on him.

What happened

HMRC did not set up Mr S's Self Assessment tax details correctly when he went into business. It then sent Mr S a computer-generated notice asking him to file a tax return for the wrong year (2009-10). When he did not submit the return by the due date, he received an automatic £100 penalty notice. However, although HMRC agreed that the penalty notice should not have been issued, it did not take the necessary steps to prevent this happening again, which it did. HMRC then sent Mr S a confusing letter claiming, contrary to what he understood he had just been told, that he *did* need to complete the 2009-10 Self Assessment return.

When HMRC eventually admitted to a number of errors that had caused Mr S worry and distress, it offered him compensation of £25. However, Mr S considered that, given the professional time he had spent dealing with HMRC's incompetence, he should have been compensated in line with the £100 penalties it had wrongly imposed on him. HMRC said it was not authorised to make such a payment.

When Mr S tried to pursue his case further, to tier 2 of HMRC's complaints procedure, HMRC failed to acknowledge his letter. By the time it did so (more than two months after he sent it), he had already escalated his complaint to the Adjudicator.

The Adjudicator then took 20 months to deal with Mr S's complaint because of major resourcing problems. It concluded that although Mr S's tax affairs and his complaint had been poorly handled by HMRC, the apologies it had offered, plus the compensation of £45 (increased by £20 for poor complaint handling), was reasonable and in line with its redress policy.

The Adjudicator also agreed with HMRC that its guidance did not allow it to pay compensation for the hypothetical cost of '*own time*', and that there must be evidence of actual loss of earnings.

What we found

We were broadly satisfied with the way the Adjudicator handled Mr S's complaint. Its decision, not to agree to his £100 compensation claim in respect of the cost of his '*own time*' spent trying to sort things out, was in line with HMRC's *Complaints and Remedy Guidance Manual*. We also agreed that there was no procedural basis for the Adjudicator to support Mr S's view that HMRC's compensation offer should be in line with its £100 penalties.

However, we took a different view to the Adjudicator on the level of the injustice and the amount of redress needed to remedy that injustice. We also upheld Mr S's complaint about the inadequacy of the redress provided by HMRC in respect of its service failures and poor complaint handling and asked it to increase its compensation from £45 to £145.

Putting it right

HMRC paid an additional £100 compensation, and this was a suitable remedy for the impact on Mr S of HMRC's poor service and complaint handling. Mr S was satisfied with this outcome.

Organisations we investigated

HM Revenue and Customs (HMRC)

Adjudicator's Office

Summary 247/July 2014

UK Visas and Immigration (UKVI) delayed deciding request to stay in UK

Mr H complained that, two years after he had applied for permission to stay permanently in the UK, UKVI had still not reached a decision.

What happened

In 2003 Mr H came to the UK from Iraq seeking asylum. UKVI refused his asylum claim, but gave him permission to stay on a temporary basis because of the situation in Iraq at that time. In spring 2011 Mr H asked UKVI to reconsider his asylum claim on some new evidence. In winter 2012, Mr H's Member of Parliament (MP) queried when UKVI would be able to decide his application. UKVI said it was actively managing Mr H's case, but could not say when it would be concluded. Mr H's MP remained in contact with UKVI.

In summer 2013, UKVI told the MP it would begin work on the case within six months. It did and in spring 2014 it decided Mr H's case. However, it refused his asylum claim and decided that there were no exceptional circumstances in his case that allowed it to grant him discretionary leave to stay in the UK. UKVI set out its reasons for that decision. But its letter incorrectly said Mr H had failed to report to it between 2004 and 2010. In fact he had not been asked to report during that period.

What we found

UKVI should have decided Mr H's further submission to his asylum application by late summer 2011. This was within the timescale it had publicly committed to. It did not. Instead, it put Mr H's application into a queue of complex and difficult cases that needed to be resolved.

When Mr H's MP queried the delay in his case in winter 2012, UKVI failed to realise the case should have been decided as a priority the year before. And, instead of deciding it, it misled the MP about how well the case was progressing. When UKVI finally decided Mr H's case, two and a half years later than it should have, its letter contained a factual error. This error had no impact on the decision on Mr H's case, but it meant that Mr H has not had an accurate explanation of UKVI's refusal of his application.

UKVI's failure to decide Mr H's application by late summer 2011, and its failure to give him an accurate explanation of the reasons for its decision, amounted to maladministration.

Putting it right

UKVI should have dealt with Mr H's request to have his asylum claim reconsidered by late summer 2011. As the decision was a refusal of Mr H's application, he benefited from UKVI's delayed handling of his case. However, Mr H has not had an accurate explanation of that decision.

UKVI agreed to apologise to Mr H for not dealing with his request for his asylum claim to be reconsidered sooner. It also agreed to send him a revised decision letter that more accurately sets out the events of his stay in the UK before his application was decided.

Organisation we investigated

UK Visas and Immigration (UKVI)

Summary 248/July 2014

Cafcass wrongly told court that Mr L had been charged with a crime

Mr L complained that a Children and Family Court Advisory and Support Service (Cafcass) officer had had a poor attitude towards him and had failed to take account of his health. Mr L also complained about the content of the Cafcass officer's report that advised the court on Mr L's contact with his child.

What happened

The court asked Cafcass for a report about residence and contact for Mr L's child. The Cafcass officer met Mr L and his ex-partner and observed their interactions with their child. The Cafcass officer completed the report to court and recommended that Mr L's child should live with her mother, with Mr L having regular contact. Mr L complained about the content of the report and the Cafcass officer's recommendations.

Cafcass replied to the complaint and said that many of the issues raised should be discussed during the court hearing to decide where Mr L's child should live. Before the court hearing, Mr L's and his ex-partner's solicitors agreed to the level of contact that was set out in Cafcass's report.

What we found

Cafcass responded reasonably to Mr L's concerns about the Cafcass officer's attitude and the account the officer took of his illness. Some of the issues raised by Mr L related to the content of the report and Cafcass was correct to say that these matters should have been challenged in court.

Cafcass wrongly reported that Mr L had been charged with harassing his ex-wife when the evidence showed that he had not been charged. We felt that that would have caused Mr L frustration and distress.

Putting it right

Cafcass apologised to Mr L for incorrectly telling the court that he had been charged with harassment and for the impact that error had on Mr L.

Organisation we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 249/July 2014

UK Visas and Immigration (UKVI) delayed deciding young man's application for further leave to stay in UK

Mr L complained that because of a delay of more than two years in UKVI reaching a decision, he could not travel outside the UK or get the work experience he needed to qualify as an electrician.

What happened

Mr L first came to the UK with his brothers and sisters in 1998, when he was aged eleven, to visit their grandmother. UKVI refused their application to enter the UK, but gave them permission to stay on a temporary basis.

Mr L's mother then applied for the whole family to stay permanently in the UK on the basis that she was married to a British citizen, but UKVI refused her application. Eventually her appeal rights were exhausted, and in spring 2007 UKVI decided to remove the whole family from the UK.

In spring 2010 Mr L applied to UKVI for permission to stay in his own right, and later that year it granted him permission to stay for six months on the basis of his family life in the UK. In spring 2011, Mr L applied to extend his leave. He should have applied on a specified form and paid a fee. However, because he could not afford the fee, he applied on an incorrect form that only applied to people who had sought asylum or humanitarian protection. This type of application was free.

When UKVI received the form, it did not check it and sent it to a team dealing with a backlog of 'legacy' asylum and migration cases. In late summer 2013 UKVI processed the application and granted Mr L permission to stay in the UK for 30 months.

What we found

It was not part of UKVI's process to carry out initial checks of cases, and when it received Mr L's application, it placed it in the queue without checking whether it was correct for it to deal with. It was not.

UKVI would have known that cases placed in its 'legacy' backlog were likely to stay there for long periods, and we found it was unfair to customers to add cases to a backlog that should not be there. Its failure to have a process for checking cases was maladministration. And even when Mr L's representatives threatened legal action in late 2012, UKVI did not identify that the application had been incorrectly made. It also failed to meet a commitment to reach a decision within six months.

Also, UKVI should not have processed Mr L's application because he did not make it on the correct form and it was therefore invalid.

We could not look at the effects of Mr L's mistakes without considering what had caused them. Mr L had knowingly applied using the wrong form in order to avoid paying the fee. Whilst UKVI should have returned his application as invalid, this might have meant that he did not make an application at all. It was because of UKVI's mistakes that he achieved what he wanted – avoiding paying a fee.

Although this did not excuse UKVI's mistakes, we could not say that Mr L suffered an injustice as a result of it processing his application. The only injustice to him was that he had to wait longer than he should have done to get a decision.

We partly upheld the complaint.

Putting it right

UKVI apologised to Mr L for the delay in dealing with his application, which was caused by its maladministration. As UKVI now carries out initial checks of applications, we did not need to make a recommendation to stop what happened in Mr L's case happening again.

Organisation we investigated

UK Visas and Immigration (UKVI)

Summary 250 /July 2014

Ministry of Defence (MOD) failed to adequately respond to enquiries and complaints

When Mr P asked the MOD about its objection to his planned wind turbine, there were errors in its responses. It did not respond to him after his Member of the Scottish Parliament asked it to, and it delayed sending a complaint response.

What happened

Mr P made a planning application for a wind turbine. The MOD objected because it said that it would affect a nearby radar station. It said that it would remove the objection if a suitable mitigation plan was agreed. Mr P emailed the MOD twice but did not receive a reply, because the MOD had incorrectly recorded its email address.

Mr P contacted his Member of Parliament (MP) and his Member of the Scottish Parliament (MSP), who wrote to the MOD. Mr P complained about not receiving a reply to his email or advice on how to complete a mitigation plan. The MOD gave him a number of reasons why it did not receive the emails. There were also a number of errors in the responses Mr P received from the MOD. The MOD delayed sending the final response, despite giving him a date by when it would respond.

What we found

The original error in recording the email address was not so serious that it amounted to maladministration. However, it was maladministration that, when Mr P complained, the MOD gave him the wrong reason for the emails not arriving and did not take responsibility for the error until months later.

It was maladministration that the MOD did not contact Mr P after his MSP wrote to the Minister specifically requesting it to do so. The time the MOD took to respond to the MP's and the MSP's letters was not unreasonable.

The letters the MOD sent contained a number of errors. While each error on its own was minor, taken together, they indicated a lack of care when MOD staff drafted the correspondence. This was maladministration.

The delay in the MOD sending its final response was maladministration. This was because it did not meet its deadline or respond to Mr P's email asking about the deadline.

The MOD's failings caused Mr P frustration and inconvenience.

Putting it right

The MOD apologised to Mr P and explained what it had learnt from the complaint and what action it had recently taken, or intended to take, to improve its handling of enquiries and complaints.

Organisation we investigated

Ministry of Defence (MOD)

Summary 251/July 2014

HM Revenue and Customs (HMRC) agreed to reduce rate of recovery of overpayment

Debt management unit accepted our recommendation that a tax credit overpayment should be recovered at a slower pace.

What happened

Mr and Mrs A were overpaid tax credits in the 2006-07 and 2007-08 tax years, totalling over £7,700.

The overpayment arose after they mistakenly entered a nil household income on their 2006-07 annual declaration, prompting HMRC to make a large payment (around £7,500) to Mr and Mrs A in summer 2007. Mrs A telephoned HMRC soon after to explain that the payment was incorrect and to discuss repaying it. The adviser explained that while the overpayment could be repaid straightaway, they could also retain it as it would be recovered through their ongoing child tax credit entitlement – as long as their son remained in full-time non-advanced education.

As a result, Mr and Mrs A retained the overpayment and paid it back through their ongoing entitlement until 2011-12, when, because of changes in government policy, their entitlement ended, and HMRC asked Mr and Mrs A to pay the remaining overpayments back directly.

Mr and Mrs A complained to the Adjudicator in summer 2012. The Adjudicator partly upheld their complaint. It saw no reason to recommend that the overpayments were written off, but considered that the advice given to Mrs A in the telephone call in summer 2007 could have been better. The Adjudicator recommended that HMRC pay Mr and Mrs A £30 in respect of that poor advice.

What we found

HMRC gave Mrs A poor advice and this gave her and her husband a reasonable expectation that their tax credit overpayment would be recovered over a far longer period than was eventually the case.

However, we could see no reason to disagree with the Adjudicator's decision that the overpayment should be recovered.

Putting it right

We recommended that HMRC's debt management unit recover the overpayment at a similar rate as it would have if Mr and Mrs A had retained their tax credits entitlement: around £50 per month.

We considered that this rate of recovery, as opposed to pursuing Mr and Mrs A for the full amount immediately, returned them to the position they were in before their entitlement unexpectedly ended.

HMRC agreed with our recommendation and provided a contact number for Mr and Mrs A to use to set up the arrangement.

Organisations we investigated

HM Revenue & Customs (HMRC)

Adjudicator's Office

Summary 252/July 2014

Asylum seeker had to wait 18 months for routine decision on application to settle in UK

UK Visas and Immigration delayed making a decision on an application to settle in the UK from Mr D, who had already lived legally in the UK for over six years.

What happened

Mr D sought asylum in the UK at the age of 15. He was allowed to stay on a temporary basis until his 18th birthday. UK Visas and Immigration (UKVI) then granted him discretionary leave until autumn 2011.

Mr D applied for further leave in 2011. But UKVI put his application into an already large backlog of old asylum cases and did not look at it for over 18 months. It finally granted him leave in late 2013.

What we found

Mr D's application was straightforward. UKVI should not have put his application in the asylum backlog that was full of difficult and complex cases. When it did this, the application got stuck in the queue. UKVI should have found a more suitable team to deal with this application; had it done so, there is no reason why it would not have made a decision by early 2012.

Mr D suffered unnecessary delay, which caused him stress. Had there been no delay, Mr D would not have had to pay his solicitors £300 to chase up his application.

Putting it right

Following our report, UKVI reimbursed Mr D's solicitor's costs and paid him £250 to recognise the stress that arose from its errors. It also apologised to Mr D.

Organisation we investigated

UK Visas and Immigration (UKVI)

Summary 253/July 2014

Child Support Agency made handling errors but put them right; ICE handled complaint reasonably

Mr P complained that the Child Support Agency (the Agency) did not accept evidence that he had made maintenance payments. He was not happy about its decision on this, or with the Independent Case Examiner's (ICE) consideration of his complaint.

What happened

In 2005 the Agency assessed Mr P's liability for child maintenance, which he paid through a deduction from earnings order. His employment ended later that year so he stopped paying that way. He says that he paid his ex-partner directly from that point.

At various times between then and early 2011, the Agency sent Mr P letters and tried to trace him, but there were big gaps in its actions (18 months at one point, eight months at another). In early 2012 the Agency managed to contact Mr P and sent him a collection schedule backdated to 2005. He told the Agency that he had been making payments directly to his ex-partner, but he could not provide any written evidence of this (for example, bank statements). His ex-partner told the Agency that, while he had made some direct payments during that period, he owed her a lot of money. The Agency calculated Mr P's arrears and told him that he had to pay them.

Mr P complained to the Agency and it gave him another opportunity to show evidence that he had made payments. He was unable to give enough evidence.

The Agency apologised for its poor service when it delayed tracing Mr P, and paid him £75. Mr P complained to ICE, which was satisfied that the Agency had acted reasonably.

What we found

The Agency was too slow when it tried to find Mr P. Had it not delayed, it would probably have contacted Mr P sooner and reminded him about the requirement to show evidence of his payments to his ex-partner sooner than it did.

However, it was his responsibility to be aware of that requirement from the start. The fact that a reminder was delayed does not remove that responsibility. That being the case, the apology and £75 offered were a reasonable remedy. We were therefore satisfied with the Agency's final position and with ICE's decision.

Putting it right

When Mr P approached us, he mentioned service improvement, which had not been a focus of his complaint to the Agency or ICE. In light of that, we have recommended that the Agency consider how it can improve its service to make sure that non-resident parents are chased promptly.

Organisations we investigated

Child Support Agency (CSA)

Independent Case Examiner (ICE)

Summary 254/July 2014

UK Visas and Immigration delayed deciding asylum seeker's request to stay in UK

Mr B complained that UK Visas and Immigration delayed dealing with his application for permission to stay in the UK.

What happened

In 2005 Mr B came to the UK from Iraq seeking asylum. At this time UK Visas and Immigration (UKVI) confused Mr B's details on its computer system with that of another asylum seeker. UKVI refused Mr B's asylum claim, but gave him temporary permission to stay in the UK because of the situation in Iraq.

In winter 2008, Mr B asked UKVI to reconsider his asylum claim, but UKVI refused him asylum. Mr B asked UKVI to reconsider his asylum claim again in spring 2012. UKVI put Mr B's case in its priority queue of cases to be decided because he was receiving public support. In winter 2012 UKVI began work on Mr B's case. However, it did not finally decide it until spring 2014, at which time it was refused.

What we found

Mr B was receiving financial support when he asked UKVI to reconsider his asylum claim. UKVI should have prioritised his case to minimise the cost to the taxpayer. UKVI put his case in its priority queue of cases, but it was nine months before it started to consider it.

When UKVI began work on Mr B's case, an error it had made when he first arrived in 2005 (when it mixed up his reference number with another asylum seeker) meant that it stopped working on his case. UKVI realised its mistake, but failed to resume its work on his case. Instead, it extended Mr B's financial support, which was contrary to the intention behind its prioritisation policy.

UKVI did not look at Mr B's application again until we intervened on his behalf. But its 2005 error brought its progress to a halt again. UKVI resumed work on Mr B's case in early spring 2014 and refused his asylum claim the next month. That decision was reasonable, but UKVI's letter explaining it included a minor factual error about the length of time it had not known Mr B's whereabouts in the UK.

Putting it right

UKVI should have decided Mr B's case by early spring 2013. It should have sent him a decision letter that accurately reflected his contact with it since his arrival in 2005. UKVI apologised to Mr B for not deciding his case sooner. It sent him a decision letter that accurately set out its reasons for refusing his asylum claim.

UKVI reviewed its learning from Mr B's case to make sure that its prioritisation procedures work. It told us it now had a dedicated team dealing with cases in which public financial support was being paid.

It also agreed to carry out a review of cases to make sure that all public financial support cases had been properly prioritised, and, if they had not been properly prioritised, to provide an action plan for dealing with them. UKVI said it would report the outcome of that review to us, the MP and Mr B within three months of our final report.

Organisation we investigated

UK Visas and Immigration (UKVI)

Summary 255/July 2014

Independent Case Examiner (ICE) decision on child support was fair, but Child Support Agency was slow to act on information

A mother complained that Independent Case Examiner's (ICE) investigation of her complaint failed to consider earlier mishandling by the Child Support Agency (the Agency).

What happened

Ms A queried the nil assessment for child support maintenance in her case and, in response, gave the Agency details of the child's father's employment. The Agency revised the assessment, but only backdated it to when Ms A had first given the information after she complained. By then, however, arrears had accrued. The father then lost his job and the Agency was slow to deduct the reduced maintenance from his benefit. When the father started working again, the Agency was slow to impose a deduction from earnings order (DEO), so yet more arrears built up.

Ms A complained to ICE about the Agency's delay in securing maintenance via benefit deductions and the DEO, and ICE upheld her complaint. It asked the Agency to pay Ms A compensation of around £50 for the missed payments from benefit, and around £450 for the missed payments via the DEO that she would have received had the Agency actioned these sooner. Ms A was unhappy that ICE did not address the fact that the Agency had originally allowed arrears to build up by failing to act on information she had given it about the father's employment, following the first nil assessment.

What we found

ICE had addressed the complaint that Ms A had put to it, which concerned the Agency's delay in securing maintenance from the father's benefit and via a DEO. ICE's findings and recommendations for compensation were appropriate and reasonable, and so we did not uphold that aspect of Ms A's complaint. However, the Agency had yet to address her complaint about its failure to act on the employment information she had initially supplied.

Putting it right

As a result, the Agency agreed to make Ms A an advance payment of over £500 for the arrears that had unnecessarily built up as a result of its delay, plus interest of around £25.

Organisations we investigated

Child Support Agency (CSA)

Independent Case Examiner (ICE)

Summary 256/July 2014

Benefits underpaid for nine years

Mr B received around £14,000 less benefit than he should have over a period of almost nine years.

What happened

From spring 2004, or possibly earlier, Jobcentre Plus incorrectly deducted between £30 and £35 from Mr B's weekly benefits, which comprised disability living allowance, child benefit, income support and a non-standard rate of carer's allowance. (The rate reflected the fact that Mr B and his wife each care for one of their sons, who are severely disabled.) At the time, the deduction represented 20% of Mr and Mrs B's overall weekly income.

Every year, Jobcentre Plus manually calculated Mr B's benefit entitlement. This meant that it had seven opportunities in the years that followed to correctly calculate the benefit entitlement. However, it was not until early 2012 that Jobcentre Plus spotted its error and increased Mr B's benefits to his full entitlement of £56.85 per week (an extra £35.24 per week).

In spring 2012, Jobcentre Plus paid Mr B around £14,000 in benefit arrears for about eight years and nine months.

After a complaint from Mr B, Jobcentre Plus paid Mr B around £1,850. This was made up of a consolatory payment of £750 for gross inconvenience, interest calculated on the underpayment of around £1,100, and £6 for postage costs.

Mr B complained to the Independent Case Examiner (ICE). ICE upheld his complaint and asked Jobcentre Plus to increase the consolatory payment to £1,500 and the interest payment to around £7,500.

In reaching these recommendations, ICE noted Mr B's family's particular situation, including the needs of his disabled children and the extra difficulty the underpayment had caused in his family's circumstances. It also noted that Mr B and his wife had been diagnosed with stress and depression; there was professional medical opinion that the underpayment had contributed to the physical and mental ill-health of Mr B and his wife; and that Jobcentre Plus had put Mr B in the position of having to live on an amount under the minimum that the law said he needed.

ICE accepted that this meant that Mr B had to use credit cards to get by. Accordingly, Jobcentre Plus should have calculated interest based on average credit card rates rather than the official interest rate of 0.5% that it had used.

What we found

Mr B told us that carers like him do not have access to average rates of credit and have to borrow at higher interest rates. He also told us that he had to pay late payment and transfer charges. He believed ICE should have taken this into account and recommended a higher interest payment.

However, Mr B did not provide enough evidence to support his claim. His evidence showed that he had paid interest at 18% in one period and 0% at another time. Consequently, ICE's recommendation that Jobcentre Plus pay the average credit card rate of interest (13.4%) was fair, based on the information available.

Normally, Jobcentre Plus requires more evidence than Mr B was able to give before it can pay interest at the rate that ICE recommended. This includes evidence of the amount of debt in the years before and after its error; evidence of the rate of interest paid on that debt; and evidence of what was purchased with the debt. In this particular case, ICE was right not to insist on further evidence, which Mr B simply could not provide, and right to take into account the circumstances of the case, in addition to the available evidence.

However, in the course of our investigation, Mr B gave us further medical evidence that we felt showed a strong link between the despair and stress he felt in resorting to credit card debt to meet the shortfall in his benefit payments and a sudden decline in his mental health. This persuaded us that Jobcentre Plus should further increase the consolatory payment in recognition of the impact of its error on the health and mental well-being of Mr B and his family.

We did not uphold Mr B's complaint about ICE. We partly upheld his complaint about Jobcentre Plus. Our basis was that, through ICE's recommendations, Jobcentre Plus had done a lot to try to address Mr B's complaint, but there was still more it could do to recognise the impact of its error on Mr B and his family.

Putting it right

At the time of the complaint to us, Jobcentre Plus had apologised to Mr B and paid him around £14,000 in benefit arrears; around £7,500 interest on the arrears; and £1,500 as a consolatory payment.

We recommended that Jobcentre Plus give Mr B a further £1,000 consolatory payment in recognition of the impact of its error on him and his family.

Jobcentre Plus agreed to our recommendation.

Organisations we investigated

Jobcentre Plus

Independent Case Examiner (ICE)

Summary 257/July 2014

Mother complained that Cafcass did not take concerns seriously

Ms B complained about Children and Family Court Advisory and Support Service's (Cafcass) handling of her case in respect of the contact arrangements for her two children. She was also worried about the work of the Cafcass officers assigned to her case.

What happened

In summer 2011 a contact order was put in place outlining contact arrangements between Ms B's two children and their father.

Ms B said these arrangements, particularly midweek overnight contact, were not in the children's best interests. Between early summer 2012 and early 2013, there were court proceedings that involved two Cafcass officers. The final hearing took place in early spring 2013. Midweek overnight contact remained in place.

Ms B believed Cafcass's actions did not place her on an equal footing in the proceedings with her ex-partner. She also felt that Cafcass did not take seriously her concerns that the contact arrangements were having an adverse impact on her children.

Ms B complained to Cafcass between autumn 2012 and early 2013. It accepted that there were times when the service she received fell below what was expected, but it did not feel that she had been disadvantaged in the proceedings. Cafcass said that it would not amend its report and that Ms B had had an opportunity to present her concerns so that the court could make a decision about contact.

Ms B was also concerned that Cafcass's documents were not shown to her and that there were factual errors in Cafcass's reports. She also felt that Cafcass had not addressed all aspects of her complaint.

What we found

We agreed with Cafcass that there were times when it had not given Ms B the service she was entitled to. However, we were satisfied that Cafcass had accepted and apologised for this and that there was no evidence that Ms B had been disadvantaged in court proceedings as she believed.

We identified no outstanding injustice to Ms B as a result of Cafcass's shortcomings so we did not uphold the complaint.

Organisation we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 258/July 2014

Mother complained she was made unfairly responsible for daughter's debt

The Legal Aid Agency's (the Agency) poor handling of a woman's complaint led her to believe that she might have to pay back almost £78,000 that her daughter had received in legal aid funding.

What happened

Mrs J's daughter received legal aid to fund the legal costs involved in separating from her husband. During this time, Mrs J bought a property from her son-in-law and allowed her daughter to continue to live there.

Although Mrs J felt that her purchase was not related to her daughter's legal case, the Agency disagreed because it believed Mrs J's daughter had benefitted from the sale. As a result, it asked Mrs J for permission to register a charge against the property. This would mean that, if the property was sold, the Agency would be able to recover all or some of the money it had paid in legal aid funding to Mrs J's daughter.

Mrs J initially agreed to this request but she subsequently withdrew her permission and asked the Agency to remove the charge. This was because she did not accept that her daughter had benefitted from the purchase. However, although the Agency had not yet registered the charge, it refused Mrs J's request and continued to insist that her daughter had benefitted from the sale.

What we found

The Agency should have acted differently when Mrs J complained about the decision to register the charge, particularly as it had not actually registered the charge at that point.

The Agency should have explained clearly how much money it might seek to recover more. Although the legal aid funding was approximately £78,000, the amount the Agency sought to get back by registering the charge was far less than that.

The Agency also did not handle well an offer Mrs J had made to settle this issue.

We could not say whether Mrs J's daughter had benefitted from the sale of the property. However, we felt that if the Agency had acted appropriately before registering the charge, all parties would have understood this point.

Putting it right

The Agency took appropriate steps to have the charge removed from Mrs J's property and apologised to Mrs J for applying for the charge to be registered when it could not be certain that it was appropriate for it to do so at that time. It also apologised to Mrs J for its poor handling of her offer of settlement and paid her £250 in recognition of the worry, inconvenience and uncertainty its errors had caused her.

Organisation we investigated

Legal Aid Agency

Summary 259/July 2014

Court hearings cancelled because of HMCTS's errors

When HM Courts & Tribunals Service (HMCTS) did not follow the directions of a judge, Mr D's appeal against a conviction had to be adjourned. HMCTS also caused confusion by sending Mr D a wrong notice of hearing.

What happened

Mr D was convicted of assault by a magistrates' court. He appealed against his conviction to a Crown Court. The appeal was listed for hearing five times, but did not go ahead on any of those occasions as the Court did not have enough time to hear it because cases that were heard before Mr D's overran.

When one of the hearings was adjourned in mid-2013, the judge ordered that Mr D's case should not be listed at the end of the week and that no other cases should be listed on the same day. HMCTS did not follow the judge's directions and listed the hearing at the end of a week and at the same time as other cases. The appeal could not go ahead again.

HMCTS also sent Mr D an incorrect notice that gave him the wrong date for his appeal.

What we found

When HMCTS sent Mr D an incorrect notice of hearing, it unfairly raised his expectations that his appeal would be dealt with. HMCTS should have sent the correct notification.

It is also extremely important that HMCTS follows the directions of a judge. Its failure to do so here amounted to a serious error that caused Mr D some considerable frustration and inconvenience.

HMCTS was not at fault with regard to the other hearings that were cancelled. It had listed those hearings correctly and, on those occasions, it was not HMCTS's fault that the cases listed before Mr D's had taken longer than expected.

Putting it right

HMCTS reimbursed Mr D for the legal fees he had paid as a result of its mistakes, and his travel expenses. It paid Mr D £500 in recognition of the frustration and inconvenience its mistakes had caused him.

Organisation we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 260/July 2014

£9,000 benefit mystery

A man's death triggered the payment of over £9,000 in arrears of disablement benefit, dating back to the 1990s. When Jobcentre Plus refused to pay interest on the arrears, his estate set out to get some answers.

What happened

Mr B received industrial injuries disablement benefit from Jobcentre Plus because his job had caused him to become ill with chronic bronchitis and emphysema. After Mr B died, his estate received over £9,000 in arrears of industrial injuries disablement benefit.

Jobcentre Plus told Mr B's executors that it should have been paying Mr B more in industrial injuries disablement benefit since 1997. In line with its policy of compensating the person who suffered the loss, Jobcentre Plus refused to pay interest on the money because Mr B was dead. Mr F, his executor, complained.

What we found

Two legal decisions in the 1990s had changed Jobcentre Plus's interpretation of the law about industrial injuries disablement benefit in 2000-01, benefiting several thousand claimants. Jobcentre Plus publicised the change at the time, but knew some claimants were still receiving less money than they were due.

Officials decided they could not trace the claimants because the industrial injuries disablement benefit computer system was too basic and there were too many paper files to check. So Jobcentre Plus relied on spotting the cases when claimants contacted it for another reason. At worst, it would pay the arrears when a person died. It found Mr B was one of the unpaid claimants only when he died.

In the circumstances, Jobcentre Plus's approach to tracing claimants had not been maladministrative. Jobcentre Plus has scope to make exceptions to its policy of refusing to pay interest on arrears paid after a claimant has died. Arguably, it saved money by refusing to pay interest and Mr B's estate lost money because it received only the nominal value of the arrears. In this case, we decided that no exception was needed. If Jobcentre Plus had paid Mr B in his lifetime, the estate would have received nothing or much less than £9,000.

It would have been better if Jobcentre Plus or, later, the Independent Case Examiner (ICE), had given Mr F a fuller explanation of why it had paid the arrears only after Mr B's death. But this omission was too small to be maladministration.

There was no maladministration in Jobcentre Plus's or ICE's handling of the complaint.

Putting it right

Unusually, given that we found no maladministration, we made a recommendation. This was because the number of industrial injuries disablement benefit claims will continue to fall, making the task of identifying claimants in Mr B's position more manageable.

Jobcentre Plus has agreed to review its policy on identifying people who might be eligible to receive additional industrial injuries disablement benefit, like Mr B. The aim is to meet Jobcentre Plus's own policy of paying benefits to people during their lifetime.

Organisations we investigated

Jobcentre Plus

Independent Case Examiner (ICE)

Summary 261/July 2014

UK Visas and Immigration gets it wrong

Mr and Mrs B complained that UK Visas and Immigration (UKVI) offered them inadequate compensation to redress the injustice caused by an acknowledged error by an entry clearance officer.

What happened

Mrs B submitted settlement visa applications for her two daughters in the summer of 2012. UKVI refused them leave to remain. The refusal was wrong because UKVI had overlooked key evidence. Mrs B sent UKVI an email saying that its decision was wrong. UKVI did not respond to the email until after the deadline for appeals had passed.

Mr and Mrs B submitted fresh applications in winter 2013, which were granted the following month.

What we found

UKVI acknowledged that it made a mistake in refusing the applications.

UKVI did not act on Mrs B's email that queried the decision within a reasonable amount of time. Had it done so, we believe that that would have given Mr and Mrs B sufficient time to appeal the refusal decision.

Putting it right

UKVI apologised to Mr and Mrs B and the children for its initial error in failing to consider all the evidence submitted with the applications, and for its failure to consider Mrs B's email in a timely manner. It reimbursed the cost of the second set of application fees, almost £1,700 in total, and paid Mr and Mrs B £1,000 for the inconvenience and distress caused to them and the children when it incorrectly refused the applications.

Organisation we investigated

UK Visas and Immigration (UKVI)

Summary 262/August 2014

Over £40,000 payment to farmer after incorrect advice

Mr J received payment after three years of complaining, as the Rural Payments Agency (RPA) had not given him the right advice at the right time.

What happened

Mr J farmed land that he leased. At the end of the lease, he tried to have his entitlements for the Single Payment Scheme (SPS) put permanently in his name. The SPS is a European Union subsidy intended as income support for farmers. To do that, he needed to send RPA an RLE1 form. His assistant called RPA to arrange this but because of a problem with its computer system, his entitlements were not visible.

While RPA said that it told the assistant to complete an RLE1 form extending the entitlements before the lease ran out, there was no evidence that the assistant was reminded to do that after the computer problem arose. Her own notes showed that she was told to wait until the computer issues had been fixed before returning an RLE1. RPA's notes of the telephone calls were very brief and did not detail any discussions about how or when to return the RLE1. The assistant's last note showed that she had been advised that she did not need to do anything because the entitlements were correctly recorded, so Mr J applied for his SPS entitlement for 2011. Because an RLE1 form had not been completed, he did not get his expected payment of approximately £46,000.

RPA argued that the assistant had been given the correct advice at the outset and it was therefore not prepared to revisit this decision. It refused to accept that it had given the assistant the wrong information and could not see that once the situation changed (for example, the computer problem was fixed), it had an obligation to make sure that Mr J understood what he needed to do to get his payment.

What we found

On the balance of probabilities, RPA had misadvised the assistant because it had no evidence to show that it had told her to complete an RLE1 at any time after the computer problems arose.

Putting it right

As a result we asked RPA to apologise to Mr J, pay him £1,000 for its poor complaint handling and pay him an amount equivalent to his single payment scheme entitlement of approximately £46,000 for 2011, plus interest.

Organisation we investigated

Rural Payments Agency (RPA)

Summary 263/August 2014

Asylum seeker waited 16 months for a decision from UK Visas and Immigration on his application to stay

UK Visas and Immigration (UKVI) delayed making a decision on a second application from an Iraqi asylum seeker who had previously been asked to leave the UK.

What happened

Mr K, an Iraqi Kurd, came to the UK in 2005 and claimed asylum. His claim was rejected and UKVI attempted to return him to Iraq. However, because of the situation in Iraq, it was unable to do so.

In 2010 Mr K asked again to stay, but was rejected, and UKVI asked him to make arrangements to leave the UK. Mr K asked again to stay in 2012. By this time he was receiving asylum support, which should have led to UKVI prioritising his case. But UKVI put his case into an already large backlog of old asylum cases, and did not look at it for sixteen months. His further request was refused in winter 2013.

What we found

As Mr K was receiving asylum support from mid-2012, UKVI should have prioritised his case. But it put his case in the backlog of asylum applications and continued renewing his asylum support for almost eighteen months. Mr K suffered an unnecessary delay in receiving a decision. However, as Mr K's applications had all been rejected, there is no reason to think that, had his most recent application been dealt with quickly, there would have been a positive outcome. Therefore, Mr K benefited from the delay by being able to remain in the UK during this time, and he did not suffer an injustice.

Putting it right

We did not make any recommendations.

Organisation we investigated

UK Visas and Immigration (UKVI)

Summary 264/August 2014

Cafcass failed to follow conflict of interest policy

Children and Family Court Advisory and Support Service (Cafcass) appointed a family court adviser without following its conflict of interest policy, and did not investigate a complaint about this.

What happened

Ms C and her ex-partner were involved in court proceedings about contact and residence for their daughter. Cafcass was asked to produce a report for court. It assigned the case to a family court adviser without investigating or acting upon any potential conflict of interest that might exist.

Ms C was unhappy about the report and believed that it was biased against her. She spoke to Cafcass on the phone about her concerns. After the final court hearing, she raised concerns with Cafcass that there had been a conflict of interest. Although this was after the six-month deadline for making a complaint, Cafcass had discretion to decide to investigate, but chose not to.

What we found

Cafcass's conflict of interest policy states that the policy applies when one of the parties perceives that there is a conflict of interest. Ms C showed us documentation that led her to believe that a potential conflict of interest might exist, and which meant that Cafcass should have followed its conflict of interest policy. Its failure to do so was maladministration. However, we found no indication of bias in the family court adviser's report.

Ms C believed that Cafcass should have treated a telephone call within the six months as a complaint, but we found no failing in how Cafcass handled her call. However, when she complained again two years later, after the final hearing, we found that Cafcass should have given her an opportunity to explain why she had breached the six-month deadline, and should have looked at the new information she presented before making a decision not to pursue her complaint.

We found that Cafcass's actions resulted in a situation that the conflict of interest policy was designed to prevent, and Ms C said that she had no confidence in its report. She should not have been put in this position. She also felt that she could not get her voice heard when Cafcass failed to respond to her complaint, and we considered that was an injustice. Had Cafcass given Ms C a full and thorough explanation, it might have alleviated her loss of confidence in Cafcass.

Putting it right

Cafcass wrote to Ms C to apologise for its failings. It paid her £250 for the frustration, distress and loss of confidence brought about by its maladministration.

Organisation we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 265/August 2014

Errors when HM Court & Tribunals Service handled a claim

When Mr P made a county court claim, mistakes by HM Court & Tribunals Service (HMCTS) prevented the claim's progress. Despite some attempt to put these matters right, it could have done more.

What happened

Mr P made a county court claim against two private organisations. The first defendant filed a defence within the deadline but the second defendant did not. Mr P requested a default judgment against the second defendant, but HMCTS did not deal with this immediately and the second defendant filed a defence in the meantime. Mr P's request for a default judgment was not granted.

Mr P contacted HMCTS to point out that it had failed to handle his correspondence when it was first received by the court before the defence. HMCTS initially did not realise that it had made a mistake but after further correspondence, it apologised and told Mr P he could make an application to strike out the defence free of charge. It said that this would be handed to a senior officer to deal with as a priority.

In the meantime, Mr P was asked to pay a hearing fee for his claim. He did not pay because he did not know what was happening to his application to strike out the defence. His claim was struck out.

It later came to light that the application to strike out the claim was lost in a file of paperwork on a senior officer's desk. HMCTS apologised for this and told Mr P he could apply to reinstate his claim free of charge. It offered him £75 compensation for distress and inconvenience.

What we found

We found that HMCTS had made a number of mistakes in handling Mr P's claim. Although we could see that it had tried to put the matter right, the attempts had been unsuccessful.

Putting it right

We recommended HMCTS raise its offer of compensation to £200 and it did so. This was to reflect the fact that Mr P had been inconvenienced and would have to go to some trouble to reinstate his claim. We also took into account the fact that Mr P had been recovering from a stress-related illness while this was happening.

Organisation we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 266/August 2014

DVLA wrongly clamped and destroyed woman's car

Driver and Vehicle Licensing Agency's (DVLA) contractors clamped Miss Y's car even though she had a Statutory Off Road Notification in place and was parked on a private road.

What happened

Miss Y's car was not working, so she got a Statutory Off Road Notification so that she could park it legally outside her home on a private road until she decided to have the car repaired. DVLA's contractors wrongly clamped her car. When Miss Y complained repeatedly to both DVLA and the contractor, neither organisation listened or put the mistake right by investigating the matter. She felt forced to sign a disclaimer to give up her car as she could not afford the release fee. Miss Y's car was destroyed.

What we found

DVLA's contractors should not have clamped Miss Y's car and both it and DVLA failed to resolve the mistake. DVLA did not make its appeal process clear to Miss Y. DVLA and its contractors should have investigated the matter when Miss Y first got in touch. Its complaint handling was poor and its explanations to Miss Y about why it clamped her car were inconsistent.

Putting it right

DVLA apologised to Miss Y and paid her the value of the car it destroyed and £300 for the stress, inconvenience and frustration it caused her.

It gave drivers, its staff and its contractors clear written information about the correct procedure to follow to resolve the problem if DVLA or its contractors make a mistake.

Organisation we investigated

Driver and Vehicle Licensing Agency (DVLA)

Summary 267/August 2014

UK Visas and Immigration refused to compensate Mrs S fully when it lost her passports

Mrs S complained that UK Visas and Immigration (UKVI) failed to reimburse her for losing her two passports when it sent them to the wrong address.

What happened

In winter 2012 Mrs S applied for British citizenship and enclosed two passports from her country of origin – one passport had expired and one was live. UKVI granted the citizenship application the next month but sent the papers with enclosed passports to the wrong address. The error was discovered in spring 2013.

She sought costs towards the lost passports, assurances they had not been used by others illegally, and improvements to the service to avoid a repeat occurrence.

UKVI apologised and offered to reimburse the costs Mrs S had incurred in replacing the lost documents on the provision of receipts. Later in 2013 it advised Mrs S it would not reimburse her £700 claim without receipts.

What we found

We discovered that the process for obtaining a replacement passport from Mrs S's country of origin was complicated as it required Mrs S, or a friend/relative, to visit the visa section in Mrs S's country of origin. Mrs S told us that she did not feel able to return to her country of origin and did not have a friend/relative who could attend on her behalf.

Mrs S told us that she sought £700 because the two passports held sentimental value for her. Therefore, she wanted both passports back exactly as they were, including the costs for the expired passport, and the expired 'indefinite leave to remain stamps' she had obtained prior to her gaining British citizenship.

It was reasonable for UKVI to refuse to reimburse Mrs S for a passport that had expired and the 'indefinite leave to remain stamps' that she had previously needed but no longer did. However, we noted that UKVI had failed to properly explore Mrs S's reasons for claiming £700, or to consider that a compensation payment might be appropriate.

Putting it right

UKVI apologised for its handling of this case and the worry and distress caused. It paid Mrs S £200 in compensation.

Organisation we investigated

UK Visas and Immigration (UKVI)

Summary 268/August 2014

Information regulator failed to complete adequate assessment

The Information Commissioner's Office (ICO) did not properly consider the available evidence when it assessed a data protection complaint.

What happened

Mr G complained to the ICO as he did not believe that a local council had given him all the information it held after he had made an information request. The ICO decided that it was likely that the local council had complied with the *Data Protection Act 1998*.

What we found

The ICO had not properly considered the information the local council had given it and as a result had not carried out an adequate assessment of the data protection complaint. The ICO's views on some aspects of the complaint were reasonable.

Putting it right

The ICO apologised to Mr G and reassessed his data protection complaint.

Organisation we investigated

Information Commissioner's Office (ICO)

Summary 269/August 2014

Misleading advice led to a partnership having to pay back nearly £400,000 in VAT

HM Revenue and Customs (HMRC) gave misleading advice to a partnership while helping it to complete a form to reclaim VAT. When the mistake was discovered, HMRC asked the partnership to pay back the VAT, which amounted to nearly £400,000 plus interest and penalties.

What happened

The partnership had an 'option to tax' the tenants of an office (the company). But there was a connection between the partnership and the company, which meant that the partnership was not allowed an 'option to tax'. The partnership started building a new office for the company to occupy and recovered VAT on the construction costs on the basis of having an 'option to tax'. That was wrong for two reasons. First, it was not allowed an 'option to tax'. Secondly, even if it was allowed one, its existing 'option to tax' did not cover the new office building.

An HMRC officer visited the partnership to check its returns.

She explained that the partnership would need to apply for another 'option to tax' for the new office building and helped it with this. The partnership continued to recover VAT.

About three years later, another HMRC officer visited the partnership and discovered the connection between the partnership and the company. HMRC issued a VAT assessment in order to collect the VAT that the partnership had recovered.

The partnership complained that the first HMRC officer to visit had misled it and/or given it a legitimate expectation that the VAT was recoverable. HMRC and the Adjudicator's Office (which looks into complaints about HMRC) did not uphold the complaint. The Adjudicator's Office said there was insufficient evidence to say whether or not HMRC had misled the partnership.

What we found

The partnership could have sought a legal determination on the matter of legitimate expectation through the courts. We noted that we cannot make legal determinations. Consequently, we limited our consideration of legitimate expectation to considering whether HMRC had applied its guidance on misleading advice fairly.

On the balance of probabilities, the first HMRC officer mistakenly reassured the partnership that it had an 'option to tax'. The officer should have disallowed the VAT the partnership had already claimed, and was about to claim. Instead, the partnership received a VAT repayment of £385,000. If it had not received that sum, it would have had to have borrowed it from the bank to pay the construction costs. While that would have probably been an option for the partnership at the time, it told us that changing circumstances meant that was no longer so, and it would have serious difficulty paying the VAT.

HMRC's guidance sets a number of conditions and a case must meet all of them before HMRC will be bound by incorrect advice. This case did not meet one of the conditions. This says that HMRC will be bound by incorrect advice it has given if *'the customer would suffer detriment if the correct statutory position were applied (e.g. he would be financially worse off than if the correct advice had been given in the first place)'*. This did not apply in this case because if HMRC had given the correct advice in the first place,

the partnership would have had to pay the VAT that HMRC was now seeking from it.

HMRC's failure to retain the first officer's notebook was another error. This deprived the partnership of documentary evidence for its case. We said that was frustrating and made it more difficult for a decision to be reached on the case.

We did not uphold a complaint against the Adjudicator's Office. We took a different view on the evidence available but we did not find that its consideration of the case was flawed or unreasonable.

Putting it right

HMRC apologised for the inconvenience it had caused. It gave up the penalties it had applied to the partnership, and invited the partnership to apply for compensation for professional representative fees. It agreed to consider this compensation claim within three months.

It agreed to take a flexible approach to the collection of the arrears and interest, discussing this with the partnership. It also agreed to use our findings on the failure to retain the visiting officer's notebook and the overall outcome of our investigation as the basis of a 'lessons learnt' and a timely reminder campaign to HMRC managers.

Organisation we investigated

HM Revenue and Customs (HMRC)

Summary 270/August 2014

Legal Aid Agency's information misled complainant

Mr P complained that the Legal Aid Agency (the Agency) assured him that he had to make no contribution to his defence costs. He thought the matter was closed but two years later he received a demand for the money and the Agency instructed bailiffs to recover the debt.

What happened

Mr P applied for criminal legal aid in early summer 2010. He was advised by the Agency that if convicted and found to have assets such as savings, equity in property or shares of £30,000 or more, he might be liable for a contribution towards some or all of his defence costs. Mr P's criminal proceedings ended in spring 2011 and he was convicted on one count.

Mr P told us that in early summer 2011, he contacted the Agency to ask if he was liable for any of his defence costs in respect of his criminal case. This information was necessary so it could be accounted for in his recent divorce settlement. By Mr P's account and that of his legal team, the Agency said that he owed nothing and that the case was closed.

The Agency's computer system was updated with Mr P's final defence costs in winter 2011 and this information was sent to the Agency's enforcement agency. He was told how much he owed in spring 2013.

Between then and early 2014, Mr P disputed that he was liable for the debt, and the Agency carried out further assessments in relation to his finances. The Agency instructed bailiffs to recover the debt before placing a charging order on Mr P's property.

Mr P complained to the Agency about the fact he was told in summer 2011 that he was not liable for the debt. The Agency maintained that he was liable as he had over £30,000 of assets at the time of his original application for legal aid.

It agreed that it was inappropriate to have instructed bailiffs and it deducted the costs of this action from what it said Mr P owed. Mr P remained dissatisfied and referred his complaint to us. He wanted the Agency to accept that it had made an error, and for the money he paid to settle the debt to be returned to him.

Mr P also wanted procedures at the Agency to be improved, to be refunded the costs he incurred, and the Agency to recognise the distress and inconvenience he had been caused.

What we found

There was no evidence to suggest that the Agency had misadvised Mr P and we were satisfied that he was liable to pay his defence costs. However, we found that there were times when the Agency did not give Mr P the best service, including unnecessarily instructing bailiffs to recover the debt.

Putting it right

The Agency reduced Mr P's outstanding liability by £250 to recognise its poor service.

Organisation we investigated

Legal Aid Agency

Summary 271/August 2014

Police failed to comply with the Victims' Code

Mr G complained that his local police had not carried out the duties required by the Victims' Code when they reinvestigated his report that he was the victim of a crime.

What happened

Mr G complained that the police did not pass his details to Victim Support as required by section 5.4 of the Victims' Code. Mr G said the police also failed to properly inform him of the outcome of the investigation and whether it would be subject to future review, as required by sections 5.10 and 5.12 of the Code.

What we found

The police did not give Mr G's local Victim Support group his details or tell him they would do this, and so they did not perform their relevant duties under section 5.4 of the Victims' Code.

The police failed to tell Mr G the reasons why they decided not to charge anyone after they had finished their investigation (5.10). They also did not tell him whether the case would be reviewed in future (5.12). The police therefore failed to perform the relevant duties under those sections of the Victims' Code.

Putting it right

The police apologised to Mr G.

Organisation we investigated

Police (Victims' Code)

Summary 272/August 2014

A small mistake with a costly result

Mrs N lost over three years of help with her housing costs, thanks to a mistake by the Pension Service. After an initial error and bad advice from officials, the mistake took five years to put right.

What happened

Mrs N's savings were too big for her to receive housing benefit, but her pension credit position was very unusual - it meant she could receive housing benefit. A computerised prompt from the Pension Service to her local council should have triggered a housing benefit claim. But in early summer 2005, due to an error in the Pension Service's computer system, that prompt did not happen.

In 2009 Mrs N's family found out that the Pension Service had made a mistake. They tried to complain on their mother's behalf but the Pension Service gave them seriously wrong information about how to complain. By the time the family had the correct information over 18 months later, their mother had died.

The Pension Service apologised, but refused to compensate the family because Mrs N had died before it had considered the complaint. It said its policy prevented it from compensating the next of kin of people who had died. The Independent Case Examiner (ICE) investigated the complaint and upheld the Pension Service's decision.

What we found

Because of the Pension Service's mistakes, Mrs N was prevented from receiving the arrears of housing benefit money in her lifetime, and her estate could not receive it after her death. Also, the family's inheritance would have included a larger sum from Mrs N's savings including the interest. This was, for the family, an actual financial loss within the Pension Service's official policy.

Again because of its mistakes in 2009, the Pension Service did not compensate Mrs N. Even if it had been unable to make the payment before Mrs N died, it should have paid her estate because a decision about compensation could have been made before her death.

Without these errors, Mrs N's family would not have needed to make a pointless housing benefit appeal, go through the Department for Work and Pensions (DWP) complaints process, complain to ICE or complain to us.

Putting it right

DWP and ICE each agreed to apologise to Mrs N family.

DWP agreed to pay Mrs N's estate over £26,000, the amount she would have received in extra help with her costs had it not been for the Pension Service's original error in 2005.

DWP also agreed to pay Mrs N's estate interest on the housing benefit and to pay Mrs N's family £1,000 to apologise for the effect of their mistakes.

ICE agreed to pay Mrs N's family £250 to apologise for the effect of its mistakes.

Organisations we investigated

Pension Service, part of the Department for Work and Pensions (DWP). (In 2005-2009 it was called the Pension, Disability and Carers Service.)

Independent Case Examiner (ICE)

Summary 273/August 2014

Man had a long wait to find out if he could stay in the UK

UK Visas and Immigration (UKVI) delayed making a decision on an application to stay in the UK from a man whose wife and children had been given refugee status.

What happened

Mr C came to the UK from Zimbabwe and claimed asylum in 2002. He married a Zimbabwean national in the UK and they had three children. She and their children were given refugee status in 2009. Mr C applied for leave to remain in 2009 but UKVI rejected his claim. He made further submissions in 2012 but UKVI did not look at his case until winter 2013. When it considered his case, it granted Mr C indefinite leave to remain in the UK.

What we found

UKVI correctly put Mr C's case into a unit dealing with asylum claims made prior to 2007. It had made a commitment to deal with all these applications by summer 2011 and we found that there was no reason why Mr C's application should not have been decided by that date. UKVI failed to consider his case by summer 2011 and for more than two years after that. We found that its failure to take action and conclude his case was so poor as to be maladministration. We found that Mr C suffered anxiety, had been unable to make plans with his family and was severely restricted in the work he was able to do. We considered that was an injustice to him.

Putting it right

The principal injustice to Mr C had been remedied as he had been granted indefinite leave to remain. UKVI apologised to Mr C for the failings we found, and made a consolatory payment of £200 in recognition of the injustice he had suffered.

Organisation we investigated

UK Visas & Immigration (UKVI)

Summary 274/August 2014

The last minute phone message that never arrived cost farmer £7,000

A farmer believed he had met a crucial deadline just in time to claim annual funding worth almost £7,000. Three months later, far too late to put things right, the Rural Payments Agency (RPA) told him he had used the wrong claim form.

What happened

Mr H had planned to claim online for his 2012 Single Payment Scheme funding, a European Union subsidy intended as income support for farmers. His online claim in 2011 had worked, but in 2012 problems with his computer stopped him from claiming online. He sent in a paper claim form instead, without seeing that the form was out of date. The RPA received his claim in spring 2012, six days after the main deadline and 19 days before the last deadline for claims.

Three days before the last deadline in early summer 2012, an official left a telephone message asking Mr H to call them urgently. RPA guidance about leaving messages was that officials should not explain that they were calling about a claim form and that they should wait five days to take follow-up action. The message did not reach Mr H.

The first Mr H knew of this was in autumn 2012. The RPA wrote to Mr H to tell him that he would receive nothing for his 2012 claim, and about the missing message. He asked it to look again at his case. The RPA's response focused on the strict application of the law. It said Mr H knew the rules and was responsible for claiming in time.

What we found

The RPA made a serious mistake in failing to follow up its attempt to speak to Mr H in summer 2012. It deprived him of a chance to correct his own mistake.

Also, in this case, its legalistic approach to his complaint was a serious mistake. It should have focused more on what good administration required of it. Its mistaken approach unduly prolonged the complaints process.

But even if the RPA had followed up its telephone message effectively, Mr H could have had too little time to make a valid claim for 2012 before the last deadline.

Putting it right

The RPA apologised to Mr H and paid him £250 in recognition of the effect on him of its mistakes.

Organisation we investigated

Rural Payments Agency (RPA)

Summary 275/August 2014

Legal Aid Agency paid £500 for poorly handling its decision to cease funding

When the Legal Aid Agency (the Agency) decided to stop funding Mr Q, because an initial grant of legal aid had been incorrect, it failed to fully consider how this decision would affect Mr Q.

What happened

The Agency wrongly granted Mr Q funding for a matter that was not eligible for legal aid. The mistake was not discovered for four years, when the funding was withdrawn. Mr Q was very disappointed by this decision. The Agency agreed to send the matter to an independent adjudicator, but there was a substantial delay in doing so. The first adjudicator made an incorrect decision, causing the Agency to appeal, which prolonged matters.

The Agency accepted that there had been poor handling surrounding the adjudication and offered Mr Q £500 in compensation. However, it said its decision to withdraw funding was correct as it should never have been granted. It felt there was no injustice as Mr Q had benefitted by receiving four years of legal aid, to which he was not entitled.

What we found

We found that the Agency had wrongly paid out over £20,000 of legal aid to Mr Q, which he should not have received. We agreed that its decision to cease funding was reasonable.

We accepted that Mr Q had gained some benefit from the Agency's funding error as he had received a substantial amount of legal advice. However, we also felt that the Agency had not handled the situation well and had failed to adequately explain its position to Mr Q.

We also felt it had not properly considered Mr Q's claimed injustice arising from the extreme disappointment of having his funding stopped. We felt the Agency should take steps to recognise its poor handling of the case.

We felt that it had offered a suitable financial remedy in relation to the adjudication delays.

Putting it right

The Agency apologised to Mr Q and paid him an additional £500 for its poor handling of the case.

Organisation we investigated

Legal Aid Agency

Summary 276/August 2014

The Information Commissioner's Office took too long to review Mr P's case and failed to keep him updated

Mr P complained about the Information Commissioner's Office's (ICO) assessment of a complaint he had made about an organisation's response to his subject access request. Mr P also complained about the time taken by ICO to deal with his complaint.

What happened

Mr P contacted Organisation A and asked for a copy of the information it held on him (a subject access request). Mr P was dissatisfied with Organisation A's response and complained to ICO. ICO found that it was likely that Organisation A had complied with the *Data Protection Act*. However, the *Data Protection Act* includes a time limit which organisations must meet, and ICO found that it was unlikely that Organisation A had met that time limit in Mr P's case. When Mr P complained about the outcome of ICO's assessment, it carried out a review of his concerns. ICO decided that its earlier assessment of Mr P's case had been correct.

What we found

ICO's assessment of Mr P's case was reasonable. ICO had followed the correct process in assessing Mr P's case and had reached reasonable decisions.

However, ICO took too long to complete its review of Mr P's concerns and it failed to keep him updated during that process. ICO's failure would have caused Mr P frustration.

Putting it right

The ICO apologised to Mr P for failing to complete its review within the appropriate timescale or keep him updated, and for the impact that had on Mr P.

Organisation we investigated

Information Commissioner's Office (ICO)

Summary 277/September 2014

Child Support Agency asked to review how it deals with victims of domestic abuse

Ms W complained that the Child Support Agency (CSA) unfairly discriminated against victims of domestic abuse.

What happened

Ms W asked the CSA to review her former partner's child maintenance liability when she found out that he had inherited a property. The CSA replied that it could only do this if she applied for a variation and explained that any information she gave would be shared with her former partner. (A variation means that the CSA can consider if a parent's additional income affects the maintenance due.)

Ms W talked to the CSA about this over the next two years. She did not apply for a variation at that time because she was worried about what impact that would have on her and her child as she had been a victim of domestic abuse. When Ms W eventually felt sufficiently safe to apply for a variation, her maintenance assessment more than doubled. Ms W asked the CSA to backdate this increased assessment over the two years, but it told her that its policy meant it could not do so.

She complained to the Independent Case Examiner (ICE), which did not uphold her complaint.

What we found

We did not uphold Ms W's complaint. The CSA had followed its guidance and the law, and ICE had also reached reasonable conclusions.

However, we were concerned that Ms W had missed out financially because the CSA's policy did not allow it to take her vulnerability into account when considering her case.

Putting it right

We asked the CSA to review its policy around variations, taking into account the needs of vulnerable customers.

It agreed to do this.

Organisations we investigated

Child Support Agency (CSA)

Independent Case Examiner (ICE)

Summary 278/September 2014

UK Visas and Immigration gave misleading information which led to errors and distress

Mr G complained that UK Visas and Immigration (UKVI) failed to compensate his wife, a doctor, after it did not lift a restriction on her visa that would have allowed her to further her training.

What happened

Mrs G got her primary medical degree in Pakistan but completed a masters and a diploma at institutions in the UK.

In 2009 she was granted a visa to work as a doctor in the UK but she was not allowed work as a doctor in training, that is, to develop new skills and further her medical training.

In 2010 the Immigration Rules changed. A national of a country outside the European Economic Area could work in the UK as a doctor in training if they had got their primary (bachelor's level) medical degree in the UK. However, the guidance with the Immigration Rules specified that a medical degree from the UK, not a primary medical degree, was needed.

Mr G contacted UKVI in early 2012 about his wife's visa in light of the guidance he had seen. However, when UKVI reconsidered Mrs G's visa, it did not lift the restriction.

In summer 2012 Mr G and his wife went to the Public Enquiry Office where they applied for an extension to Mrs G's visa. They paid extra to use UKVI's 'premium' service to try and explain their confusion about Mrs G's case. Again, the restriction on Mrs G's visa was not lifted and Mr G was unsure why.

During our previous involvement in the case, UKVI wrongly told us that there was a window between spring 2010 and summer 2012 when a degree (not a primary medical degree) from a UK institution would be sufficient to lift the doctor in training restriction under the Immigration Rules. On that basis, we asked UKVI to honour its offer from early 2012 to consider Mrs G's visa under the Immigration Rules in place at that time. UKVI agreed to do this and lifted the restriction in winter 2013. However, it refused to offer any compensation for loss of earnings or the distress to Mrs G of not being able to further her career. It considered that lifting the restriction was a sufficient remedy.

In addition Mr G said he had not been compensated for his time spent trying to resolve the complaint, or for using the Public Enquiry Office's premium service.

What we found

UKVI wrongly told us and Mr G that Mrs G would have been able to have the restriction on her visa lifted between 2010 and summer 2012. In fact, Mrs G never qualified to have the restriction on her visa lifted under the Immigration Rules, as her primary medical degree was from Pakistan, not the UK. Mrs G had probably benefited from UKVI's mistake because the restriction on her visa would not otherwise have been lifted until she got indefinite leave to remain in the UK.

The Immigration Rules and guidance were at odds because the guidance did not specify that a primary medical degree from the UK was needed. Until we pointed this out, UKVI did not realise that this was the case. As a result, Mr G and his wife did not receive a full explanation about Mrs G's case until they read our report. We considered that UKVI's actions had unfairly raised Mrs G's expectations about her visa in 2012 and caused her distress by failing to properly explain the situation for two years.

Mr G and his wife had gone to the Public Enquiry Office to use UKVI's premium service in summer 2012, so that they could resolve their confusion over the guidance. However, their concerns were not settled, which meant they had made a wasted journey and unnecessarily paid for this service.

Putting it right

UKVI apologised to Mrs G for its handling of her case and paid her £250 compensation. It also paid £70 to Mr G and his wife for the cost of using the premium service and their travel costs. UKVI agreed to review its guidance to make sure that it reflects the Immigration Rules.

Organisation we investigated

UK Visas and Immigration (UKVI)

UK Visas and Immigration's guidance could have been more helpful and it failed to properly address a complaint

Mr C complained about UK Visas and Immigration's (UKVI) handling of his application for a permanent European Economic Area (EEA) residence card. Mr C said his application was refused as a result of UKVI's inadequate guidance.

What happened

Mr C applied for a permanent EEA residence card but UKVI refused because he did not have enough evidence of Comprehensive Sickness Insurance (CSI). Mr C complained to UKVI and appealed the decision at the same time.

UKVI did not initially reply to Mr C's complaint, but following our involvement (on the basis that Mr C told us he was not seeking legal action, although he was in fact actually appealing the decision) it responded and explained that applicants must hold CSI, which Mr C did not. It declined to comment further because the matter was going to appeal. Mr C lost his appeal because the judge said that his European Health Insurance Cards (one form of evidence of CSI) were undated and so he could not show that they covered all his stay in the UK.

Mr C then complained to UKVI that he had been misdirected by guidance on its website about what could signify evidence of CSI. UKVI apologised for giving him wrong information but clarified that he had failed to show evidence of CSI. UKVI did not address Mr C's concerns about the website guidance.

What we found

UKVI's website information about prescriptive what could constitute evidence of CSI was strict, but it needed to be, because there were only a few documents that could demonstrate CSI. However, there was potential for confusion in the case of undated European Health Insurance Cards, such as Mr C's, where supplementary evidence might be required to prove the validity dates of the Cards.

Whilst we acknowledged that Mr C thought this had affected his case, we noted it had been put before a judge who had decided that Mr C did not show he had CSI for the period he claimed. We also noted that Mr C had told us that there were gaps in his European Health Insurance Cards.

It was reasonable for UKVI not to engage with Mr C's complaint while his appeal was ongoing. However, it ought to have explained this to Mr C rather than ignoring his complaint. UKVI also gave Mr C wrong information during the complaints process and did not respond to Mr C's concerns about its website guidance.

Putting it right

UKVI apologised to Mr C for its poor complaint handling. It agreed to review its guidance in relation to supplementary evidence that might be required to demonstrate comprehensive sickness insurance.

Organisation we investigated

UK Visas and Immigration (UKVI)

Summary 280/September 2014

Inappropriate personal information included in a Cafcass report

Children and Family Court Advisory and Support Service (Cafcass) included information in a report to court about a woman's parents.

What happened

A court asked Cafcass to produce a report after Mr F's former partner made an application for residence for one of his children. In that report, Cafcass included information about the parents of one of Mr F's adult children. When the report was sent to Mr F, he left the report 'on the side' and it was read by other family members who were unaware of the adult child's parents. The family members were upset that Mr F had not told them about this before.

Mr F was also unhappy with the report because he felt that Cafcass had included a lot of supportive information about his former partner, but not enough about him. He complained to Cafcass but when it replied to him, it got the names of his children wrong and called them by an incorrect surname.

What we found

Cafcass should not have included information about the adult child's parents in its report, as it was not relevant to the court proceedings that were ongoing. That said, the report was correctly addressed to Mr F and he could have done more to make sure that it was not seen by his family members.

Despite that, even though Cafcass did not cause Mr F's children to find out about the adult child's parents, having to read the unnecessary information in the report would have caused Mr F some frustration and to lose some confidence in Cafcass's service. Cafcass should also have taken more care to refer to his children by the correct name.

We did not uphold Mr F's complaint about the amount of supportive information Cafcass included in the report. That was a matter for the Cafcass officer's professional judgment, which could have been challenged in court.

Putting it right

Cafcass apologised to Mr F for the mistakes it made in his case.

Organisation we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 281/September 2014

HM Courts & Tribunals Service did not mark a letter as urgent so the case was struck out

When Ms R wrote to the court, HM Courts & Tribunals Service (HMCTS) did not mark the letter as urgent. As a result, her letter was not on file in time for her hearing.

What happened

Ms R put in a claim through the small claims court. She wrote to the court explaining that she could not come to the hearing and asked for the case to be heard in her absence. The letter was received by the court within the time frame required, but as it related to an upcoming hearing, HMCTS should have marked it as urgent and processed it quickly. That did not happen and the letter was not on file in time for the hearing. The case was struck out on the grounds that Ms R had not attended the hearing or contacted the court.

Ms R complained. The court then referred her file and the letter to another judge for review, explaining what had happened. The judge reviewed matters but decided that the letter made no difference and upheld the original decision to strike out the claim.

What we found

HMCTS failed to make sure that Ms R's letter was on file in time for the hearing. However, it took reasonable steps to put this right by referring matters to another judge for review. As the judge upheld the original decision, we saw no evidence that HMCTS's mistake had affected the outcome of Ms R's case.

HMCTS's complaint handling was mostly adequate, but it would have been better if it had offered Ms R some compensation to recognise the frustration and inconvenience that the delay in filing the letter had caused.

Putting it right

HMCTS paid £100 compensation to Ms R and reminded staff to identify and process correspondence correctly.

Organisation we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 282/September 2014

Asylum seeker waited nine months for UK Visas and Immigration to decide on his application

Mr J complained about UK Visas and Immigration's (UKVI) delay in making a decision on his application. He said that he had to live in temporary accommodation for asylum seekers, and that the delay had affected his health.

What happened

Mr J, a Kurd from Iran, came to the UK in 2004 and claimed asylum. Immigration officials rejected his claim and he later left the UK without telling UKVI's predecessor organisation. He came back to the UK at an unknown date and applied to stay on four further occasions, but his application was rejected each time. Immigration authorities asked Mr J to make arrangements to leave the UK.

Mr J applied to stay again for a fifth time in early 2013. Shortly afterwards, he started receiving asylum support, which should have led to UKVI prioritising his case. But UKVI put his case into storage and did not look at it for eight months. It refused his further request in autumn 2013. Mr J has since applied again to stay in the UK.

What we found

Because Mr J was receiving asylum support from early 2013, UKVI should have prioritised his case. However, it did not do so and extended his asylum support instead of deciding his case. Mr J had to wait longer than he should have for a decision. However, UKVI had rejected all his previous applications and when it reached a decision on his early 2013 application, it refused him again. There is no reason to think that, had this application been dealt with quickly there would have been a positive outcome. Mr J benefited from UKVI's delays because he was able to stay in the UK during that time. He did not suffer an injustice and we partly upheld his complaint.

Putting it right

We did not make any recommendations.

Organisation we investigated

UK Visas and Immigration (UKVI)

Summary 283/September 2014

UK Visas and Immigration took too long to decide a single parent's application to stay in the UK

Ms T's four-year wait for UK Visas and Immigration (UKVI) to make a decision caused her and her child hardship and stress.

What happened

Ms T came to the UK in 2000. She was refused permission to stay as a student but remained in the UK. In 2001, she had a child who became a British citizen in 2011.

In 2009, Ms T applied to stay in the UK. Immigration officials gave her case to the wrong team, who put it in a backlog of old asylum cases UKVI had promised to finish by summer 2011. However, it did not deal with Ms T's case by then and passed it to successive teams dealing with the same backlog. UKVI finally sent it to the right team in summer 2012. This team made a decision on Ms T's application in winter 2013 and gave her permission to stay in the UK.

What we found

If UKVI had allocated Ms T's case to the right team when she applied in summer 2009, she would have received a decision on her case over three years earlier. UKVI told us that the decision would probably have been in her favour, even if it had been made then.

The delay caused Ms T and her child stress and uncertainty.

Ms T also missed the opportunity to look for work to support them both and to claim benefits. This could have prevented some of the hardship they suffered.

Putting it right

UKVI agreed to apologise to Ms T and pay her £2,500 compensation.

Organisation we investigated

UK Visas and Immigration (UKVI)

Summary 284/September 2014

UK Visas and Immigration handled Ms G's application poorly

Ms G applied for permission to stay in the UK but her case was caught in a backlog for six years.

What happened

Ms G and her child had been in the UK since 2000. In 2007 she applied for permission for them to stay permanently. This was under a concession introduced in 2003 for failed asylum seekers with children.

UK Visas and Immigration (UKVI) should have granted Ms G indefinite leave to remain by the end of 2008, but it did not do so until the end of 2013. This was because Ms G's case was caught in a backlog of old asylum cases it was dealing with called the 'legacy case backlog'.

What we found

UKVI failed to prioritise Ms G's case in late 2007 or add her child's details to its computer system at this time. This delayed her application unnecessarily. Additionally, UKVI failed to respond to all but one of the seven letters Ms G's representatives sent to UKVI about the delay. The one reply it sent contained misleading information.

Ms G should not have had to wait so long for UKVI to decide her and her child's application. The delay caused her frustration and inconvenience. Ms G said the delay stopped her child from becoming an apprentice and her from working, but we did not find that was the case. They both could have asked for permission to work.

Putting it right

UKVI apologised to Ms G for the delay deciding her application and for not dealing well with her representatives' correspondence. It also paid her £300 compensation.

Organisation we investigated

UK Visas and Immigration (UKVI)

Summary 285/September 2014

Asylum seeker should have had an earlier decision on his case

UK Visas and Immigration (UKVI) delayed making a decision on Mr L's application for two and a half years.

What happened

Mr L came to the UK in late summer 2003 and unsuccessfully claimed asylum, although he incorrectly continued to receive financial support. He remained in the UK, met his partner and had three children with her between 2006 and 2011.

In early 2011 Mr L applied for leave to remain in the UK. UKVI put his case in the backlog of old asylum cases that it had promised to finish by summer 2011. However, UKVI did nothing more on his case until late 2013, when it granted Mr L leave to remain for thirty months.

What we found

UKVI made a decision on Mr L's case in late 2013 but it should have done so by the middle of 2011. UKVI communicated poorly with Mr L. However, Mr L may have benefited from UKVI's delay in making a decision because he continued incorrectly to receive some financial support for ten years.

Mr L suffered stress and uncertainty about what would happen to his case, and he lost the opportunity to look for work from summer 2012 when he would have been granted discretionary leave.

We partly upheld the complaint.

Putting it right

UKVI apologised to Mr L and paid him £250 for the injustice because of its delay in deciding his case.

Organisation we investigated

UK Visas and Immigration (UKVI)

Summary 286/September 2014

HMRC's poor administration and appeals process, and its threat to take man to court

HM Revenue and Customs (HMRC) failed to consider whether certain information could be used to defend an appeal and it caused confusion over what matters were subject to appeal.

What happened

After an enquiry into Mr T's financial affairs, HMRC sent him income tax and VAT assessments. An internal review of the case considered the VAT assessment, but not the income tax assessment.

In autumn 2010, Mr T's accountant appealed against the results of the internal review. In the months that followed he asked HMRC to confirm that the internal review and appeal covered both the income tax and VAT assessments. If not, he asked it to do so, in order that Mr T could appeal against the income tax assessment. He also asked HMRC to postpone collection of all the assessments and penalties while Mr T pursued the appeal.

The officer who had issued the income tax assessments was unaware of the appeal. She told the accountant that the internal review had covered both types of tax, which it had not. She also told him that he had missed a time limit to appeal. In the following months HMRC sent Mr T revised income tax and VAT assessments totalling over £55,000, plus penalties and also payment demands. It threatened court and bailiff action.

Despite complaints from Mr T's accountant, it was not until early spring 2011 that HMRC told Mr T that it recognised his income tax appeal.

In late spring 2011, HMRC's appeals department looked at the case. It found that the internal review had not considered whether a key piece of evidence was acceptable to a tribunal hearing. It decided that it was not, and this meant it should not defend the appeal. Accordingly, HMRC withdrew the income tax and VAT assessments and the penalties.

Mr T complained to HMRC that its basis for pursuing the assessments had been flawed from the outset. He said it had hounded him, caused him stress and that he had had to sell his business. He asked for compensation for this. HMRC and the Adjudicator's Office did not uphold his complaints.

Subsequently, Mr T asked HMRC to meet the cost of his accountant's work on his case.

HMRC said that the decision not to defend the appeal might have been made sooner, at the internal review stage, if it had considered that the key piece of evidence was acceptable. However, it added that it could be argued that only its appeals department could take the decision to withdraw. On that basis, HMRC met half the cost of the accountant's work in appealing against the VAT (£1,500).

What we found

There were flaws in HMRC's internal review. On the balance of probabilities, HMRC would have decided not to defend the appeal at the internal review stage were it not for these flaws. Because of this Mr T paid unnecessary accountancy fees.

HMRC handled the attempts to appeal against the income tax assessments poorly. It sent payment demands instead of suspending them, which meant more worry and accountancy fees for Mr T.

There were mistakes in HMRC's actions during the course of its enquiries. It gave misleading information about how its VAT enquiries came about, and it did not properly grant Mr T his right to object to an inspection of his business.

We partly upheld the complaint about HMRC. We did not uphold the complaint about the Adjudicator's Office that it had not dealt with Mr T's case fully and fairly.

Putting it right

HMRC apologised to Mr T and to his accountant. It paid Mr T £100 for the worry caused by its poor handling of the appeal against the income tax assessment. HMRC paid the other half of the accountant's fees in relation to the VAT appeal (£1,500), and a further £3,255 to meet all the accountant's fees for trying to sort out the confusion over the income tax assessments. HMRC agreed to highlight this case within the relevant business areas so that lessons could be learnt.

Organisations we investigated

HM Revenue and Customs (HMRC)

Adjudicator's Office

Summary 287/September 2014

Poor communication by the Gambling Commission when it dealt with a complaint about the National Lottery

Mr G complained about delays and lack of action by the Gambling Commission when it investigated his complaint about Camelot, the National Lottery's operator.

What happened

Mr G complained to Camelot about a retailer who he believed had defrauded him out of a high-value win on the Lottery. Camelot's investigation found that there had been no large wins in the area where Mr G had bought his Lottery ticket.

Mr G remained convinced that he had won, and asked the Gambling Commission to investigate. The Gambling Commission carried out an investigation to check that Camelot had investigated Mr G's complaint properly. At the end of this, the Gambling Commission told Mr G that it had found no evidence that a high-value prize had been claimed at the retailer in question.

What we found

As the regulator of the Lottery, the Gambling Commission did not have the power to resolve Mr G's consumer complaint or change the outcome. Although the Gambling Commission could investigate Mr G's complaint, it could only do so as a regulator in order to make sure that the Lottery is properly run.

The Commission did not clearly explain its limited role as a regulator, and its communications led Mr G to believe that it could resolve his complaint. This raised his expectations unrealistically.

Putting it right

The Commission agreed to apologise to Mr G and to pay him £50 to recognise the effect of its poor communication with him.

Organisation we investigated

Gambling Commission

Summary 288/September 2014

Cafcass's poor record keeping caused confusion

Mr A complained that the Children and Family Court Advisory and Support Service (Cafcass) put wrong information about him in a letter it sent to court.

What happened

The police sent Cafcass information about Mr A, and Cafcass then sent that information to court. Cafcass did not speak to Mr A before doing that.

Cafcass later acknowledged that most of that information was not relevant to Mr A's case, and it wrote to the court and Mr A to tell them that. But because Cafcass sent the letters to the wrong address, Mr A got those letters late.

Mr A complained that Cafcass did not follow its procedures when it dealt with his case. He was also unhappy about the way that the Cafcass officer at court spoke to him, and how Cafcass had dealt with his complaint.

What we found

The Cafcass officer who handled Mr A's case did not record the reasons for her actions. It was therefore impossible to find out exactly what she had done. However, she acknowledged that she should not have included the police information in her letter to the court. She had already resolved this by writing to the court.

The police information did not come from the police national computer, but from the local force. Cafcass said that Mr A could complain to the local police force if he was unhappy about what the police had said about him.

Cafcass sent Mr A's post to the wrong address because it had been given that address by a third party (so the mistake was not its fault).

We partly upheld the complaint.

Putting it right

Cafcass apologised to Mr A and showed us that its recording standard had improved since Mr A had complained.

Organisation we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 289/September 2014

Cafcass failed to give the correct documents to its court duty officer for a court case

Mr and Mrs B complained about the actions of a Children and Family Court Advisory and Support Service (Cafcass) court duty officer. They said that he mishandled their case, and they complained about his attitude.

What happened

Mr and Mrs B wanted contact with their grandson after his mother stopped the previous arrangements, so they went to court to enforce those arrangements. The Cafcass court duty officer was asked to get involved by the court, but Cafcass had not sent him the necessary paperwork beforehand. The officer put forward a compromise solution to the visiting arrangements in court which the court accepted. Mr and Mrs B complained about that, because they said that it had set matters back by months. They also complained about the officer's attitude immediately after the hearing.

Cafcass did not uphold Mr and Mrs B's complaint. It said that if they had wanted to challenge what the Cafcass officer said, they should have done so in court.

What we found

The Cafcass officer was right to get involved, and it was reasonable for him to try and put forward a compromise solution. However, Cafcass realised that the officer should have had certain documents relating to Mr and Mrs B, but it had not sent them to the court. The court duty officer was therefore put in a situation in which he had to make recommendations about the case without knowing much of the background.

Cafcass confirmed that since this case happened, its court duty officers have access to all the electronic files for a particular case via a portable tablet device.

Cafcass was right to tell Mr and Mrs B that they should have challenged the court duty officer's recommendations in court. We also found that Cafcass badly handled Mr and Mrs B's complaint, because it failed to identify the mistakes that we found. We partly upheld the complaint.

Putting it right

Cafcass apologised to Mr and Mrs B.

Organisation we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 290/September 2014

UK Visas and Immigration incorrectly rejected a family's application for leave to remain in the UK

A family's entitlement to social security benefits and local authority housing was delayed by UK Visas and Immigration's (UKVI) error.

What happened

Miss K applied for leave to remain in the UK for herself and her three children. She asked UKVI to waive the fee on the basis that she could not afford it. When it refused, she sent in an application enclosing the fee, which the local authority had paid. UKVI rejected the application on the basis that no photographs had been enclosed and it returned the fees to the local authority.

UKVI later realised that it had wrongly rejected Miss K's application as the photos had been enclosed. But it decided that its error did not now matter because Miss K would benefit from a new policy that allowed fees to be waived in circumstances such as hers.

UKVI also told Miss K that it no longer had the family's documents she had sent it because everything had been returned to her.

UKVI later granted Miss K and her children leave to remain in the UK.

What we found

UKVI incorrectly rejected Miss K's application, which delayed her and her children's entitlement to social security benefits and local authority housing by eleven weeks.

UKVI found Miss K's documents and returned them to her.

Putting it right

UKVI apologised for its error in rejecting Miss K's application and for not returning her documents promptly. It agreed to pay Miss K around £500 for lost social security benefits and £750 compensation for the inconvenience caused.

Organisation we investigated

UK Visas and Immigration (UKVI)

Summary 291/September 2014

Cafcass failed to investigate and respond to a complaint properly

Mr D complained to the Children and Family Court Advisory and Support Service (Cafcass) about the way he and his partner were treated in relation to a decision about where his child would live.

What happened

Mr D made an application to a court about where his child would live. The Cafcass officer arranged a meeting with him. Mr D had to travel a long way from where he lived to attend the meeting. Mr D was unhappy about this, the delayed start to the meeting, and also what happened during and after the meeting. The Cafcass officer interviewed Mr D's partner, who was also upset about the Cafcass officer's conduct. The Cafcass officer prepared two reports for the court and Mr D was not happy about what the reports said. Although those issues were resolved before the case was heard in court, Mr D was upset that the Cafcass officer was involved on the day of the court hearing.

Mr D and his partner complained to Cafcass. Cafcass responded to Mr D's complaint but said that it would not investigate his partner's complaint because she was not a party in the proceedings.

What we found

We agreed it was more appropriate for Mr D's complaints about the content of the reports to be raised in court. However, Cafcass did not contact Mr D as it should have done when it prepared the second report. The apology Cafcass had already offered was an appropriate remedy.

There were no failings to the arrangements for the meeting or what happened during or after the meeting. However, Cafcass did not properly investigate Mr D's complaints about the delay to the start of the meeting. There were no faults in the actions of the Cafcass officer on the day of the hearing.

It was unfair that Cafcass did not investigate Mr D's partner's complaint, and this was an injustice to her that had not been put right.

Putting it right

Cafcass apologised to Mr D for not properly investigating his complaint and not investigating his partner's complaint. It also reviewed Mr D's partner's complaint and the way it handles complaints from people who are not party to proceedings.

Organisation we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 292/September 2014

Unreasonable delay by Child Support Agency

Mrs R believed the Child Support Agency (the Agency) was slow in dealing with her case.

What happened

In 2009, the Independent Complaints Examiner (ICE) had tried to resolve Mrs R's complaint that the Agency had handled her maintenance case poorly. As a result of ICE's actions, the Agency paid Mrs R a consolatory payment of £750 and an exceptional advance payment of maintenance.

Mrs R was still unhappy about the Agency's actions and complained to us that it had not collected child support maintenance arrears from her child's father that she had been owed since 2004.

This had caused her and her family financial and emotional distress. Mrs R wanted the Agency to pay her an exceptional advanced payment of maintenance for the arrears due to her.

What we found

We partly upheld Mrs R's complaint. There were around two years of delay when the Agency did not take any action to progress Mrs R's case.

On one occasion, the Agency unreasonably decided not to take any enforcement action to recover the maintenance from the child's father as it believed that Mrs R did not want it to pursue the arrears. The Agency's failings caused Mrs R inconvenience, stress, worry and frustration and this would have affected her health.

Even if the Agency had acted more quickly, Mrs R may not have received the child support due to her. This is because the child's father deliberately avoided his responsibilities and made no attempt to pay what he owed.

The Agency's attempts at enforcement were correct, despite being unsuccessful and limited for some time because of a bankruptcy restriction in place.

We were satisfied that the Agency took correct enforcement action. It cannot be held responsible for the child's father's failure to pay the money owed. In addition, despite the Agency's delays, Mrs R's case did not meet the criteria for it to make her an exceptional advance payment of maintenance.

Putting it right

The Agency apologised to Mrs R and paid her £350 in recognition of the impact of its failings.

Organisation we investigated

Child Support Agency (CSA)

Summary 293/September 2014

Legal Aid Agency did not respond to enquiries about a missing application for legal aid

The Legal Aid Agency (the Agency) failed to deal properly with enquiries, and Mr S was kept waiting for legal aid.

What happened

Mr S's solicitor applied for legal aid on Mr S's behalf. However, the Agency refused the application, apparently because Mr S's solicitor had not provided all the necessary information.

The solicitor made several enquiries to the Agency to find out what information was needed but it did not respond. Eventually Mr S complained to the Agency and then to us about what had happened.

What we found

The Agency had never actually received Mr S's application (although, at around the same time, it had received and processed another application he had made). But because the Agency did not respond to his solicitor's enquiries, Mr S remained unaware of this until we investigated the matter.

Although Mr S still had the opportunity to submit the application, he could have done this so much earlier if the Agency had responded properly to his solicitor's enquiries.

Putting it right

The Agency apologised to Mr S and paid him £250 in recognition of the frustration and inconvenience it had caused him.

Organisation we investigated

Legal Aid Agency

Summary 294/September 2014

Coal Authority did not give a reasoned response to a complaint

Complainants were not aware that there were mineshafts on their land. When they found out in 2011 they complained to the Coal Authority but were unhappy with the response.

What happened

Three sets of neighbours bought properties in the 1970s and early 1980s and had relied on either local searches that had been carried out by the property developer (two sets of neighbours) or a search that had been carried out when they purchased the property (one set of neighbours).

In 2011, as part of the Coal Authority's ongoing mine shaft safety inspection programme, it sent letters to the three sets of neighbours, to tell them that it was going to inspect the mine shafts relevant to their properties.

The neighbours complained to the Coal Authority about the mineshafts devaluing their properties. A representative from the Coal Authority met them but it is not clear exactly what was discussed at those meetings because of the lack of records. The Coal Authority then sent them a written response that said that they were out of time to make a negligence claim and could not claim under subsidence legislation because they had not suffered actual damage.

We partly upheld the complaints.

What we found

We did not look at the Coal Authority's decision itself – we did not have sufficient information. However, the Coal Authority had not given the complainants a reasoned response to their complaints and so caused them distress and inconvenience.

Putting it right

The Coal Authority considered and responded to the complaints made. It apologised for its failure to properly deal with the complaints at the start, and for the distress and inconvenience that resulted.

Organisation we investigated

Coal Authority

Summary 295/September 2014

Driver and Vehicle Standards Agency failed to properly investigate allegations about a driving examiner

A driving instructor complained to the Driver and Vehicle Standards Agency (DVSA) about the attitude of a driving examiner, but it did not properly investigate the allegations.

What happened

Mr W, who is a driving instructor, visited the local test centre with one of his pupils to prepare for a driving test. Mr W alleged that the driving examiner used inappropriate language and raised his voice. Mr W complained to DVSA, who spoke to the driving examiner, but he refuted the allegations.

Mr W escalated the complaint to the Independent Complaints Assessor (ICA) which asked DVSA to interview Mr W's pupil as he had witnessed the events. DVSA wrote to Mr W's pupil who produced a statement with the help of Mr W. The ICA decided that it could not reach a view on what the examiner had done, because Mr W had helped his pupil prepare the statement, and it did not uphold the complaint. ICA found that DVSA had not properly investigated the complaint as it did not interview the pupil at the time of the original complaint.

Mr W remained unhappy. He wanted DVSA to apologise and an assurance that it would handle complaints better in the future.

What we found

We could not reach a view on the driving examiner's actions because there was no independent evidence we could rely on.

DVSA failed to properly investigate Mr W's complaint, and did not take account of all the potential evidence because it did not interview Mr W's pupil. This meant Mr W did not get a full response to his concerns based on all of the available evidence.

Putting it right

During our investigation, DVSA said it wanted to apologise to Mr W and explain what action it had taken as a result of his complaint. It said it wanted to make sure that complaints would be dealt with better in the future. This was an appropriate remedy so we did not make any recommendations.

Organisation we investigated

Driver and Vehicle Standards Agency (DVSA)

Summary 296/September 2014

Mr C relied on UKVI's guidance but this information was at odds with Immigration Rules

Mr C complained because he applied for indefinite leave to remain in the UK and this was refused by UK Visas and Immigration (UKVI) despite Mr C following UKVI's guidance.

What happened

Mr C committed a criminal offence between spring and early summer 2011, for which he was convicted in mid-2012.

In summer 2013 Mr C applied for indefinite leave to remain in the UK using the premium same day service, which cost just over £6,000 for him and his family. He applied at this time because UKVI's guidance said that the application had to be more than two years after the offence. Mr C said his offence was more than two years ago (by one day) as it had happened in summer 2011.

But UKVI refused Mr C's application because the Immigration Rules said that it should be refused if an applicant had been convicted of a crime within two years, and this was not so.

Mr C complained to UKVI but it explained that he did not qualify for indefinite leave to remain under the Immigration Rules. UKVI also noted that Mr C signed a declaration stating that he was aware of the Immigration Rules at the time.

When he complained, Mr C said that UKVI did not put the situation right.

In winter 2013 Mr C successfully applied to extend his leave to remain in the UK.

What we found

Although Mr C had also signed a declaration that he understood UKVI's rules in his application, it was reasonable for him to have relied on UKVI's guidance that he could put in his application two years from his offence.

Mr C had applied for indefinite leave to remain two years and one day after he had committed the offence as UKVI's guidance stated. This was at variance with the Immigration Rules that stated the application had to be put in two years after the date of conviction.

We noted that there were other misleading references in UKVI's guidance.

UKVI did not listen to the complaint when Mr C first contacted it and failed to address his complaint. It had not corrected the guidance.

Putting it right

UKVI apologised to Mr C for misleading him and for not fully responding to his complaint. It agreed to reimburse Mr C the cost of submitting his application, with interest. It also agreed to pay £250 compensation to Mr C for the inconvenience and distress that its actions had caused him and his family.

UKVI will review its guidance in relation to applications for visas/indefinite leave to remain/leave to remain where non-custodial convictions and offences that have been admitted need to be declared. This is so that terminology is clearly defined and the guidance properly reflects the Immigration Rules.

Organisation we investigated

UK Visas and Immigration (UKVI)

Healthcare cases

Summary 297/July 2014

Delayed complaint response added to stress for patient with tumour

Mrs A's oesophagus was perforated during an endoscopy procedure. She was later diagnosed with a tumour, which her daughter, Ms C, believed got worse because of the incident.

What happened

Mrs A attended the Trust for an endoscopy procedure to improve her difficulty with swallowing. During the endoscopy, the surgeon perforated her oesophagus. Mrs A was transferred as an emergency for specialist care at another Trust.

Ms C complained that the surgeon had made a mistake when the perforation happened. She said that Mrs A had a tumour at the time, and the tumour was missed. She said the perforation caused the tumour to spread, which eventually led to Mrs A's death nine months later.

What we found

There were no failings in the clinical care and treatment. Mrs A experienced an unfortunate but known complication of the procedure. It would not have been possible to diagnose the tumour through an endoscopy, and a CT scan after the procedure did not show any evidence of a tumour.

However, there were delays in the Trust's response to the complaint, which caused Mrs A and Ms C additional stress and anxiety during a difficult time.

Putting it right

The Trust wrote to Ms C to acknowledge it should have handled the complaint in a timelier manner. It identified the reasons for the delays, apologised for them, and explained what actions it had taken to avoid delays in responding to complaints in future. It also explained a number of other actions it had taken to improve its complaint handling.

Organisation we investigated

The Hillingdon Hospitals NHS Foundation Trust

Location

Greater London

Region

London

Summary 298/July 2014

Doctors and nurses failed to identify baby's cleft palate

Miss T complained that her son R had an undiagnosed cleft palate for the first few weeks of his life.

What happened

For the first six weeks of his life, R was unsettled and had a cough and problems with feeding. A doctor and a midwife checked R immediately after his birth. A GP and a nurse practitioner checked him later, and health visitors saw him at home.

When he was six weeks old, clinicians found that R had a cleft soft palate. Since then he has had successful surgery, but his mother has said she faced financial costs because she bought numerous unsuitable bottles and teats. She was also affected emotionally and physically by the time spent trying to feed him.

What we found

Doctors and nurses at George Eliot Hospital NHS Trust did not assess R's mouth adequately. The failings by four different clinicians amounted to service failure.

There were no failings on the part of the health visitors, who were provided by South Warwickshire NHS Foundation Trust.

Miss T suffered unnecessary expense and distress as a result of what happened.

Putting it right

The Hospital Trust acknowledged and apologised for its failings and paid Miss T £500 in compensation. It prepared an action plan to make sure that it learnt from the complaint.

There were no failings on the part of South Warwickshire NHS Foundation Trust.

Organisations we investigated

George Eliot Hospital NHS Trust

South Warwickshire NHS Foundation Trust

Location

Warwickshire

Region

West Midlands

Summary 299/July 2014

Trust managed patient's psychotherapy care appropriately

Mrs J felt that the Trust did not manage her psychotherapy care appropriately when she wanted to see a female psychotherapist. She also felt there were insufficient black and minority ethnic (BME) therapists available in the Trust.

What happened

When Mrs J's mental health suffered as a result of a prolonged period of stress, she was referred for therapy. She saw Dr P, a consultant psychiatrist, during summer 2013 but the relationship became strained.

Mrs J asked to see a female therapist in autumn 2013. When a suitable female therapist could not be found at the usual venue, Dr P offered Mrs J a referral for an assessment at an alternative venue. Mrs J did not want to go to the alternative venue and the situation reached an impasse.

What we found

Dr P behaved reasonably throughout Mrs J's therapy sessions, and took appropriate and timely action to try to provide an alternative therapist for Mrs J.

The Trust demonstrated that it took equality and diversity issues very seriously and monitored its strategies to make sure that people from BME backgrounds were not disadvantaged.

Organisation we investigated

Manchester Mental Health and Social Care Trust

Location

Greater Manchester

Region

North West

Summary 300/July 2014

Failings found in maternity care at Trust

Mrs T complained about the care up to and during the birth of her son.

What happened

Soon after Mrs T's son was born, he needed to be resuscitated. He then needed surgery because of problems with his trachea, (his windpipe) and his oesophagus (his food pipe).

Mrs T complained that she did not get enough counselling before her son was born, and about the lack of care during her son's birth. She was also unhappy about how the Trust handled her complaint.

What we found

There were failings in the lack of counselling and the care given before and during the birth of Mrs T's son. There were also failings in the way the Trust handled Mrs T's complaint.

Putting it right

The Trust created an action plan to meet the failings we identified. It paid Mrs T £1,000 compensation for the emotional distress she suffered and for its poor complaint handling.

Organisation we investigated

Derby Hospitals NHS Foundation Trust

Location

Derby

Region

East Midlands

Summary 301/July 2014

Trust failed to communicate properly

Mrs A wanted the Trust to recognise failings in her mother's care. She believed that better communication between doctors involved in her mother's care could have minimised her suffering on the day she died.

What happened

Mrs A's mother, Mrs J, was in hospital for treatment for myeloma, a type of cancer. Mrs A says that staff inappropriately discharged Mrs J home to an empty house in a taxi, and did not tell her family. Mrs J fell ill again and the Trust readmitted her to hospital the next day. She died in hospital soon after.

Mrs A said if her mother had remained in hospital, the Trust might have realised how ill she was and talked to Mrs A about her condition earlier. The Trust failed to respond properly to her complaint.

What we found

Although the discharge was not unreasonable, there were faults in communication between clinical teams. There were inadequate records of discussions with Mrs J about her condition and her wish to go home; these did not reflect the reasons for discharge.

There were also failings in communication with social services, and documentation was not appropriately filled in. The Trust failed to fully address Mrs A's complaints.

We partly upheld the complaints.

Putting it right

The Trust apologised for the failings we identified. It explained the policies and guidelines in place for communication across the clinical directorate, the action it has taken following this complaint and how it will make sure documentation is completed, medical records reflect discussion, and staff make adequate discharge notes.

Organisation we investigated

Central Manchester University Hospitals NHS Foundation Trust

Location

Greater Manchester

Region

North West

Summary 302/July 2014

Family denied opportunity to spend time with patient before he died

Mr B's family felt that his care was inadequate after he was admitted to the Trust through A&E. They were unhappy that he died alone.

What happened

Mr B was admitted to A&E at the Trust after he developed breathing difficulties during dialysis treatment at another trust. Although his family stayed with him overnight, staff advised them to go home early in the morning. Mr B had a cardiac arrest later that morning, and did not regain consciousness. His family were called but Mr B died before arrived.

Mr B's daughter, Ms P, complained about the care that her father received from the Trust. She was concerned about whether there was enough senior staff involvement in her father's care, and whether staff considered other conditions. In particular, she felt that medical staff did not consider sepsis. Ms P also complained about the lack of discussion with the family about the do not attempt resuscitation (DNAR) decision and that they were not given an indication of how serious Mr B's condition was.

Ms P felt that the failings led to her father's death. She said that because the Trust had not fully addressed her concerns, she and her family did not know if her father would have survived if the Trust had given him appropriate treatment. She also said that her family felt guilty that her father died alone.

What we found

There was fault in the lack of senior involvement in the early stages of Mr B's admission, and in the differential diagnosis. However, Mr B did not meet the criteria for a diagnosis of sepsis and, despite the failings we found, it was clear that Mr B was very ill and different treatment would probably not have altered the outcome. There was therefore no injustice linked to this fault.

However, the failings in communication with Mr B's family caused a considerable injustice to them. Because the Trust gave them poor information about Mr B's condition, the family were denied the opportunity to make an informed decision about whether to stay with him shortly before he suffered his cardiac arrest. This was understandably very distressing for the family.

Putting it right

We upheld Ms P's complaint. The Trust acknowledged the faults we found and apologised for these. It also paid Mr B's family £1,000 to recognise their distress. In addition, it drew up an action plan to stop the mistakes happening again.

Organisation we investigated

Blackpool Teaching Hospitals NHS Foundation Trust

Location

Blackpool

Region

North West

Summary 303/July 2014

Practice did not appropriately manage woman's treatment

A GP practice did not follow national guidance for the management of a rare inflammatory condition that led to rheumatic problems. This caused Mrs A considerable anxiety and distress.

What happened

Mrs A was diagnosed with a relatively uncommon disorder, which the practice managed without referring her to a specialist rheumatology clinic. The practice did not refer Mrs A for a biopsy or clearly tell her about the medication regime, which it tapered off more rapidly than the guidance recommended.

Mrs A did not get enough information about her condition or any medication side effects.

What we found

The practice did not follow relevant guidance for the management of the condition. It should have referred Mrs A to a rheumatology clinic, where she would have received specialist support, as soon as it had diagnosed her illness.

Mrs A suffered considerable confusion and anxiety for a year, during which time she did not have full confidence in her care.

Putting it right

The practice prepared an action plan to show learning from the mistakes. It paid Mrs A £200.

Organisation we investigated

A GP practice

Location

South Yorkshire

Region

Yorkshire and the Humber

Summary 304/July 2014

Clinical commissioning group did not follow correct process when it withdrew continuing care funding

Mrs P complained that the clinical commissioning group withdrew NHS continuing care funding for her daughter, D.

What happened

D was 17 and was cared for at home by her mother. She received a jointly-funded package of care. However, after it reviewed her needs, the primary care trust (which was the responsible body at the time) recommended that she no longer remained eligible for NHS continuing care funding.

On this basis, Mrs P was told that funding for the health portion of D's care package would be withdrawn.

What we found

The PCT had not followed the proper process (set out in the *National Framework for Children and Young People's Continuing Care*) when it decided to withdraw D's funding.

Putting it right

The CCG (which inherited the case when the PCT ended) apologised for the failings we identified and paid Mrs P £250 for the injustice she had suffered.

We also recommended that the CCG retrospectively review D's eligibility for funding and give Mrs P a further decision. In addition, we asked the CCG to draw up an action plan identifying the action it intended to take to address the failings identified.

Organisation we investigated

Ipswich and East Suffolk CCG

Location

Suffolk

Region

East

Summary 305/July 2014

Misdiagnosis caused patient additional worry

Mr N was concerned about possible heart problems after an abnormal ECG. Trust staff carried out further investigations and diagnosed Mr N with a heart problem. He subsequently had investigations at another hospital which found he did not have this condition.

What happened

Mr N had an electrocardiogram (ECG). This showed an abnormality in the electrical activity of his heart. He then had an echocardiogram (echo), which is an ultrasound image of the heart. The echo showed a problem with the contraction of the muscle of the left ventricle. It found that the left ventricle was not pumping as effectively as it should.

Further tests did not find any significant problems in the arteries supplying the heart.

When the consultant wrote to Mr N's GP, he said the angiogram confirmed the diagnosis of dilated cardiomyopathy. This is a condition in which the heart muscle becomes stretched and weak, and the heart becomes enlarged and pumps less effectively.

Doctors gave Mr N medication and lifestyle advice. He had two follow-up appointments and was discharged into the care of his GP ten months after the diagnosis.

Mr N was very concerned about his heart and thought his life might be cut short. He gave up his stressful job and the running and competitive cycling he enjoyed.

Mr N's GP referred him to another trust, where he had another set of tests. The problems the ECG identified were still there but there was no evidence he had an enlarged heart.

Mr N also disputed the accuracy of referral information in the electronic cardiology records and asked the Trust to remove it. It added a note saying that he disputed the information but refused to remove it because it came from Mr N's GP. The GP practice and the Trust did not keep the original referral form, so no one could establish that there was an inaccuracy.

What we found

The diagnosis of dilated cardiomyopathy was not correct, and this diagnosis caused Mr N worry and anxiety. However, Mr N still had problems with reduced heart pumping efficiency and the muscle of the left ventricle. There was also an electrical abnormality.

The medication the doctors gave Mr N was appropriate for the problems he had.

The advice Mr N got about stress and exercise (as noted in the records) was reasonable. We were unable to decide about what the doctor said about work and exercise in consultations.

The Trust took reasonable action in response to Mr N's concern about incorrect information in the electronic record.

We identified learning points about complaint handling and follow-up care for patients like Mr N, and we told the Trust about these.

Mr N said that he made huge and unnecessary changes to his life because of the misdiagnosis and the advice the doctor gave him. As the treatment and documented advice were correct for the heart problems Mr N actually had, we did not agree that the changes could be linked to failings on the Trust's part. It is possible there was a problem in the verbal advice the doctor gave but we were unable to decide whether this was the case.

Putting it right

The Trust apologised to Mr N for the misdiagnosis and for the impact this had on him.

Organisation we investigated

Barnsley Hospital NHS Foundation Trust

Location

South Yorkshire

Region

Yorkshire and the Humber

Summary 306/July 2014

Trust did not record patient's wedding ring carefully

Failure to follow guidance on the care of patients' property meant there was no evidence about whether Mrs A came into the Trust wearing a ring.

What happened

Trust staff admitted Mrs A through A&E. Her son, Mr C, complained that her wedding ring had gone missing when he saw her on the ward. The Trust offered 50% of the replacement value of the ring but said that there was no evidence that Mrs A had arrived at hospital wearing it.

What we found

The Trust failed to follow its own process and the NHS guidelines on the care and recording of property brought into hospital. The guidance makes it clear that a patient does not have to prove that an organisation has been negligent, but the organisation must show it took all reasonable care of such items.

This led to an injustice to Mrs A, who was unable to prove beyond doubt that her property was lost while she was in the Trust's care.

Putting it right

The Trust apologised to Mrs A and Mr C for the distress caused by its failings and paid £975 (the lower estimate of replacement value). It will implement its patient property policy (already underway) and set up a training programme to ensure compliance.

Organisation we investigated

Barking, Havering and Redbridge University Hospitals NHS Trust

Location

Essex

Region

East

Summary 307/July 2014

Clinical commissioning group was wrong to say that bigger care home room was lifestyle supplement

Mr P complained that the local CCG refused to pay the full cost of his mother, Mrs G's, continuing healthcare care home fees because her room was larger than a standard room. He also complained that the CCG did not reconsider funding when his mother's health deteriorated.

What happened

Mrs G lived in a care home. Although the CCG had agreed she should have fully-funded care, it was only prepared to fund part of her care home fees. This was because it said her room was three square metres bigger than a standard room.

The CCG took legal advice and said the larger room constituted a lifestyle supplement, based on a previous court ruling. Mr P had no choice but to pay the shortfall until Mrs G's death. This amounted to £7,500.

Mr P said that after Mrs G's stroke, the CCG should have reassessed her needs and eligibility for NHS-funded healthcare using a checklist in accordance with national guidance.

What we found

The CCG reasonably explained that it is not its role to consider whether continuing healthcare eligibility should be revisited if a person's health deteriorates.

It unreasonably decided that Mrs G benefited from a lifestyle supplement solely on the basis that she had a larger room. And it unfairly applied the court judgement and failed to consider other options, such as moving Mrs G to a different care home.

Putting it right

The CCG acknowledged its failings, apologised to Mr P and paid him £7,500. It prepared an action plan to show that it had learnt lessons and explained what it will do differently to prevent this mistake from happening again.

Organisation we investigated

Nene Clinical Commissioning Group (CCG)

Location

Northamptonshire

Region

East Midlands

Summary 308/July 2014

Postoperative bleeding in 15-month-old baby

Miss A complained about the care of her young son, Baby B, before and after an operation to correct a birth defect in his urethra.

What happened

Baby B's surgery was delayed, so he fasted for longer than necessary. He then suffered significant bleeding after his operation.

Staff tried to control the bleeding, but this was unsuccessful, and he had emergency surgery shortly after. Baby B made a good recovery.

What we found

There were no errors in the first surgery that could account for Baby B's bleeding, and it is a known complication of the type of surgery he had. There were also no failings in Baby B's postoperative care, and staff carried out emergency surgery in a timely manner.

Because of the delays to his surgery, Baby B was fasted from liquids for longer than necessary. This was not in line with the relevant guidelines.

As Baby B experienced a significant complication, the Trust could have given his parents the chance to talk to his surgeon. The Trust's failure to do this made Baby B's parents' distress worse, and left them feeling something had gone wrong with the surgery.

Putting it right

Following our investigation, the Trust agreed to take further steps to make sure that children do not fast excessively.

It also agreed to make sure that it offers parents the opportunity to meet clinical staff if a child experiences a surgical complication.

Organisation we investigated

Cambridge University Hospitals NHS Foundation Trust

Location

Cambridgeshire

Region

East

Summary 309/July 2014

NHS failed to arrange fast-track care package

Mr L complained that his mother's former primary care trust (PCT) failed to action a fast-track request within the required 48 hours.

What happened

Mr L had cared for his mother, Mrs L, at home for many years. Her health got worse over time, and eventually the situation began to break down as Mrs L became more dependent.

Mrs L's consultant submitted a fast-track application for continuing care funding, expecting the PCT to admit Mrs L to a nursing home within 48 hours. Mrs L's GP wrote a letter in support of the application.

The PCT did not accept the fast-track application and instead carried out a full continuing care assessment. Although the PCT told Mr L that his mother's case was at the top of the queue and it would make a decision within 48 hours of an assessment, it took three months for the PCT to decide that Mrs L was eligible for continuing care funding. Seven weeks into this period, Mrs L deteriorated so much that social services intervened and arranged for her to be admitted to a nursing home.

Mr L complained to the PCT about the failure to accept the fast-track application and the time it took to decide that his mother was eligible.

What we found

We fully upheld the complaint. The PCT had enough information to accept the fast-track application, and this should have led to a nursing home admission within 48 hours.

The PCT then failed to carry out the full continuing care assessment quickly.

Putting it right

The PCT's successor commissioning organisation, Redbridge Clinical Commissioning Group, apologised and paid Mr L and Mrs L £4,000 each for their distress. It also paid Mr L £360 for his legal expenses.

Organisation we investigated

Redbridge Clinical Commissioning Group

Location

Greater London

Region

London

Summary 310/July 2014

Patient was worried about poor outcome of operation

Mrs D was concerned that the surgeon who carried out a second operation on her abscess had not done the operation properly. She felt that this had led to her being seriously ill for a long time.

What happened

Mrs D said her treatment was not as good as it should have been. She had more operations than she had originally needed, had a longer recovery period, and was left with ongoing health problems.

The Trust did not address her concerns about the competence of the surgeon who carried out her second operation.

What we found

There were failings around the second operation, either in the preparation for the operation or in the surgeon's failure to ask for assistance, or both. There were also shortcomings when the Trust answered Mrs D's complaint.

However, Mrs D's condition was serious and she would always have had a long recovery period. We did not think her ongoing health problems were linked to this second operation.

Putting it right

The Trust agreed to explain why the surgeon was considered suitable to carry out the operation, and how this decision was reached. It apologised for the failings.

The Trust paid Mrs D £500 in recognition of her additional operation, and for the subsequent distress.

The Trust told Mrs D how it would make sure that similar failings do not happen again. It shared this information with the Care Quality Commission and Monitor.

Organisation we investigated

South Tees Hospitals NHS Foundation Trust

Location

Middlesbrough

Region

North East

Summary 311/July 2014

Trust did not give sick child the right ongoing care

Although the Trust acknowledged its failings in P's care, it did not make sure that staff carried out the suggested improvements.

What happened

Mrs Y's son P was 20 months old (at the time of the complaint). He suffered from a number of illnesses and conditions. Mrs Y complained about P's ongoing treatment, including that the Trust failed to communicate adequately, did not manage his vitamin D levels and did not arrange appropriate reviews promptly.

What we found

The Trust acknowledged its failings and made the appropriate recommendations to reduce the risk of these happening again. However, there was little evidence that staff carried out the suggested recommendations.

Because of this, Mrs Y remained unsure whether P's care and treatment would have an adverse effect on his development and health.

Putting it right

We asked the Trust to explain, in an action plan, how it will prevent similar events happening again.

We asked the Trust to make sure that P got the appropriate follow-up appointment for all his medical problems, including appropriate liver, renal and cardiac specialists. We also asked it to make sure that P had consultant input into his ongoing treatment, and was under the care of a named consultant.

The Trust should also make sure that results and changes in P's medications are reviewed and communicated in good time.

We asked the Trust to apologise to Mrs Y for failing to ensure that staff had implemented the previous recommendations.

Organisation we investigated

Kings College Hospital NHS Foundation Trust

Location

Greater London

Region

London

Summary 312/July 2014

Failings in nursing care of woman in her nineties

Mrs P complained that the Trust had wrongly moved her mother, Mrs Q, to a nurse-led unit. Mrs P felt that this made Mrs Q's health deteriorate. Mrs P also felt that the care her mother received on the nurse-led unit was inadequate.

What happened

Mrs Q was admitted to hospital with shortness of breath and chest pain. Staff diagnosed congestive heart failure and treated her with antibiotics. After her condition stabilised, staff moved her from a medical ward onto a nurse-led unit.

Mrs P did not think that Mrs Q was well enough to be on such a unit. She felt that the level of care on the unit was inadequate. Mrs Q's condition deteriorated and after a few days on the nurse-led unit, staff moved her back to a ward. She died a few days later.

Mrs P complained that a lack of care on the nurse-led unit had contributed to her mother's deterioration. She was particularly concerned that Mrs Q was not given a drip on the nurse-led unit, that nurses did not give her adequate attention or care, and that she was not moved back to a ward early enough. Mrs P was dissatisfied with how the Trust responded to her concerns.

What we found

The records that show that Mrs Q was fit to be moved to the nurse-led unit were inadequate. However, it did not seem that the move was ill-considered or inappropriate. Mrs Q did not need a drip while she was on the unit and a drip might even have worsened her condition. However, some of the nursing care provided on the unit was inadequate.

Mrs Q's medical care on the nurse-led unit was adequate. It was difficult to be sure about whether Mrs Q should have been moved back to a ward earlier, but we did not believe that any shortcomings here caused Mrs Q's deterioration.

Because of the shortcomings in nursing care, we partly upheld Mrs P's complaint.

Putting it right

The Trust handled Mrs P's complaint appropriately but we asked it to apologise for the nursing failings it had acknowledged, and provide more information about lessons learnt.

Organisation we investigated

Isle of Wight NHS Trust

Location

Isle of Wight

Region

South East

Summary 313/July 2014

Missed opportunities to better manage patient's and family's needs towards the end of her life

Mr M complained about the Trust's failure to properly care for his mother, who died from complications associated with a bleeding stomach ulcer.

What happened

In late 2012, Mr M's mother, Mrs M, was admitted to the Trust with a urinary tract infection. Mrs M's condition deteriorated during her admission, and staff found she had a gastric bleed from stomach ulcers.

Clinicians decided that Mrs M would not survive surgery, and so continued to treat her conservatively. She died in hospital early the next month.

What we found

Mr M raised several issues about Mrs M's care and treatment. We did not uphold Mr M's concerns about delays in finding Mrs M a bed when she was admitted to the Trust, the impact of a fall she suffered, and her medication.

However, it was likely that staff did not help Mrs M with her personal care or when she was eating. The decision to transfer Mrs M from the high dependency unit to an open ward the night before she died was inappropriate, and the Trust did not give her family the opportunity to say their goodbyes to their mother in private after her death. In addition, communication about Mrs M's end of life care was poor.

These failings did not contribute to Mrs M's death from a gastric bleed. However, they caused Mrs M and her family unnecessary distress.

Putting it right

After our report, the Trust apologised for what it had got wrong. It agreed to put together an action plan to show that it had learnt from its mistakes.

Organisation we investigated

Nottingham University Hospitals NHS Trust

Location

Nottinghamshire

Region

East Midlands

Summary 314/July 2014

PCT failed to properly consider funding request

Mr J, who had a rare disfiguring condition, was refused funding for liposuction because the commissioning body, a primary care trust – the PCT, used the wrong process to consider his application.

What happened

The PCT's individual funding policy gave applicants two possible routes. The first was for patients with rare medical conditions for which the PCT had no commissioning policy. In these cases, the PCT was entitled to approve requests for funding if there was evidence that the treatment was likely to be clinically effective as well as cost effective.

The second route was for patients who had a medical condition for which the PCT had a commissioning policy, but where the requested treatment had not been agreed for funding under that policy. In these cases, in addition to satisfying the clinical and cost effectiveness tests, the patient would have to also prove that they were 'exceptional'. In other words, that they were significantly different to other people in the general population with the condition in question, and were likely to get significantly more benefit from the requested treatment than might normally be expected.

The PCT declined Mr J's individual funding request on the basis that it did not think that there were any exceptional circumstances in his case.

What we found

The PCT should have recognised that Mr J was suffering from a rare condition (affecting around 1 in 50,000 people) for which it had no commissioning policy.

It was unfair to expect Mr J to prove that he was an atypical patient or that he presented an exception to a commissioning policy that did not exist.

Putting it right

We recommended that the PCT's successor commissioning organisation, Coastal West Sussex Clinical Commissioning Group, acknowledge and apologise for the failings and injustice, pay Mr J £500, and keep to a commitment it made to us to fund the liposuction.

Organisation we investigated

Coastal West Sussex Clinical Commissioning Group (CCG)

Location

West Sussex

Region

South East

Summary 315/July 2014

Treatment delayed by Trust's failure to diagnose

Mrs A was concerned about a delay in the diagnosis of her anal fistula, which left her with untreatable slight anal incontinence.

What happened

Mrs A's GP referred her to the Trust in spring 2012. After staff saw her in the emergency assessment unit, she had gynaecological surgery for an infected cyst.

During the operation, the surgeon asked for a consultant's help. Although the findings at surgery were not typical of this type of cyst, clinicians diagnosed a long-standing infection in the cyst and removed as much as possible. Test results, which were available to staff several days after the operation, did not show any cyst tissue; this should have prompted staff to question the original diagnosis.

After surgery, Mrs A returned to her GP because the wound was not healing. Staff from the Trust's gynaecology outpatients department saw her in summer 2012. They sent her for a scan, which showed she had an uncommon, complex anal fistula (a fistula is an abnormal opening between two parts of the body). In late summer 2012, staff referred Mrs A to the Trust's surgeons who specialised in treating the lower digestive system, and she had two more operations.

Mrs A was concerned about the delays in diagnosis and treatment so she sent the Trust a written complaint. After it investigated, the Trust did not acknowledge that there were any failings in Mrs A's care.

Mrs A was unhappy the Trust's responses at the local resolution meeting, so she brought her complaint to us.

What we found

There was service failure because the Trust missed several opportunities to diagnose Mrs A's anal fistula. Consequently, there were significant delays to her treatment. We upheld the complaint.

The Trust did not acknowledge any failings in Mrs A's care after its complaint handling process. This added to Mrs A's distress, because she felt very embarrassed when she had to discuss her symptoms.

Although Mrs A's fistula was treated, she still has slight anal incontinence. However, we could not directly link her symptoms to the delay in her diagnosis and treatment because we think the complex nature of her fistula and the necessary surgical treatment are more likely reasons for this.

Putting it right

The Trust apologised and paid Mrs A £750 for the failings in her care that led to delays in treatment, and for her distress.

The Trust prepared an action plan that described how it would make sure that it has learnt the lessons from the failings identified by this complaint, and how it would avoid similar failings in future.

Organisation we investigated

South Devon Healthcare NHS Foundation Trust

Location

Devon

Region

South West

Summary 316/July 2014

GP delayed recalling patient for follow-up investigation

Mrs C complained about the GP's delay in taking further action after a blood test showed that she needed further investigation for a possible heart problem.

What happened

In spring 2012 Mrs C became short of breath and had a swollen ankle. She saw a registrar GP (a qualified doctor who is training to be a GP) at the practice. The GP arranged a blood test to check for heart failure.

In autumn 2013 Mrs C received a letter from the practice about the blood test it had carried out in the spring of the previous year. The practice said the result suggested that she had heart failure and should have further tests. It subsequently referred Mrs C to hospital, where staff found out that a valve in her heart was leaking.

Mrs C complained about the delay in finding this out and the possible failed opportunity to do something sooner for her.

The practice said that when it reviewed her records it had identified that no further tests had been done and so it arranged them.

What we found

The practice did not do enough when it received the blood test result in spring 2012. It must have been upsetting to find out about this and it made Mrs C worry about what could have happened. However, we found nothing to suggest that this failing had any adverse consequences for Mrs C.

Although the practice identified its mistake, this took a long time. The practice did not explain what it had done to prevent a recurrence, or apologise.

Putting it right

The practice acknowledged the delay in taking appropriate actions following the positive test result and apologised.

It provided an action plan explaining how it monitors the work of registrar GPs and saying what it has done or plans to do to make sure that it has learnt lessons from the failings.

Organisation we investigated

A GP practice

Location

Merseyside

Region

North West

Summary 317/July 2014

Trust did not respond appropriately to father's concerns about his child

Mr R complained that the Trust did not respond to his concerns that his daughter, Q's, tumour was expanding. He says that this meant that surgery to remove the tumour was delayed so that Q had to have radical surgery.

What happened

Q suffered from a tumour behind her eye. Doctors removed most of the tumour and Q wore a false eye.

Over the next six months, the Trust monitored Q's condition. However, a doctor made a mistake in Q's clinical notes about her false eye. After this, there were indications that Q's tumour was expanding but doctors did not notice. This was partly because they relied on Q's notes and thought her symptoms were caused by the false eye.

Q's parents raised concerns about this. Eventually, doctors noted that the tumour was expanding and some months later Q had surgery to remove most of the tumour. The remaining tumour continued to grow and Q underwent more significant surgery.

What we found

Doctors did not provide adequate follow up. There was poor communication between the ophthalmologist (eye specialist) and Q's parents, and the ophthalmology team did not respond appropriately to Mr R's concerns about Q's false eye.

Although these failings did not mean that Q needed more radical surgery than she otherwise would have, Q's family experienced uncertainty and worry.

Putting it right

Following our report, the Trust apologised for the failings and prepared an action plan to make sure that it has learnt lessons from the failings in care and treatment identified.

Organisation we investigated

Great Ormond Street Hospital for Children NHS Foundation Trust

Location

Greater London

Region

London

Summary 318/July 2014

NHS England appropriately followed national guidance when it decided continuing care funding

NHS England upheld a decision that the NHS was not responsible for funding ongoing care.

What happened

Mrs T lived in a nursing home from 2003 until her death in 2010. She funded her own care until 2010, when she was found to be eligible for continuing care funding. This meant that the NHS paid her nursing home fees for the final three months of her life.

Mrs T's daughter, Ms P, asked the NHS to review whether her mother should have received continuing care funding in the past, because she did not think that her mother's needs had changed. The NHS considered the available information and decided that Mrs T had not been eligible for continuing care funding in the past. Ms P appealed this decision and NHS England reviewed it. NHS England upheld the decision and concluded that Mrs T had not been eligible for continuing care funding in the past.

Ms P subsequently asked us to review NHS England's decision.

What we found

NHS England followed national guidance when it reviewed Mrs T's case and reached a decision. It had established the relevant clinical facts about Mrs T, and there had been an appropriate discussion about how her needs affected her and interacted with one another. NHS England applied the correct eligibility criteria and the conclusions were clinically reasonable.

We did not uphold the complaint from Ms P.

Organisation we investigated

NHS England (Midlands and East)

Location

Cambridgeshire

Region

East

Summary 319/July 2014

Dental practice should have considered whether to waive time limit for complaint

Mr L complained that the practice's decision not to investigate his complaint (because it had been made outside the time limit) was unfair and unreasonable.

What happened

In early 2014 Mr L wrote to the practice and said that a crown that it had fitted in 2005 had fallen out and been lost. Mr L complained that the crown had never fitted properly and asked the practice to fund the cost of a replacement.

The practice replied less than a week later. It said that, because the events had taken place more than a year before, it would not investigate the complaint.

What we found

The practice was right to state that Mr L had made his complaint outside the time limit. However, in line with the relevant regulations, it should have considered Mr L's reasons for the delay and whether it would still be possible to investigate the complaint thoroughly and fairly. The practice was at fault for failing to do this.

However, we decided that the overall decision would have been the same, even if the practice had considered the complaint properly. This was because we could not find a persuasive reason why Mr L delayed making the complaint, and because we did not consider that there would be enough evidence to investigate the complaint fairly.

Putting it right

We did not make any formal recommendations. However, we said that the practice should note the shortcoming we identified. Furthermore, we suggested that it should review its complaints policy to make sure that it complies with the complaint regulations about 'out of time' complaints, and whether it should consider waiving the time limit if appropriate.

During the investigation process the practice confirmed that it accepted our findings and would use our report to learn from this complaint.

Organisation we investigated

A dental practice

Location

Cornwall

Region

South West

Summary 320/July 2014

Medical centre missed opportunities to treat patient who later died from problems associated with blood poisoning

A medical centre, which was run by a group of GPs, failed to adequately manage Ms D's care. She later developed cellulitis (a bacterial skin infection) and died of multiorgan failure associated with septicaemia (blood poisoning caused by the spread of infection).

What happened

Ms P, the complainant, told us that in spring 2013 her mother, Ms D, saw her usual GP at the medical centre about fluid that was building up in her legs. The GP decided that Ms D should wait for an upcoming review with her heart specialist, and planned to discuss her care with her kidney specialist.

Later the same month, Ms D saw a locum GP from the medical centre about the same problems. The locum GP noted that the fluid was leaking, and recommended that Ms D dress, bandage and elevate her legs. She also contacted the district nursing team to help Ms D with this treatment.

The district nurse contacted the medical centre on her first visit because Ms D's right leg was discoloured. A different (third) GP visited Ms D at home that day and diagnosed her with cellulitis. He prescribed oral antibiotics.

Shortly after, the district nurse contacted the third GP at the medical centre again because Ms D's cellulitis had worsened. The third GP arranged for Ms D to go into hospital that day.

Ms D died in hospital soon after. Her death certificate records her cause of death as multiorgan failure, septicaemia and cellulitis.

What we found

Ms P raised several issues about her mother's care and treatment from the medical centre. We did not uphold all aspects of her complaint.

However, the medical centre should have referred Ms D to the district nursing team when the first GP saw her. When she saw Ms D, the second GP should have arranged an urgent referral to the district nursing team to dress Ms D's legs in a sterile way, and/or considered prescribing antibiotics. In addition, the third GP should have arranged for Ms D to go into hospital for intravenous antibiotics when he visited her at home.

While we could not say that Ms D would not have died when she did, the medical centre should have taken action that might have prevented the development and spread of cellulitis and consequent septicaemia.

Ms P and her sister will now never know whether things could have been different if their mother had received the treatment that she needed from the medical centre. This has been, and will continue to be, a source of continual upset and distress to them.

Putting it right

After our report, the medical centre acknowledged and apologised for its failings, and put together an action plan that demonstrated that it had learnt from its mistakes.

Organisation we investigated

A medical centre

Location

Merseyside

Region

North West

Summary 321/July 2014

Poor communication by hospital

Mr H wanted the Trust to accept that there had been failings in his mother-in-law's care.

What happened

Mr H complained that the Trust wrongly assumed that his mother-in-law, Mrs M's, health needs had not changed when it discharged her to a respite placement, and it did not carry out appropriate assessments. Mr H said the Trust did not update Mrs M's care plan and did not communicate with her care home. Mr H complained that Mrs M needed more care than she received when the Trust discharged her to the placement.

What we found

The Trust failed to communicate with the care home and potentially Mrs M did not receive all the care she should have done after her discharge. The Trust could not explain how it had decided Mrs M's needs had not changed, for example through a team assessment or review. We partly upheld the complaint.

The Trust did not fully address Mr H's complaints and had not recognised some failings.

Putting it right

The Trust apologised to Mr H for the failings we found and paid him £500 in recognition of the injustice suffered. It produced an action plan that identified how it would avoid similar failings happening again.

Organisation we investigated

North Tees and Hartlepool NHS Foundation Trust

Location

Hartlepool

Region

North East

Summary 322/July 2014

Delay in neurology review did not lead to serious failings in patient's care

Mr K went into hospital in spring 2012 after he collapsed and suffered sudden stomach pain. He stayed in hospital for over two weeks.

What happened

While he was in hospital, Mr K was taken for an MRI scan (a procedure that uses a strong magnetic field to create images). The scan did not go ahead because Mr K had had an operation to fit a stent (a tube used to relieve a constricted vein) in 1997, and staff could not be sure the stent would be safe for an MRI. Dr B, a consultant neurologist, examined Mr K. He found no serious neurological symptoms and decided that Mr K did not need an MRI scan. Mr K was sent home that day.

Mr K continued to have problems, and he had an MRI scan privately. He was diagnosed with spinal cord compression. Mr K died in late 2012, and Mrs K continued with the complaint on his behalf. She said that he had been kept in hospital for too long without staff finding what was wrong.

What we found

It took too long for the Trust to arrange for a neurologist to see Mr K. We could not say that he would have been discharged from hospital sooner if a neurologist had seen him earlier, but we recognised that this was possible.

It was reasonable not to give Mr K an MRI scan while there was uncertainty about his stent. Once Dr B had seen Mr K and decided there was no need to carry out an MRI scan, it was reasonable to send him home without one.

There was evidence that Mr K's condition got worse after he was discharged from hospital, so the fact that he later had a scan did not show that the Trust's decision not to carry one out was wrong. It was also reasonable for the Trust to say that most cases of spinal cord compression are managed conservatively, and that it would not have treated Mr K any differently if it had done a scan.

Putting it right

The Trust acknowledged that it took too long for Mr K to see a neurologist, and apologised for this.

Organisation we investigated

Maidstone and Tunbridge Wells NHS Trust

Location

Kent

Region

South East

Summary 323/July 2014

Trust did not properly consider rights of person with disabilities

Mr A complained that some aspects of the Trust's care and treatment of his late daughter, B, were inadequate and that staff did not consider sufficiently her needs as a person with learning disabilities and a visual impairment. He also complained about the way the Trust handled his complaint.

What happened

B had diabetes, learning disabilities and was registered blind. In the five years before her death in summer 2009, she developed a number of other conditions. Because of these conditions and a fall in winter 2008, B had more than a dozen admissions to the Trust's hospital in 2008. In early 2009, Trust staff admitted B to hospital again. She stayed in hospital until summer 2009, when she died.

What we found

Mr A complained about a number of aspects of his daughter's care and treatment between early 2008 and mid-2009. There were no failings in some of those areas.

Mr A complained that when his daughter was transferred to another trust's hospital for an eye procedure in early 2009, the other hospital was not told that his daughter had MRSA. He complained that when his daughter returned to the Trust's hospital, she was placed in an open ward, even though she had tested positive for MRSA (a bacterial infection that is resistant to a number of widely used antibiotics). There were no failings in the Trust's screening of B for MRSA before she was transferred to the other trust's hospital. But the Trust's staff did not 'get it right' when B was transferred back to the Trust's hospital, because they did not screen B for MRSA at this time, as the Trust's own MRSA policy said they should have done. This meant that staff did not start a process to remove or reduce the bacteria as soon as they could have done.

Furthermore, staff did not tell B, her family or her carer about her MRSA status, as established good practice said they should have done. We recognised that it would have been distressing for B's family and carer to find out that she had tested positive for MRSA and that they were not told to take additional precautions.

Mr A also complained that he had asked the Trust for information about his daughter's eye procedure and the Trust had told him that it could not answer his questions. Had the Trust contacted the other trust (or even suggested that Mr A contact the other trust), as we did, it was likely that it could have answered Mr A's questions. However, although we recognised that Mr A would have been frustrated by the Trust's inability to give him the information he sought, we noted that the Trust had apologised for this.

Mr A said that the Trust did not consider his daughter's needs as a person with learning disabilities and a visual impairment. The advice we received told us that B's nursing assessment should have established how her learning disabilities and visual impairment affected her daily activities, her thought processes and her mental well-being.

It would have been good practice for staff to have identified how to improve communication with B at the outset. However, although there was evidence of the care given to B, there was little evidence of assessment and care planning.

This meant that B's nurses could not be sure that the care they gave B met her individual needs. Furthermore, B's doctors did not give proper consideration to her learning disabilities. This meant that they could not be sure that she

understood what they told her or that she had the mental capacity to make decisions about her care and treatment for herself.

There was also maladministration in the time it took the Trust to investigate Mr A's complaint and in the way it provided answers to some of his key questions.

Putting it right

The Trust acknowledged and apologised for its failings. It agreed to put together an action plan that showed how it had learnt from its mistakes so that they would not happen again.

It also paid Mr A £1,250 to acknowledge the impact these failings had on his daughter, himself, his ex-wife and his daughter's carer.

Organisation we investigated

The Whittington Hospital NHS Trust

Location

Greater London

Region

London

Summary 324/July 2014

Delay in removing stent increased risk of complications and caused patient distress

Mr A had acute pancreatitis (a condition where the pancreas becomes permanently damaged through inflammation) and was admitted to hospital.

What happened

Trust doctors found that Mr A had inflamed tissue in his pancreas that was beginning to die. Mr A's bile duct (a narrow tube coming out of the liver which delivers bile, a digestive juice, to the bowel) had become narrowed. The doctors inserted a plastic tube (a stent) into his bile duct to treat this.

The doctors tried unsuccessfully to remove the stent after five months. Another attempt three months later was also unsuccessful. There was a six-week delay in arranging a CT scan (a scan that uses X-rays and a computer to create detailed images of the inside of the body) that was necessary to help decide the next course of treatment.

Mr A began to suffer from severe vomiting, constipation, swollen stomach and weight loss. Doctors thought that he might have an obstruction and ordered a barium meal test (a special X-ray test used to examine the stomach). It took Trust staff over five weeks to carry out the test, but no obstruction was found. Doctors were eventually able to remove Mr A's stent.

Mr A complained to the Trust about his care and treatment. He was dissatisfied with its response and complained to us.

What we found

There was a delay in the doctors' attempt to remove Mr A's stent. The difficulty in removing the stent was probably caused by technical problems related to complications of Mr A's pancreatic disease. There were also delays in arranging tests, and these further delayed staff removing the stent.

The Trust's avoidable delays amounted to service failure that caused Mr A concern.

Mr A was also concerned that the delays led him to develop type 1 diabetes. However, this was not the case.

We therefore partly upheld Mr A's complaint about the Trust.

Putting it right

The Trust wrote to Mr A to acknowledge and apologise for the service failure and the effect that had on him.

The Trust also prepared an action plan that showed what it had done or planned to do to avoid the failings happening again.

Organisation we investigated

Imperial College Healthcare NHS Trust

Location

Greater London

Region

London

Summary 325/July 2014

GP practice missed chance to diagnose fatal heart condition

Ms L complained that the GP practice failed to investigate her father, Mr M's, symptoms adequately, especially his breathlessness. Instead, GPs treated Mr M for anxiety, so his underlying heart condition, which contributed to his death in spring 2012, was not treated. Ms L believed that Mr M died prematurely, and this caused the family distress.

What happened

In summer 2011, Mr M told a GP at the practice that he became breathless when he walked uphill. The GP did not investigate this further or advise him to return if the breathlessness continued.

In early 2012, Mr M told the GP that he was irritable, had disturbed sleep and was unable to cope with going out. He was treated for anxiety and depression. Ms L recalls that Mr M also told the GP that he was breathless and that by now his breathlessness was evident. The GP records do not note breathlessness. The next month, Mr M saw a second GP and told him he was worried about his lung capacity. The GP asked him to return in two to four weeks. Mr M died later that month of acute heart failure.

What we found

The practice should have investigated Mr M's breathlessness in summer 2011. If the practice had done this, and if staff had advised Mr M to come back if his breathlessness continued, his heart condition might have been identified and treated.

We partly upheld the complaint because although we could not say that Mr M's death was preventable, he was not given the best chance of survival.

Putting it right

The practice acknowledged and apologised for the shortcomings we found. It drew up an action plan to address these.

Organisation we investigated

A GP practice

Location

Essex

Region

East

Summary 326/July 2014

Appropriate investigations for cardiac symptoms let down by poor communication with patient

Ms B complained that her symptoms were not taken seriously during a twelve-day hospital admission for apparent cardiac symptoms.

What happened

Ms B was in hospital for twelve days in 2012 with chest pains and shortness of breath. She then went to the hospital for reviews and in summer 2013 it discharged her back to her GP.

Ms B complained and attended a local meeting. She wrote several letters after this. The Trust overlooked some of her letters and delayed replying to others. When Ms B first came to us, we saw that some of the issues she raised had not been answered and the Trust agreed to look at the complaint again. Although the Trust should have provided a further response in one month, it was four months before it replied again.

Ms B complained to us that her symptoms were ignored, she did not receive a diagnosis, she was only reviewed by a consultant once and no one told her what they were doing or what they had found. Ms B also complained that a junior doctor made an inappropriate comment that anxiety or depression could be the cause of her symptoms.

Ms B also complained about how the Trust had handled her complaint.

What we found

The Trust managed Ms B's treatment appropriately and carried out appropriate investigations.

However, it did not always tell her what was going on or discuss its conclusions following the tests. There was no evidence that this poor communication affected the treatment Ms B received but it meant that the Trust did not keep Ms B adequately informed, and this caused her uncertainty.

Ms B's complaint should have been handled more promptly and more thoroughly. The Trust acknowledged this, but we did not think that it went far enough.

Putting it right

The Trust apologised for the failings we identified and paid Ms B £300 as a tangible acknowledgment of poor complaint handling. It agreed to draw up an action plan to describe what it has done or plans to do to avoid a repeat of these failings.

Organisation we investigated

Hull and East Yorkshire Hospitals NHS Trust

Location

Hull

Region

Yorkshire and the Humber

Summary 327/July 2014

Trust delayed arranging surgery

Mrs G went onto a waiting list for bowel surgery in winter 2011. She was still waiting when she was admitted as an emergency in autumn 2012.

What happened

Mrs G, who was in her sixties, was referred to a general surgeon for her bowel problems in winter 2011. The Trust put her on a waiting list for bowel surgery in the next month, but surgery scheduled for summer 2012 was cancelled and the Trust did not arrange another date.

Mrs G went into hospital as an emergency with bowel problems in summer and autumn 2012 because she had still not had the surgery she needed. When clinicians finally carried out the surgery in autumn 2012, it was a complex operation which then necessitated further surgery at a later date.

What we found

There were significant delays in arranging surgery and updating Mrs G about this. Mrs G was in great discomfort while she waited for her surgery, and she had to be admitted to hospital twice as an emergency. She had to have complex surgery that might not have been necessary if surgery had taken place within a reasonable time. She then had to have a second operation.

The Trust's handling of the complaint was also poor and did not address the failings that occurred.

Putting it right

The Trust wrote to Mrs G acknowledging the faults in her care and treatment that we found, and apologising for them. It drew up an action plan that addressed all the faults it had not then addressed, and paid Mrs G over £2,000 in recognition of the failings in her care and the additional distress and pain caused by this.

Organisation we investigated

Imperial College Healthcare NHS Trust

Location

Greater London

Region

London

NHS

Summary 328/July 2014

Dental practice failed to give patient opportunity to make informed choice about treatment

Mrs J said that the information the practice gave her left her unaware of the treatment options available. As a result, she said, she paid for private dental work that could have been given as NHS treatment. Mrs J wanted a financial remedy, an apology and an improvement in the service provided by the practice.

What happened

In early 2013 the practice filled one of Mrs J's teeth as an NHS procedure. The next month, she had root canal treatment to an upper left tooth. She says that the filling material was not discussed until the procedure was underway, at which point she was offered a choice of an NHS amalgam filling or a private white composite filling. Mrs J says that she was only able to signify her choice by hand signals. She chose the privately provided white filling at a cost of £90. Follow-up NHS treatment to this tooth cost another £57.

Mrs J complained to the practice that she should have been offered NHS white fillings for both teeth. She also said that she should not have been charged for more treatment to her upper left tooth because problems with the tooth arose from the failure of NHS root canal treatment earlier in the year. She suggested that if the practice had applied the charges properly, the unsuccessful root canal treatment to her upper left tooth, and all the necessary follow-up treatment for this tooth, would have been covered by the NHS dental treatment band 2 charge she had paid earlier in 2013.

The practice did not accept any failings and explained that white fillings were not the expected NHS option for the large multisurfaced fillings required for these two teeth.

Mrs J then complained to us about the practice's decision to charge for the white fillings, its failure to discuss treatment options before the start of the upper left tooth treatment, and that she had not been offered either an NHS-funded bridge or an implant to replace her upper left tooth. She explained that, had she been aware of the probability that the tooth would eventually need to be extracted, she would not have chosen to have a private white filling for this tooth.

What we found

There were no failings on the part of the practice when it decided not to offer Mrs J NHS white composite fillings for her teeth; when it decided to charge for additional work to the upper left tooth, or when it did not offer an NHS bridge or an implant to replace the upper left tooth.

However, in the case of the upper left tooth root canal treatment, the practice failed to discuss treatment options or get Mrs J's consent to private treatment in advance. In fact, according to Mrs J, the only discussion was when the treatment was underway and she was unable to speak. This denied her an opportunity to make a properly informed decision that included the possibility that the tooth might eventually need to be removed.

Putting it right

The practice wrote to Mrs J to apologise for the failings we found. It explained what it had done to make sure that these failings did not happen again.

It paid Mrs J £90 in recognition of the fact that she did not give informed consent to the private root canal treatment to her upper left tooth, and to recognise the inconvenience of bringing her complaint to us.

Organisation we investigated

A dental practice

Location

Portsmouth

Region

South East

Summary 329/July 2014

Failings in care and communication did not cause death of woman in her late seventies

Mrs F had chronic obstructive pulmonary disease, a condition that causes breathing difficulties. She was on long-term oxygen therapy at home. In winter 2012 she went into hospital with increased shortness of breath and rapid heartbeat.

What happened

Doctors decided that a chest infection was making Mrs F's chronic obstructive pulmonary disease worse, so they treated her with antibiotics. Over the next few days they noticed Mrs F had swollen ankles. A chest X-ray showed fluid overloading in her lungs. Trust staff prescribed furosemide (a drug which reduces fluid retention) five days into the admission and did a blood test, which confirmed Mrs F had heart failure.

Trust staff discharged Mrs F two days after they had prescribed furosemide and one day after the heart failure diagnosis. Her GP saw her two days later and prescribed another drug similar to furosemide. Mrs F deteriorated and was readmitted to hospital five days after she had been discharged. She was treated in the intensive care unit and died three days later.

Mr T, Mrs F's son, complained that his mother had not been fit for discharge. He said she had eaten very little, did not produce much urine, could not lie down comfortably and had swollen legs. Mr T also complained that communication about Mrs F's condition was poor and staff did not tell her family she had heart failure.

Mr T said that if the family had had full knowledge of the facts and his mother had received good care, she might not have died. He wanted the Trust to acknowledge that the care it gave was substandard and the decision to discharge his mother was wrong.

What we found

There were failings in care and communication. We noted that staff discharged Mrs F before her fluid balance had stabilised on the furosemide. This was contrary to guidelines on the care of patients with heart failure. We also saw no evidence that staff told Mrs F or her family about her heart failure. The Trust should not have discharged Mrs F unless she and her family agreed to this in full knowledge of her condition, her care needs and what to expect. We do not believe that this was the case.

We did not conclude that Mrs F died as a result of the failings. If she had remained in hospital, doctors would have responded to her deteriorating condition slightly sooner but it is very unlikely that this would have made a difference to the sad outcome.

We do not believe that Mrs F would have lived any longer if she had stayed in hospital. However, the inappropriate discharge caused her family anger and distress and made them question whether her death was avoidable. The situation was made worse because Mrs F's family did not know about her heart failure diagnosis and were not aware of how serious her condition was.

Putting it right

The Trust wrote to Mr T apologising for the failings we identified. It drew up an action plan that detailed how it will improve communication with patients and their families.

Organisation we investigated

West Hertfordshire Hospitals NHS Trust

Location

Hertfordshire

Region

East

Summary 330/July 2014

Patient's death was avoidable

Mr N complained to us that Trust staff did not investigate his wife, Mrs N's, symptoms and this delayed any treatment. As a consequence, Mrs N developed sepsis and died one month after Trust doctors first saw her.

What happened

Mrs N went into hospital in spring 2011 with abdominal pain and blood in her urine. Staff discharged her the next day because test results were inconclusive. Mrs N went to hospital several more times because of her pain.

Eventually, staff admitted her for exploratory surgery to try and find the cause of her symptoms. Before the procedure could take place, Mrs N's condition deteriorated and she died in early summer 2011 from sepsis.

What we found

The Trust failed to adequately assess Mrs N's condition, treat her with appropriate antibiotics in a timely manner, or take enough steps to control the clotting of her blood before surgery. The Trust should not have discharged Mrs N after her admissions in spring and early summer, and should have carried out exploratory surgery sooner than planned.

After Mr N complained, the Trust responded promptly and provided evidence-based responses to most of his concerns. However, it did not acknowledge some shortcomings, or apologise for the consequences of the failings it found.

Putting it right

Before our involvement, the Trust reviewed its urology department and took steps to improve its services.

Following our report, the Trust apologised to Mr N for his wife's avoidable death, and drew up an action plan that set out how it would improve its complaint handling.

Organisation we investigated

Imperial College Healthcare NHS Trust

Location

Greater London

Region

London

Summary 331/July 2014

Trust did not adequately describe proposed surgery or assess its impact on woman with mental health problems

Miss C was denied the opportunity to fully consent to surgery and lost faith in the Trust's ability to manage the treatment of her bladder and pelvic problems.

What happened

Miss C had a history of bladder and pelvic problems. She also had mental health problems, such as anxiety and obsessive compulsive disorder.

The Trust carried out three different surgical procedures on her during the same operation in 2011. Miss C complained that this led to a range of significant side effects, including pelvic pain and incontinence, which affected her mental health.

Miss C made a number of other complaints, including that she was not told why she was having the different surgeries or about their possible side effects, and that she felt pressured into undergoing the surgery. She also complained that Trust staff were rude to her and discharged her from their care when they should not have.

What we found

The Trust did not give Miss C enough information to allow her to fully consent to two of the three surgeries. It handled her complaint about this poorly, which caused her frustration and distress. However, we did not consider that there was enough evidence that Trust staff pressured Miss C to have the surgery, or that the physical or mental symptoms she experienced afterwards were caused by the surgery.

The Trust also failed to book Miss C for a postsurgical review to assess the impact of the surgery on her bladder, and her pelvic problems. This meant she lost faith in the Trust.

We did not uphold her complaint that she was discharged from the Trust, on the day of surgery or from the urological department, too early. There was not enough evidence to uphold this or some other aspects of her complaint, including that Trust staff were rude to her.

We noted that many of the Trust's responses to her complaint were reasonable.

Putting it right

The Trust apologised to Miss C for its failings and paid her £500 to recognise that she did not fully consent to all of the surgery and her loss of faith in the Trust, as well as the frustration and distress caused by the Trust's complaint handling.

Organisation we investigated

York Teaching Hospitals NHS Foundation Trust

Location

North Yorkshire

Region

Yorkshire and the Humber

Summary 332/July 2014

GP failed to take relevant factors into account when prescribing

Mr W, who was in his seventies, complained that his GP did not prescribe enough glucose test strips or painkillers and would not prescribe vitamin D at all.

What happened

Mr W had a number of long-term health conditions. He complained that his GP practice did not prescribe enough glucose test strips or painkillers to meet his needs. Mr W also complained that the practice would not prescribe vitamin D supplements, which had been recommended by a hospital consultant.

The practice refused to change the prescribing arrangements, saying that more glucose test strips and painkillers could be ordered when required. The practice explained that it was local policy not to prescribe vitamin D because it can be bought over the counter.

What we found

The practice did not think carefully about Mr W and his health problems when it decided how many glucose test strips to prescribe. However, it was reasonable and was safe practice to prescribe a limited amount of painkillers at a time so the practice could monitor how many of them Mr W used.

It was also reasonable, in the first instance, to encourage Mr W to buy vitamin D supplements over the counter. However, the practice should have reviewed the decision, taking into account Mr W's individual circumstances.

Putting it right

The practice drew up tailored care plans to manage Mr W's healthcare. The plans took into account his personal circumstances and his health conditions, and clarified the prescribing arrangements.

Organisation we investigated

A GP practice

Location

Greater London

Region

London

Summary 333/July 2014

GP failed to refer patient to specialist for on-going symptoms

Mr F saw his GP several times with symptoms including passing stones in his urine. His GP did not refer him to a specialist until two years after his first visit. He was diagnosed with bladder cancer and later died.

What happened

Mr F went to his GP complaining of lower urinary tract symptoms that had been going on for a year. His GP carried out tests but did not refer Mr F to a urology specialist. Mr F saw his GP three more times before the GP made a referral.

A urology team later diagnosed Mr F with cancer and he sadly passed away.

What we found

Although Mr F's symptoms did not suggest that he had cancer, they warranted a referral to a specialist for investigation. Had this referral been made promptly, there is a chance that Mr F's cancer would have been diagnosed sooner and his prognosis would have been better.

Putting it right

Following our investigation, the practice apologised to Mr F's wife and acknowledged the fault we found. It paid Mrs F £250 compensation and shared learning from the complaint with its doctors.

Organisation we investigated

A GP practice

Location

Herefordshire

Region

West Midlands

Summary 334/July 2014

Patient suffering miscarriage was kept in A&E

Ms E was in A&E for over two hours without seeing a doctor, and staff did not treat her severe pain.

What happened

Ms E was 20 weeks pregnant when she attended A&E with severe abdominal pain. Staff did not give her adequate pain relief or escalate her situation to any senior staff over the next two hours.

By the time Trust staff took Ms E to the maternity unit, she had already suffered a miscarriage. Ms E acknowledged that this could not have been prevented, but said she was distressed by her poor treatment. She felt staff should have done more to make her comfortable.

What we found

Ms E's care and treatment was poor. Staff should have taken further observations and responded to her pain. Doctors were busy with an emergency but nevertheless, staff should have escalated the situation.

The Trust acknowledged its failings and said it had addressed these matters with the staff involved and had improved its policy for the treatment of pregnant women arriving in A&E.

Putting it right

The Trust spoke to the nurse about undertaking further physiological observations, evaluating Ms E's pain relief, and how she responded to Ms E's bleeding. It also apologised to Ms E.

Organisation we investigated

Lancashire Teaching Hospitals NHS Foundation Trust

Location

Lancashire

Region

North West

Summary 335/July 2014

Severe delay in accessing psychological therapy

Ms H had to wait a long time for therapy, and the Trust did not communicate well with her during this time.

What happened

Ms H's GP assessed that she needed face-to-face psychological intervention. The Trust initially told her, in mid-2013, that there would be a short wait. However, as the months went by, she was given contradictory information and it then proved difficult to access treatment at a convenient time and place. In late 2013 Ms H asked to be removed from the waiting list.

What we found

The main reason for the delay was that the Trust had taken on hundreds of referrals from another provider's waiting list during early summer 2013. The Trust had only had ten days' notice and so had been unable to plan for this.

However, the Trust's communication with Ms H was poor; it had been unable to tell her accurately how long the wait would be and it had not returned all her calls. This added to her distress.

Putting it right

The Trust acknowledged that its communication had been poor and it undertook to make improvements. It agreed to apologise to Ms H for not returning all her calls and Ms H was satisfied with this.

Organisation we investigated

Surrey and Borders Partnership NHS Foundation Trust

Location

Surrey

Region

South East

Summary 336/July 2014

Poor record keeping made it difficult to investigate dentist's care and treatment

Mrs A complained that in early 2012 her young son had an inadequate dental assessment from his dentist. The dentist did not identify that her son had problems with his teeth. Mrs A said that the dentist's communication was poor and he was not proactive in treating her son. She was also dissatisfied with the practice's complaint handing because it did not properly address her concerns and there were lengthy delays.

What happened

Mrs A's young son attended dental appointments once a year at the dental practice. He was unco-operative at times.

Mrs A said that during an appointment in early 2012 the dentist did not raise any concerns about her son's teeth and gums. However, when they returned for a further appointment in the summer, Mrs A's son had severe tooth decay and needed a number of extractions.

The practice referred Mrs A's son to the community dental services, where he was put on the waiting list for treatment. He developed an infection late in 2012 and was referred to the children's hospital.

At an appointment with the community dental services in early 2013, he needed ten extractions under general anaesthetic.

Mrs A complained to the practice. She raised another concern, that her son's teeth had not been fluoride coated and that the dentist had been abrupt. In reply, the dentist said that he reviewed her son's teeth and had concerns about decay developing, so he gave advice on brushing to prevent this. The dentist apologised that Mrs A felt he was abrupt and said he would reflect on this in the future. Overall the dentist said that because of Mrs A's son's difficulty in coping with dental treatment and the rapid progression of his decay, the loss of his teeth was unavoidable.

What we found

We asked one of our clinical advisers whether we could say with any certainty that the dentist's examination in early 2012 failed to identify decay, or the extent of it. She said we could not, and it was possible that the decay significantly worsened after the examination. However, the dentist's record keeping fell well below the expected standard so, while we could not say with certainty that he failed to spot the decay, we could not reach any firm conclusions about the standard of his examination in spring 2012.

The dentist had apologised if he seemed abrupt and in our view this was a reasonable response to this issue.

The relevant guidance on fluoride coating is that dentists should apply fluoride varnish to the teeth of child patients between three and six years old twice yearly. This can be increased to three or four times a year for children whose teeth are giving concern. The dentist had not done this, which was a failing. However, we could not specifically link this to the decay in Mrs A's son's teeth.

Putting it right

The practice apologised that the dentist's record keeping was insufficient to properly address Mrs A's concerns. It paid Mrs A £250 to recognise this, and also apologised that her son's teeth were not fluoride varnished, or if this was not appropriate, that she was not told why.

The practice also took action to improve its record keeping and complaint handling and worked to make sure that all dentists at the practice were aware of the guidance on fluoride varnishing.

Organisation we investigated

A dental practice

Location

Derbyshire

Region

East Midlands

Summary 337/July 2014

Patient's wound care not investigated properly

Mrs M complained that she had been treated poorly whilst detained under the *Mental Health Act 1983*.

What happened

Mrs M was detained under the *Mental Health Act 1983* after cutting her wrists.

She said the Trust had covered up failings when it investigated her complaint about her treatment. She complained about her medication, the care of her wounds and the discharge arrangements.

What we found

The Trust had properly investigated the complaint and the discharge was reasonable, as was the painkilling medication it prescribed when it discharged Mrs M.

However, the Trust had made a mistake in the complaint response about when Mrs M's wound dressings were changed. It also did not keep proper records about wound care and there were failings in how staff recorded Mrs M's medication while she was in hospital.

Putting it right

The Trust agreed to interview the person who had changed the wound dressings and take appropriate action; to audit care plans and medication charts to see what went wrong in this case; and to put in place any improvements needed to prevent something similar happening again.

The Trust agreed to write to Mrs M and apologise and to send her a copy of the action plan for improvements.

Organisation we investigated

Derbyshire Healthcare NHS Foundation Trust

Location

Derbyshire

Region

East Midlands

Summary 338/July 2014

Trust did not accommodate patient's complex needs after knee replacement surgery

A physiotherapy clinic did not meet Mrs T's needs after her knee replacement surgery. Mrs T had a condition that merited extra consideration.

What happened

In early summer 2013 Mrs T had a total knee replacement in her right leg. She was discharged to the physiotherapy department at The Royal Marsden NHS Foundation Trust for ongoing treatment.

Mrs T had an outpatient appointment with a locum physiotherapist. She then raised concerns about the conduct of the physiotherapist and it was agreed she would be seen by different physiotherapists at subsequent appointments. There was a delay in some of the Trust's responses, which upset Mrs T.

What we found

The Trust took relevant and proportionate steps to apologise for the delays in responding to Mrs T's complaint, and to address the issues about the physiotherapist's attitude and behaviour as part of its complaint response. The Trust appropriately identified that the physiotherapist should have referred Mrs T to her GP for pain relief during the appointment, and said that it would remind her to do this in future. However, we felt that the Trust should apologise to Mrs T that this did not happen at the time.

There was not enough evidence to conclude that the physiotherapist acted inappropriately during the appointment when she raised the issue of home exercises with Mrs T; when she referred Mrs T for counselling; or when she attempted to bend Mrs T's knee. Instead, given Mrs T's complex clinical history, she should have been given enough time in an appointment in a more specialised clinic with a physiotherapist whom she knew and who could respond to her needs. Because this did not happen, Mrs T would have felt unsupported, and this would have caused her unnecessary upset at a difficult time.

Putting it right

The Trust apologised for its failings. It agreed to put together an action plan to demonstrate that it had learnt from its mistakes.

Organisation we investigated

The Royal Marsden NHS Foundation Trust

Location

Greater London

Region

London

Summary 339/July 2014

GP practice handled test results and application for employment support allowance poorly

When Mr P found out he had MRSA (a bacterial infection that is resistant to a number of widely used antibiotics), he had the treatment suggested by an infection control team and was told he needed to have three consecutive weeks of negative swabs before he could be classed as MRSA-free.

What happened

Mr P approached his GP and was told he would need to have the swabs taken elsewhere. When the results came back, Mr P said the hospital was not told and this caused significant distress when he returned to hospital for an operation and was placed on a ward with MRSA patients.

When Mr P tried to arrange to have forms completed so he could claim employment support allowance, he could not see his GP of choice and then the relevant forms were not available.

What we found

The practice properly explained what happened and apologised for things that it could have handled better. However, it did not do enough to recognise how its failure to send the MRSA test results to the hospital affected Mr P.

The practice had already explained what happened in relation to Mr P's employment support allowance, had recognised that it had made mistakes and had apologised.

Putting it right

The practice wrote to Mr P to acknowledge the upset and distress caused at an already stressful time.

Organisation we investigated

A GP practice

Location

Merseyside

Region

North West

Summary 340/July 2014

Concerns about trust's discharge arrangements and complaint handling

Mrs L made a number of complaints about the co-ordination of her discharge from hospital in 2013. Initially the Trust missed the point of Mrs L's complaint and when she complained about the time taken to respond, it did not answer her concerns.

What happened

Mrs L was admitted to an intermediate care unit after she fell ill at home. When staff made plans to discharge her, her GP intervened because of concerns about lack of heating, food and carers at home. When Mrs L complained, the Trust considered Mrs L's eventual discharge rather than the original plan to discharge her. When she complained about the length of time taken to respond to her complaint, the Trust did not address her concerns.

What we found

Staff carried out appropriate assessments before the original failed discharge. When staff became aware that Mrs L's home did not have heating or hot water, they properly delayed discharging Mrs L. However, there was no evidence of an initial comprehensive nursing assessment that should have documented the information about Mrs L's home circumstances.

The Trust's complaint handling could have been better.

Putting it right

The Trust wrote to Mrs L to apologise for the poor complaint handling. It explained the action it would take to learn from these events.

Organisation we investigated

East Sussex Healthcare NHS Trust

Location

East Sussex

Region

South East

Summary 341/July 2014

Failings in orthopaedic services

Mrs T complained about her wait for treatment for a chronic spinal condition.

What happened

Mrs T was involved in a road accident in 2010 and injured her back. Following the collision, she was under the care of her GP, who referred her for treatment at the spinal department at Torbay Hospital in spring 2011. However, she complained later that year because she felt the Trust had breached the 18-week rule for referral for treatment set out in the NHS Constitution.

What we found

There were failings in the way the Trust managed Mrs T's treatment. These led to a delay in treatment that breached the 18-week rule.

Putting it right

The Trust apologised and paid Mrs T £500 compensation for the distress she had suffered.

Organisation we investigated

South Devon Healthcare NHS Foundation Trust

Location

Devon

Region

South West

Summary 342/July 2014

Trust did not acknowledge serious failings and distressed bereaved wife with poor complaint handling

Mr H's wife, Mrs H, complained that an incident with continuous positive airway pressure equipment meant that Mr H had low levels of oxygen for a significant period of time. She felt that this contributed to his deterioration and the train of events that ended in his death 12 days later. She believed that nurses on the medical assessment unit were not competent in providing continuous positive airway pressure therapy.

What happened

Mr H went to the Trust's emergency department early one morning with acute shortness of breath. Staff treated him with continuous positive airway pressure before transferring him to a medical assessment unit.

Mrs H says that later the same day, a nurse appeared to 'bump into' continuous positive airway pressure equipment, and a piece of the equipment fell off. After this, Mr H complained that he was not getting oxygen. Although Mrs H repeatedly told ward staff about this, staff did not take any action for around an hour.

The Trust admitted Mr H to intensive care, and then transferred him to a trust that could offer treatment using a different process. Despite his treatment, Mr H died 12 days later.

Mrs H's distress at the time of her husband's death was made worse by her knowing that there had been an untoward incident during his care that the Trust had failed to investigate properly. Mrs H's grief was exacerbated by having witnessed her husband's distress and discomfort when he did not receive oxygen.

Mrs H complained to the Trust about the incident, but she was unhappy about the Trust's investigation of her complaint.

What we found

There were serious failings in the way in which the Trust managed Mr H's continuous positive airway pressure therapy. Staff did not diagnose and treat his acute cardiac failure until 24 hours after his admission. Although he subsequently had very aggressive and sophisticated treatment, this was ultimately not successful.

On balance, however, we considered that his cardiac disease was so severe that he would not have survived.

Mrs H had to pursue her complaint for nearly two years in order to obtain an accurate response to her concerns and recognition that something went wrong that had not been put right.

During this time, the Trust failed to reassure her. It did not thoroughly identify and address the problems highlighted by this complaint and it was not open about failings in Mr H's care and treatment.

Putting it right

The Trust apologised to Mrs H for the serious failings we identified in his care and in its complaint handling. It paid her £1,250 compensation.

The Trust agreed to prepare an action plan that described what it had done to make sure that it had learnt the lessons from this complaint and detailed what it had done or planned to do, to avoid these failings happening again.

Organisation we investigated

Croydon Health Services NHS Trust

Location

Greater London

Region

London

Summary 343/July 2014

Teenager forced to undergo complex orthodontic treatment that should have been carried out at primary school

Mr Q complained that although he had attended his dental practice regularly since age seven, his dentist had failed to recognise that he needed to be referred to an orthodontic specialist because his permanent teeth did not come through.

What happened

Mr Q had to have significant repeated orthodontic procedures in his final year at school while he was trying to manage revision for his exams. He could have had this treatment when he was much younger.

What we found

There were some failings in the way the dentist assessed Mr Q. It would have been appropriate for Mr Q to have been referred to an orthodontist five years earlier than he was, and the dentist's failure to do this fell short of the accepted clinical standard.

The delay in being referred for necessary treatment caused Mr Q significant distress and inconvenience.

Putting it right

The practice paid Mr Q £750 to recognise the distress and inconvenience it had caused. It apologised for the lost opportunity to resolve Mr Q's dental problems earlier.

We did not consider that the practice should pay for private orthodontic treatment, as requested by Mr Q, because he was already having the NHS treatment to which he was entitled.

Organisation we investigated

A dental practice

Location

West Berkshire

Region

South East

Summary 344/July 2014

Older patient discharged with pressure sores

Mrs G developed pressure sores after a hip replacement operation.

What happened

Mrs G went into an independent hospital for hip replacement surgery funded by the NHS. After her operation, she complained to nursing staff that her heels were sore. Her heels had been healthy before she went into hospital, and she had been independently mobile at home.

When staff discharged Mrs G several days later, she had a blister on her heel that developed into a pressure sore. She needed multiple visits from district nurses for treatment once she got home.

What we found

There were some failings in the way nurses in the hospital assessed Mrs G's skin and in how they managed the risk. We could see no evidence that staff took or planned appropriate and timely action to try and avoid a pressure wound.

Putting it right

The Clinical Commissioning Group acknowledged and apologised for its failings and put together an action plan that showed how it had learnt from its mistakes so that they would not happen again.

Organisation we investigated

Stoke-on-Trent Clinical Commissioning Group (CCG)

Location

Stoke-on-Trent

Region

West Midlands

Summary 345/July 2014

Communication problems between GP practice and pharmacy

Mrs B's husband, Mr B, complained about the care and treatment she received from her GP practice towards the end of her life.

What happened

Mrs B was diagnosed with an illness that meant she had a very short life expectancy. Mr B felt that there had been no continuity in his wife's care from the practice. He said that different doctors at the practice were responsible for her, and this led to failures in how Mrs B's illness was monitored and how staff prescribed her medication.

Mr B said that Mrs B's care and treatment by the practice had been criticised by other practitioners involved in her care. He also complained that authority to undertake a cremation was unnecessarily delayed and that the practice investigated his complaint poorly.

What we found

Although it was not ideal that the practice was unable to provide a single doctor to oversee Mrs B's condition, this did not affect the quality of care she received. The remarks made by other health professionals were made during a post mortem review meeting of the multidisciplinary team that treated Mrs B to investigate how it could improve its practice. This has led to positive improvements in the way the multidisciplinary team operates. The practice was only one element of the multidisciplinary team.

The practice followed national guidance with regard to the cremation certificate, and the delay involved was minimal.

There were problems with repeat prescriptions. The practice explained that this was a communication problem with a local pharmacy but it did not give Mr B an adequate response. This also indicated a shortcoming in the practice's complaint handling processes.

Putting it right

The practice acknowledged the identified shortcomings and agreed to give Mr B more detailed explanations and a suitable apology.

Organisation we investigated

A GP practice

Location

Plymouth

Region

South West

Summary 346/July 2014

GP practice failed to follow its triage protocol

Reception staff did not find out that a patient was suffering from chest pains when he wanted to book an appointment with his GP.

What happened

Mr G was suffering from chest pains and tried to book an appointment to see his GP. He telephoned the GP practice but was told that there were no appointments that day and that he should contact it again the next day, which he did.

The following week Mr G visited a local hospital. He was told that the hospital would contact his GP that day to ask for an ultrasound referral. However, the GP practice did not receive the request until two days later.

What we found

The practice operates a triage system for booking GP appointments and has in place a duty doctor listing protocol. This protocol says it is imperative that the receptionist establishes the patient's symptoms or problems. If the patient has a serious health problem, such as acute chest pain, the receptionist must alert the duty doctor immediately.

The receptionist who spoke to Mr G did not ask him why he wanted to see his GP and what his health problem was. Therefore, the practice failed to follow its own protocol. We decided to partly uphold Mr G's complaint because, although we found failings, we felt that he did not suffer as a result because he saw his GP the next day.

The GP practice dealt with the referral request in a timely manner. It received the request two days after Mr G's visit to hospital and made the ultrasound referral the same day. We saw no evidence that the hospital sent the request any earlier. We therefore did not uphold this part of Mr G's complaint.

Putting it right

The practice wrote to Mr G describing what it had done to make sure that reception staff follow the triage protocol.

Organisation we investigated

A GP practice

Location

Greater Manchester

Region

North West

Summary 347/July 2014

Trust discharged outpatient without recent clinical review

Mrs F had annual reviews at the Trust. The Trust's decision to discharge her ten months after her last review was not in line with good practice.

What happened

Mrs F had annual reviews at the Trust's rheumatology department, which is a centre of excellence. The Trust is over 200 miles from Mrs F's home. Mrs F was due to have an annual review at the Trust in autumn 2012. However, in summer 2012, the Trust cancelled the appointment because it decided that she could be reviewed by a haematology service nearer to her home. Mrs F had already booked travel and accommodation for the appointment. She decided to request a private referral for future care as she was not happy with the NHS services available locally.

What we found

It was not in line with good practice for the Trust to discharge Mrs F without a further review, because her last review had been ten months earlier. This affected her continuity of care and caused her undue stress. However, it was reasonable for the Trust to decide that Mrs F's condition could be managed locally and that this could be through a rheumatology or haematology service.

In addition, the consultant who discharged Mrs F gave a poor explanation of her diagnosis, which seemed to call it into question.

The failing did not lead to Mrs F's financial expenses for the cancelled appointment, because she chose to travel to appointments rather than use a local service. We also did not find that this led to Mrs F's expenses for future private appointments because she could have used NHS care locally.

Putting it right

We asked the Trust to draw up an action plan that showed what it had done to make sure transfer of care is safe.

Organisation we investigated

Guy's and St Thomas' NHS Foundation Trust

Location

Greater London

Region

London

Summary 348/July 2014

Failure to arrange face-to-face review demonstrated serious error in clinical judgment

A GP's failure to appropriately assess a patient's condition and failure to adhere to practice protocols and professional standards meant that a patient did not get a face-to-face medical review.

What happened

Mrs Y lived alone in sheltered housing. She was unwell one morning and her cleaner called the GP practice to ask for a home visit. The cleaner spoke to Mrs Y's GP. The GP noted that Mrs Y had been unwell for two weeks and that she had a number of symptoms, including chest pain, and was feeling feverish, weak and lifeless. The GP diagnosed an infection and prescribed antibiotics over the telephone.

The cleaner and the GP give different accounts of what was said during the consultation. The GP says he asked the cleaner to let him know if there was no improvement and he would visit Mrs Y. The cleaner disputes that the GP suggested a home visit and says she told the GP that she was not Mrs Y's carer and would not be there later that day to let him know if Mrs Y did not improve. Mrs Y was found dead the next morning.

Mrs Y's daughter complained to the practice about the GP's decision not to visit her mother. The GP responded and maintained that he had acted appropriately.

What we found

The GP's decision not to visit Mrs Y or arrange some other form of face-to-face medical review was contrary to both the practice's internal protocols and professional standards. The GP made a serious error in clinical judgment.

The GP did not have enough information at the time of the telephone consultation to safely conclude that Mrs Y had an infection and did not require face-to-face review. There was also no evidence that the GP put an appropriate safety net in place.

Mrs Y's medical history and her reported symptoms, in particular her chest pain, should have alerted the GP to arrange a face-to-face medical review. Furthermore, the practice's own protocols state that if a patient (or a friend or relative) phones to say a patient has chest pain and a past history of heart problems, as Mrs Y had, the practice should call an ambulance and tell a GP. This did not happen.

Putting it right

The practice apologised to Mrs Y's daughter and prepared an action plan that described what it has done or planned to do to make sure that it had learnt from the complaint.

We felt that the GP's actions and his responses to the complaint showed a lack of insight into the failings in his care, so we shared information about our investigation with the General Medical Council.

Organisation we investigated

A GP practice

Location

Greater Manchester

Region

North West

Summary 349/July 2014

Mistakes between two organisations delayed ambulance

Mrs W complained that mistakes by an ambulance service and NHS Direct delayed an ambulance for her father-in-law who was in severe pain at home.

What happened

When Mr G was taken ill at home, his son dialled 999 for an ambulance. The ambulance service wrongly passed the call to NHS Direct. Mr G remained in pain and a second 999 call shortly after was again passed to NHS Direct. Mr G's son then called NHS Direct himself and after he spoke to an adviser, an ambulance was sent. The ambulance arrived to take Mr G to hospital an hour after his son had made the first 999 call.

Mr G needed emergency surgery to clear a blood clot affecting the blood supply to both of his legs. Very sadly, he died during the operation.

What we found

Mr G's symptoms did not match the criteria for passing the call to NHS Direct. The ambulance service should have put the call through to one of the clinician advisers in its control centre for further assessment. The ambulance service therefore did not follow the nationally agreed process when it transferred the two 999 calls to NHS Direct. It also spelt Mr G's name differently on each referral, so NHS Direct did not realise that a second referral had been made.

NHS Direct should have identified sooner that the calls did not meet its criteria. As a result, it took too long to send an ambulance to Mr G. However we found no evidence that the delay was a contributory factor in Mr G's death.

When Mrs W complained, NHS Direct's investigation was thorough and transparent. It identified and apologised for the mistakes that had occurred. We did not uphold the complaint about it.

The ambulance service's investigation did not identify the mistakes. We therefore partly upheld the complaint about it.

Putting it right

The ambulance service apologised to Mrs W and asked for and made changes to its electronic coding system to prevent similar mistakes happening again.

Organisations we investigated

The East Midlands Ambulance Service NHS Trust

NHS Direct

Location

Nottingham

Region

East Midlands

Summary 350/July 2014

Poor care delayed postoperative healing of wound

After a minor operation, Mr B's wound became infected. Failings in his postoperative care meant that the wound took longer to heal than it would have otherwise.

What happened

Staff at a surgery centre run by Clinicenta, part of Carillion PLC Health Services, removed a cyst from Mr B's foot. When they took the stitches out, the wound had become infected. Staff re-dressed the wound and gave Mr B antibiotics, but he wasn't reviewed by a doctor.

Mr B returned to the surgery centre three more times, but although staff dressed his wound, he still did not see a doctor. Just over a week later, Mr B needed to be admitted to hospital for three days to treat the infection and it took a number of weeks (during which time his care was taken over by his GP) before the wound healed fully. This meant he had to take additional time off work.

Mr B complained to the surgery centre but was unhappy with the outcome and contacted us.

What we found

There was no evidence that Mr B's infection was the result of any failings during or after the operation, or when he was initially discharged. However, the lack of observations and medical follow up immediately after staff took out Mr B's stitches, and for the following week, probably contributed to the delay in the wound healing.

Putting it right

We recommended that Clinicenta apologise to Mr B for the failings we identified. We also recommended that it pay £350 in partial recognition of the additional time Mr B missed from work.

Organisation we investigated

Carillion PLC Health Services (Clinicenta Ltd)

Location

Hertfordshire

Region

East

Summary 351/July 2014

Poor communication about end of life care

A family was left upset and distressed when their father died after being put on the Liverpool care pathway, which had not been explained to them fully.

What happened

Mr G had leukaemia. In late summer 2012, the Trust treated Mr G in hospital for the leukaemia and for sepsis.

Unfortunately, despite treatment, Mr G's condition did not improve, and so medical staff made the decision to stop active treatment and start him on the Liverpool care pathway (an end of life pathway no longer used by the NHS).

His wife, Mrs G, and his daughter, Mrs L, complained to the Trust and the family met Mr G's consultant to discuss their concerns. In particular the family complained that the Liverpool care pathway had not been explained to them. They said that if it had been, they and Mr G would not have agreed because of their religious views. They were also concerned that the Liverpool care pathway and the drugs Mr G was given may have hastened his death.

The Trust accepted that there were problems in the communication with the family. For example, staff did not give them a booklet about the Liverpool care pathway, which they should have. However the Trust said that Mr G's clinical management had been reasonable. Mrs L remained unhappy and asked us to investigate.

What we found

There were no failings in Mr G's clinical management and we were satisfied that, from a clinical perspective, the decision to start him on the Liverpool care pathway was appropriate. There was no evidence that his death was hastened by this decision or by the medication given to him.

However, communication with Mrs L and her family, in particular about the Liverpool care pathway, was inadequate, so the family did not fully understand the implications of what staff proposed. This caused Mrs L's family a great deal of distress and left Mr G's wife with strong feelings of guilt about his death.

Putting it right

The Trust apologised to Mrs L and acknowledged the failings in communication we identified.

The Trust gave Mrs L an update on the various measures it had taken to improve communication.

Organisation we investigated

Derby Hospitals NHS Foundation Trust

Location

Derby

Region

East Midlands

Summary 352/July 2014

Poor communication led to unnecessary treatment

Mrs N was refused funding for a surgical procedure. She was advised, wrongly, that she would need a psychological assessment to get the funding.

What happened

Mrs N sought approval for a surgical procedure not normally funded by NHS Halton and St Helens (the PCT). The letter setting out the PCT's decision suggested that she seek treatment that had no bearing on her application. Mrs N complained about the failure to fund the surgery she required, which had forced her to seek the procedure privately. She also complained about the inaccurate information she received.

Halton Clinical Commissioning Group (CCG) has inherited the PCT's responsibility in this matter.

What we found

The PCT reached a reasonable decision that was in line with local policy and guidance when it decided not to fund Mrs N's surgery.

However, the letter the PCT sent Mrs N was confusing, contained factual errors and suggested unnecessary treatment that ran counter to the PCT's policy. The letter fell well below the standard we would expect from a public body.

As a result, Mrs N embarked on a futile and time-consuming course of action that ultimately caused her great distress.

Putting it right

The CCG paid Mrs N £250 in compensation for her distress.

Organisation we investigated

Halton Clinical Commissioning Group (CCG)

Location

Halton

Region

North West

Summary 353/July 2014

Trust delayed giving Parkinson's medication

Mr P complained that the Trust did not provide his mother's, Mrs P's, Parkinson's disease medication soon enough.

What happened

Mrs P was admitted to the Trust in spring 2012 after her condition deteriorated following an operation. There were initial delays (four days) in providing one or two doses of most of Mrs P's Parkinson's disease medications because they were 'non stock' drugs.

What we found

The Trust should have, in line with established good practice, provided necessary medication sooner. Not providing timely medication for Parkinson's disease was service failure.

Putting it right

We recommended that the Trust should prepare an action plan that describes what it has done to make sure that it has learnt lessons and details what it has done or plans to do to prevent the same failing happening again.

Organisation we investigated

The Royal Wolverhampton Hospitals NHS Trust

Location

West Midlands

Region

West Midlands

Summary 354/July 2014

Stroke patient received poor care

Mr H complained about the care and treatment given to his late father, Mr R. He was particularly concerned about nursing care, too few scans, a fall and poor record keeping.

What happened

Mr R had a stroke at home and went into his local stroke unit. Trust staff carried out a scan and an assessment. Later that evening, nurses were worried that Mr R was deteriorating and called a doctor to see him. The doctor felt Mr R's condition had not changed but told nurses to check on him more frequently. During the night, Mr R fell out of bed, but a doctor checked him and found him unharmed.

Most of Mr R's clinical records for the next day are missing, and there is no evidence to suggest that a doctor saw him during the day, although nurses monitored him. A doctor saw Mr R during the night shift and his condition at that time was unchanged.

The next morning, doctors found that Mr R's condition had severely deteriorated. He had an urgent scan and was referred to neurosurgery. Staff transferred him to a specialist centre at another trust, but he died a few days later.

What we found

Generally, Mr R received good care from night shift staff but the care he received during the first day was not good enough.

A junior doctor failed to identify that Mr R was deteriorating during his first night on the unit. If the junior doctor had noted the deterioration, staff would have carried out a second scan sooner. However, even if Mr R had had another scan, it was unlikely that he would have survived his stroke.

There were also significant failings in the Trust's record keeping as some records were missing and record keeping was not good overall.

Putting it right

The Trust apologised to Mr H and paid him £1,000 in recognition of the distress caused to him and his father.

It also prepared an action plan that addressed the failings we identified to prevent others having similar experiences.

Organisation we investigated

County Durham and Darlington NHS Foundation Trust

Location

County Durham

Region

North East

Summary 355/July 2014

Unusual birth complication not identified

Midwives did not identify shoulder dystocia during Mrs A's labour, and there was a delay between the baby's head and his body being delivered. The Trust handled Mr and Mrs A's complaint poorly.

What happened

During Mrs A's labour, there were seven minutes between the baby's head being delivered and the rest of his body. This was caused by shoulder dystocia, a rare complication that happens when a baby's shoulder becomes stuck in the birth canal during labour.

Mr and Mrs A asked questions and raised concerns about what had happened and, because they were unhappy with the Trust's answers, they obtained a private review before meeting the Trust to discuss what had happened.

What we found

There was a possible two-minute delay when midwives did not identify shoulder dystocia and the appropriate process was then not followed.

The Trust apologised for this fault and the poor handling of Mr and Mrs A's initial concerns over what had happened. This had caused the family to lose confidence in what the Trust said and led them to pay for a private review.

Putting it right

The Trust apologised and acknowledged that the initial handling of Mr and Mrs A's concerns was inadequate and did not reassure them.

The Trust paid £250 for the cost of the private review, and £750 in recognition of the distress caused by the faults we identified.

It also completed an action plan to address all of the faults found.

Organisation we investigated

Oxford University Hospitals NHS Trust

Location

Oxfordshire

Region

South East

Summary 356/July 2014

Failure to adequately assess a mole

The GP practice did not assess Mr L's mole adequately in 2010 and did not refer him to hospital with suspected cancer. His daughter, Mrs N, was distressed because she believed that her father was not adequately assessed or referred when he should have been. The inadequate handling of her complaint by the practice and the Trust caused her further unhappiness.

What happened

In 2003 the practice assessed and removed a mole from Mr L's back and sent it to the Trust for biopsy. Although the Trust said that there was no evidence of cancer, after Mr L's death in 2011, it retested his mole and found cancer had been present. It apologised to Mrs N but explained that her father's chances of survival had not been affected by the error.

Mr L had visited the practice in 2010 because his mole had come back. The assessment was brief, and the practice did not refer Mr L to hospital for further investigations.

During a routine hospital appointment a month later, doctors discovered that Mr L had cancer. He subsequently died in spring 2011. After Mrs N's complaint, the practice wrote to her to explain that there was no suspicion of cancer during its assessment, and that it had followed the relevant guidelines.

What we found

The Trust's comments about Mr L's chances of survival were appropriate. However, it did not respond to subsequent correspondence from Mrs N, which caused her distress.

The practice failed to adequately assess Mr L in 2003 or 2010. There was not enough evidence to conclude that the practice should have referred Mr L to hospital in 2003. However, there was evidence that it should have referred him in 2010, but it did not.

Some of the practice's responses to Mrs N's complaint were evidence-based, but others were not and were ambiguous. The failure to adequately assess Mr L, or refer him to hospital when it should have done, caused Mrs N distress that was compounded by the practice's, and the Trust's, inadequate complaint handling.

Putting it right

The practice and the Trust acknowledged and apologised for the failings and the injustice these led to.

The practice paid Mrs N £250 compensation. It produced an action plan that set out how it will prevent these problems happening again.

The Trust explained how it will communicate better with complainants in future.

Organisations we investigated

University Hospitals of Morecombe Bay NHS Foundation Trust

A GP practice

Location

Cumbria

Region

North West

Summary 357/July 2014

Complaint about antidepressant prescribing in pregnancy and support after miscarriage

Mrs F complained about how the practice managed her antidepressant medication during her pregnancy. She was also unhappy about the support she received following her miscarriage. She felt that this contributed to her mental breakdown.

What happened

Mrs F suffers from depression and was prescribed an antidepressant. She became pregnant and in summer 2012 discussed this with Dr O. He advised her to wean off the antidepressant over two weeks but review this if her depression worsened. Mrs F's depression worsened and the next month she again spoke to Dr O, who advised her to restart the antidepressant. He said that, whilst the manufacturer advised that the drug should be avoided during pregnancy, there was no firm evidence of risk.

Soon afterwards, Mrs F miscarried and her mental state worsened. Her antidepressant dose was increased and lowered again. The following spring it was replaced with another antidepressant. Mrs F also said that Dr O was not helpful when she asked for counselling to help with her depression. She said that she had a mental breakdown and later required hospitalisation.

Mrs F complained to the practice later in 2013. Dr O explained that his advice was appropriate, based on his understanding of the risks the first antidepressant presented during pregnancy. He did not respond to Mrs F's other issues about the lack of support she received, although she was offered a meeting, which she declined.

What we found

Dr O managed Mrs F's medication appropriately. While guidance explains that there may be a small risk of birth defects if taking the first antidepressant during pregnancy, it does not mean it should never be used. In some cases it is still appropriate. There is no suggestion that it can lead to miscarriage.

Dr O appropriately reduced and increased Mrs F's medication. When he changed it, this was on the instruction of Mrs F's mental health trust.

The mental health support Mrs F received from the practice was reasonable and she was referred to appropriate organisations for help.

The practice's complaint handling could have been better. Its responses did not fully address Mrs F's concerns about the reduction of the antidepressant and the support she received for her mental health problems. The poor complaint handling contributed to Mrs F's distress.

Putting it right

The practice acknowledged that its complaint handling was poor and apologised for this. It undertook to improve its complaint handling.

Organisation we investigated

A GP practice

Location

Leicestershire

Region

East Midlands

Summary 358/July 2014

Poor cardiology care led to postoperative death and poor complaint handling

Mrs D complained about the care and treatment her late husband, Mr JD, received from the Trust in spring and early summer 2013. She complained about preoperative advice, that staff did not carry out an operation properly, her husband was discharged too soon and the Trust's complaint handling was poor.

What happened

Mr JD was admitted to the Trust in spring 2013 suffering from chest pain. Medical staff diagnosed three-vessel coronary artery disease. Doctors told Mr JD that a coronary artery bypass graft was the better treatment option. However, Mr JD wanted a quicker recovery time so he chose to have a percutaneous coronary intervention (through a needle puncture of the skin), which involved inserting a stent.

Staff gave Mr JD several tests after the operation and declared him fit for discharge in early summer 2014. Sadly he died suddenly at home soon afterwards. It appears he suffered a stent thrombosis. The pathologist's report concluded that Mr JD's death was caused by ischaemic heart disease and that he had died of natural causes.

Mrs D complained to the Trust later in the year and went to a resolution meeting. The Trust did not give her a written response when she asked for one. Instead she was given CDs of the meeting.

What we found

There were no clinical failings by the Trust, and our adviser said that Mr JD received a good standard of care. Mr JD suffered a very rare complication and sadly this was fatal.

However, there were failings in the Trust's complaint handling because the NHS complaint regulations state that Trusts should reply to a complaint in writing. Recordings of a meeting may be enough if the complainant is satisfied with these; however, if the complainant asks for a report, the Trust should provide one.

Putting it right

The Trust reflected on our comments about its complaint handling and took steps to make sure that this does not happen again. The Trust wrote to Mrs D to acknowledge this, and sent us a copy of the letter.

Organisation we investigated

Nottingham University Hospitals NHS Trust

Location

Nottingham

Region

East Midlands

Summary 359/July 2014

Delay confirming diagnosis meant that family will never know if a young woman might have lived longer or had better quality of life

Miss D complained that in 2005 an NHS Trust failed to diagnose her daughter, Miss E, with a condition that is a rare complication of measles. The condition is progressive and terminal. She also complained that another trust failed to diagnose the condition between 2005 and 2008.

What happened

Miss E was diagnosed with the condition overseas in 2000. She was prescribed medication to help control her symptoms. Miss D moved to England in 2004 with Miss E and took the diagnostic report with her. The first Trust, Barts Health NHS Trust (formerly Barts and The London NHS Trust) considered that the diagnosis was wrong, even though it had not confirmed a different diagnosis or carried out any investigations.

In 2005 Miss E was referred to the second Trust, Barking, Havering and Redbridge University Hospitals NHS Trust, which also felt that the initial diagnosis was incorrect. It took a 'wait and see' approach to Miss E's care.

During this period, doctors stopped the medication previously prescribed to control Miss E's symptoms. Miss E's condition started to deteriorate and, despite her family's concerns about her deterioration and the change of medication, clinicians did not carry out further detailed investigations and tests until Miss E's condition had deteriorated significantly.

The original diagnosis was reconfirmed in 2008 after the second Trust contacted the overseas consultant who had made the initial diagnosis, and carried out further tests. Miss E was prescribed the medication she had been prescribed abroad but her condition continued to worsen and sadly she died in 2012.

What we found

The decision by the first Trust to change Miss E's diagnosis without confirming another diagnosis and neither exploring the deterioration reported by her family nor telling the second Trust about the family's concerns, was a failing in care.

The second Trust delayed carrying out proactive enquiries and further investigations until Miss E's condition had significantly deteriorated. These were failings in care.

Because of the rarity of the condition and its terminal nature, we could not say that the delay confirming the diagnosis and prescribing the medication hastened Miss E's deterioration and death. We concluded that the delay confirming the diagnosis meant that Miss E did not have the opportunity to live as healthy a life as was possible in the circumstances. This was a source of anxiety and distress to Miss D.

Miss D also experienced the further injustice of having her hopes raised that the initial diagnosis was wrong only to have to have them dashed, and never being able to know if the outcome would have been different if the medication had not been stopped or if it had been restarted sooner.

Putting it right

The first Trust apologised to Miss D and paid her £750 compensation. It agreed to make sure that it learnt lessons from the failings and draw up an action plan that detailed what it had done or planned to do to prevent these failings happening again.

The second Trust apologised to Miss D and paid her £1,500 compensation. It also agreed to draw up an action plan.

Organisations we investigated

Barts Health NHS Trust (formerly Barts and The London NHS Trust)

Barking, Havering and Redbridge University Hospitals NHS Trust

Location

Greater London, Essex

Region

London, East

Summary 360/July 2014

Trust provided poor care for fractured ankle

Ms T fractured her ankle. She had poor care from the hospital, which caused further pain and led to an unremedied injustice.

What happened

Ms T fractured her ankle and went to A&E at the Trust. Staff gave her a moulded cast and made an appointment for an operation.

Ms T later went back to the hospital because she was in severe pain. She had an operation and stayed in hospital for around a fortnight. She raised a number of concerns about the quality of care she received both in this period and her outpatient appointments.

What we found

From the 12 issues brought to us by Ms T, we found four amounted to failings. We found evidence of failings because a doctor who saw Ms T did not record the consultation. Also staff switched off equipment Ms T was using, a nurse used a dressing with iodine, which Ms T is allergic to, on Ms T's wound, and some aspects of the Trust's complaint handling were poor.

Putting it right

The Trust agreed to apologise to Ms T for the failings we identified, and draw up an action plan to show it had learnt from this complaint and had improved services.

The Trust had implemented a new complaints policy after a previous investigation we carried out. This involved a new process of quality assurance through master classes and buddying to review responses, as well as additional training.

Organisation we investigated

Leeds Teaching Hospitals NHS Trust

Location

West Yorkshire

Region

Yorkshire and the Humber

Summary 361/July 2014

Inadequate management of pain after operation

A surgeon did not give enough pain relief or discuss the full implications of a procedure with patient.

What happened

Mrs M consented to the removal of her haemorrhoids. After the procedure, staff discharged her without antibiotics or painkillers. She developed an infection after the operation and was off work for two months although she had been told that she would only need two days.

What we found

The Trust had not told Mrs M that this operation can cause a significant amount of pain. It did not acknowledge that staff should have given Mrs M adequate pain relief when she was discharged.

We agreed with the Trust's response that antibiotics were not necessary after the surgery.

Putting it right

We asked the Trust to apologise for the failings we found. In particular, we recommended the Trust apologise for not giving Mrs M adequate pain relief, and for not telling her that she was likely to suffer significant pain after the operation.

We also asked it to write to Mrs M to explain how it would prevent this happening again and how it would make sure patients get enough information about pain, and adequate pain relief when they go home.

Organisation we investigated

East Kent Hospitals University NHS Foundation Trust

Location

Kent

Region

South East

Summary 362/August 2014

Mrs A died unexpectedly, only a few minutes before her husband arrived

Mrs A was terminally ill. Her deterioration and death were relatively unexpected and highlighted failings in the care of patients at the end of their life.

What happened

Mrs A had late-stage metastatic lung cancer and had lived for longer than had been expected. However, she was admitted to hospital in summer 2012 with shortness of breath. Staff treated her initially in the Trust's acute medical unit before they transferred her to a ward the following evening. Staff did not think she was at any risk at this stage.

Mrs A was distressed because of previous bad experiences when she had moved wards. She asked staff to contact her husband to ask him to visit. Soon afterwards, nursing staff noticed a change in Mrs A's breathing and asked for the on-call doctor to review her. The doctor was delayed in attending as he had been called to treat another patient.

Sadly, only a few minutes before her husband arrived at the hospital, Mrs A died. This was approximately two hours after staff noticed the change in her breathing and was not long before midnight. When Mr A arrived, the doctor met him to discuss the events of the evening and confirmed Mrs A's death.

Mr A subsequently complained to the hospital about a number of issues, including the move to a ward and the date and time of death recorded on his wife's medical certificate of confirmation of death.

What we found

Mrs A's deterioration and death were sudden and relatively unexpected. Before her change in breathing, there were no clinical indications of Mrs A's imminent deterioration.

Ward staff had failed to recognise the significance of the change in Mrs A's breathing. Although staff had requested medical review, they did not escalate this when the doctor was delayed in arriving. Although we could not say that Mrs A's death could have been avoided, we considered an earlier medical review might have led to the prescription of medication for the build-up of secretions. This might have helped Mrs A's distress and could have allowed some additional time for her husband to arrive on the ward to be with her.

The checks staff carried out to verify death were appropriate. There was not enough evidence for us to query the details of the time of confirmation of death recorded in Mrs A's notes by the doctor. However, we reassured Mr A that the date recorded on the medical certificate of confirmation of death was appropriate because it was carried out after midnight.

Putting it right

The Trust acknowledged and apologised for the failings we found. It created and implemented an action plan to ensure that appropriate plans are in place for end-of-life stage patients, should their condition deteriorate unexpectedly. The action plan also ensured that staff on non-palliative care wards are trained to recognise the signs and symptoms of sudden, and unexpected, deterioration in end-of-life stage patients.

The Trust also agreed to Mr A's request to create and put in place a policy and guidance for the provision of care and respect in death.

Organisation we investigated

Western Sussex Hospitals NHS Foundation Trust

Location

West Sussex

Region

South East

Summary 363/August 2014

Trust did not try hard enough to contact a woman whose husband had just died

The Trust failed to communicate appropriately with Mrs B on the morning of her husband's death. She found out her husband had died when she rang the ward.

What happened

Mr B was admitted to the Trust in 2013. He was treated for a lung infection and was discharged home. He was readmitted a few weeks later but died in hospital soon after. Mrs B complained about her husband being discharged without support; the use of the end of life pathway and discussions about it; the lack of oxygen offered to her husband; and failure to notify her when he died.

What we found

The Trust had said it had tried to contact Mrs B on the morning of her husband's death, but we found no evidence of this. Mrs B only found out that her husband had died when she telephoned the ward, which was very upsetting for her.

There was no failure in the use of the pathway or discussions surrounding it or the administration of oxygen.

Putting it right

The Trust apologised to Mrs B for the distress caused. It said it will raise awareness among staff of the need to follow its own guidelines. It will also carry out regular audits of nursing documentation to ensure compliance with this and with Nursing and Midwifery Council guidance.

Organisation we investigated

County Durham and Darlington NHS Foundation Trust

Location

County Durham

Region

North East

Summary 364/August 2014

Was major surgery the only option?

Mrs A complained about a Trust's decision to operate on her rather than consider alternative therapies and its failure to explain how her wound would heal after her discharge from hospital.

What happened

Mrs A, who had a history of inflammatory bowel disease, was admitted to hospital as an emergency. After a series of tests, staff decided that her large bowel was about to perforate. Clinicians considered that surgery was the only option, so she underwent major bowel surgery.

Unfortunately, Mrs A went on to develop worsening pain and a wound infection and needed two more surgical procedures. The Trust also treated her for pneumonia, septicaemia and pressure sores before she was discharged from hospital.

In response to Mrs A's complaint, the Trust was unable to confirm Mrs A's view that staff did not explain the purpose of the surgery and what it would entail. Overall, the Trust maintained that Mrs A had been given an appropriate standard of care and treatment throughout her hospital admission.

What we found

We looked at the information provided by Mrs A's representative and the Trust. We also looked at the Royal College of Surgeons' guidance *Good Surgical Practice 2008* and the British Society of Gastroenterology guidelines for the management of inflammatory bowel disease.

The Trust did not follow the surgical guidance and there were failings in relation to communication and record keeping. However, Mrs A was extremely unwell so we were satisfied that the surgery was justified since her health would have continued to deteriorate, and her illness would have become immediately life-threatening without the surgery.

The decision to offer Mrs A surgery to remove her large bowel, rather than risk making her infections worse, was appropriate. Surgery was the only feasible treatment by the time it was performed.

We were satisfied that the discussions with Mrs A regarding the wound's recovery were reasonable.

Putting it right

The Trust apologised for the failings we identified and agreed to draw up an action plan to address the failings.

Organisation we investigated

Walsall Healthcare NHS Trust

Location

West Midlands

Region

West Midlands

Summary 365/August 2014

Care and treatment in pregnancy and labour

Mrs Y complained about her GP referring her to midwifery care, and her subsequent care and treatment in pregnancy and labour.

What happened

Mrs Y said that her GP practice did not take on board her previous complaint about the local midwifery service she used during her first pregnancy, and did not refer her to a chosen midwife for the next pregnancy.

The midwife allocated by the Trust did not accommodate Mrs Y's requests for appointments, and referred her to the safeguarding team manager. The safeguarding team should be contacted if a member of staff has a concern about mother or baby's safety. The midwife did not have a good reason for doing this. Mrs Y also complained that her partner was forced to leave the labour ward when she was in labour, so a forthcoming home visit could take place.

What we found

The practice properly referred Mrs Y for midwifery care. The Trust properly escalated concerns about safeguarding since midwives needed to conduct at least one home visit before the baby was born and they could not get access to Mrs Y's home. The Trust should have told Mrs Y what it had done.

The Trust's records did not fully support the Trust's explanation about what happened, and the Trust should not have asked Mrs Y's partner to leave the labour ward.

Putting it right

The Trust apologised for not telling Mrs Y that her case was being referred to the safeguarding team and explained what action it would take to make sure this could not happen again.

It also apologised for asking Mrs Y's partner to leave the labour ward and acknowledged the upset and distress this had caused.

The Trust paid Mrs Y £400 in recognition of the upset and distress caused to her during her labour.

Organisations we investigated

Sheffield Teaching Hospitals NHS Foundation Trust

A GP practice

Location

South Yorkshire

Region

Yorkshire and the Humber

Summary 366/August 2014

GP practice limited frequency of blood tests that patient claimed were necessary

Mrs J complained that her GP practice had prevented her having blood tests that her consultant required.

What happened

The practice discovered that Mrs J had had more blood tests than clinically necessary, and it had not requested some of these. The practice restricted Mrs J's access to blood tests by making sure that they could only be carried out with permission from either of the two senior GPs or the practice manager, and could only take place at the practice.

A locum GP at the practice told Mrs J that she needed a blood test, but reception staff refused to organise this because there was no permission from one of the three nominated members of staff. There was an altercation with reception staff, but the locum GP gave Mrs J the blood test form and her blood test went ahead. It was not clinically necessary.

When Mrs J complained, the practice refused to respond until she provided a written explanation for what the practice called her unacceptable behaviour towards reception staff and the practice manager.

When the practice responded (after discussion with us), it did not fully explain its decision. It said staff had decided to restrict Mrs J's access because it had received a telephone call from the local polyclinic that said that Mrs J had presented two blood test request forms with the same bar code. It also said that, when staff contacted Mrs J's consultant at the local Trust, he agreed that the number of blood tests she was having was clinically unnecessary.

What we found

The practice's decision to restrict access to blood tests was reasonable but it failed to give Mrs J a full and accurate explanation.

Reception staff and Mrs J gave different accounts of the incident when a locum GP had requested a blood test. We were unable to reach a firm conclusion on this issue.

The practice had unreasonably delayed its complaint response making this dependent on Mrs J offering a written account of her behaviour.

Finally, while reception staff had on the one occasion initially refused to organise a blood test, this was not unreasonable because the appropriate permission had not been given and the test was not clinically necessary.

Putting it right

The practice apologised to Mrs J for the manner in which it had handled her complaint.

Organisation we investigated

A GP practice

Location

Brighton and Hove

Region

South East

Summary 367/August 2014

GP carried out inadequate home visit and did not arrange follow up for Mr B who died soon after

Mr B's daughter, Mrs A, complained that there was a delay in his GP visiting him, that his assessment was poor and that there was no follow up.

What happened

Mr B had multiple health issues but had to wait 24 hours for a home visit. His GP, Dr C, visited and made some changes to Mr B's medication. Mr B was admitted to hospital and died later that month.

What we found

There were failings in how the medical centre that Mrs A contacted prioritised her visit request and in the time taken for the visit to take place.

At the visit itself, Dr C saw Mr B but did not carry out, or arrange, appropriate investigations, monitoring, or review visits. There was also poor record keeping.

However, this visit did not result in a long delay in Mr B getting treatment, because he was admitted to hosptial.

Putting it right

The medical centre apologised for the injustice caused by the faults identified and paid Mrs A £1,000 in recognition of the pain and distress she and her family experienced. It produced an action plan to document how it will address the faults found and what will be done to prevent the same thing happening again.

Organisation we investigated

A medical centre

Location

Lancashire

Region

North West

Summary 368/August 2014

Trust failed to tell woman that her husband was dying

When Mrs A's husband's condition deteriorated, the Trust did not tell her. This meant he died before she could get to the hospital to be with him.

What happened

When Mr A's condition deteriorated, a nurse mistakenly rang Mrs A twice at her workplace instead of her home, even though it was during the night.

By the time the Trust realised the error and contacted Mrs A at home, she was not able to get to the hospital to be with her husband before he died.

What we found

The nurse had made a genuine mistake, and although the consequences were very serious, we did not consider the mistake to be a failing.

However the Trust's responses repeatedly failed to acknowledge or apologise for the mistake. This was a failing in complaint handling.

Putting it right

The Trust apologised and acknowledged its mistake. It paid Mrs A £250 compensation.

It put a plan in place to make sure it learnt lessons from this complaint and to ensure this did not happen again.

Organisation we investigated

Plymouth Hospitals NHS Trust

Location

Cornwall

Region

South West

Summary 369/August 2014

Administrative failings led to delay in treatment plan

Mrs G's GP asked the Trust to diagnose the cause of her back pain and put a treatment plan in place. This did not happen, so Mrs G paid to have private treatment.

What happened

After her GP's referral, Mrs G was first seen at the Trust's rheumatology clinic in mid-2013. The rheumatologist decided that there were two possible diagnoses for Mrs G's back pain.

He told her that he would seek further information from a colleague in the radiology department and give her a firm diagnosis and a treatment plan within the next two weeks.

This did not happen and Mrs G repeatedly phoned the clinic to ask for an update on her case. Two months later, Mrs G had had no diagnosis or treatment plan from the Trust and asked her GP to refer her to a private specialist.

The private specialist diagnosed Mrs G's condition and formulated a treatment plan. Mrs G started her treatment privately later in 2013.

Mrs G complained to the Trust about the delays and the failure to give her a treatment plan. She said she had been forced to seek private treatment because of failings at the Trust and asked the Trust to reimburse her for the cost of her private treatment.

The Trust apologised to Mrs G and said that the delay had occurred because of failings in the communication between the radiology and rheumatology departments. The Trust said that it would not reimburse Mrs G for the cost of private treatment because the decision to go private was ultimately hers. The Trust gave Mrs G a treatment plan in winter 2013.

Mrs G came to us because she felt the Trust should financially compensate her for what had happened.

What we found

The Trust had acted reasonably in relation to the clinical issues in this case. It was reasonable for the rheumatologist to seek further information from radiology, and the treatment plan recommended was appropriate.

There was service failure in the administrative processes. The radiology department had taken longer than it should have done to respond to the query from rheumatology, and when it responded, it sent the response to the rheumatologist's individual email address rather than to the clinic. The rheumatologist did not see the information in his inbox and so did not forward this to the clinic.

The clinic had no process in place to ensure that information requests about patients were followed up. This meant that no one at the clinic chased radiology for the information, and no one kept Mrs G up to date with what was happening.

There were also failings in the way the Trust dealt with Mrs G's complaint. Although Mrs G complained in summer 2013 that she did not have a treatment plan, the Trust did not provide one until much later in 2013. The Trust did not fully investigate Mrs G's complaint when she contacted it. The Trust told Mrs G it could not answer all her questions when in fact information was available that would have allowed it to respond in full.

Putting it right

In its response to Mrs G's complaint, the Trust said that it had put new measures in place to address the administrative issues highlighted by Mrs G. We were satisfied that the changes should reduce the likelihood of similar issues occurring again.

The Trust paid Mrs G £400 in recognition of the pain she suffered as a result of her delayed treatment and because of the frustration caused by the administrative error and the Trust's poor complaint handling.

Organisation we investigated

Oxford Radcliffe Hospitals NHS Trust

Location

Oxfordshire

Region

South East

Summary 370/August 2014

Emergency department failed to X-ray patient with a fractured spine

Mr P complained that despite repeated requests, emergency department staff refused to X-ray his injured back. This meant his spinal fracture and his tumour were not diagnosed.

What happened

Mr P injured his back and was taken to the emergency department by ambulance. After an examination, the emergency department doctor concluded that an X-ray was not clinically necessary. Mr P was discharged on the same day.

Mr P continued to have back problems in the following months. After an MRI scan, he was diagnosed with a spinal fracture and a tumour. Mr P then had surgery on his back and chemotherapy to treat his tumour.

Mr P complained to the Trust about what he considered to be inadequate care and treatment, and the failure to diagnose his fracture and tumour.

Mr P said that as a result, he was put at risk of paralysis and moreover, his cancer prognosis was worsened.

What we found

The Trust failed to take an X-ray when Mr P was in the emergency department. After carefully considering all of the evidence, including comments made by our clinical advisers, we were unable to establish a link between the failing we identified and the injustice claimed by Mr P.

This was because Mr P's condition and prognosis did not worsen and the delay did not alter the treatment he received for his spinal fracture and tumour.

Putting it right

The Trust apologised for the failings we identified and prepared an action plan.

Organisation we investigated

Brighton and Sussex University Hospitals NHS Trust

Location

Brighton and Hove

Region

South East

Summary 371/August 2014

GP practice and Trust kept man with multiple sclerosis waiting too long

Mrs F complained that a GP practice did not refer her husband to hospital soon enough, and that he waited too long in the Trust's emergency department.

What happened

Mr F had multiple sclerosis. The GP visited Mr F at home after Mrs F called the practice because he felt unwell. The GP told Mr F that she thought his symptoms were the result of multiple sclerosis, and asked Mrs F to call 999 if his condition deteriorated.

In the evening, Mrs F telephoned 999 as her husband's condition had worsened. An ambulance arrived and the crew noted that Mr F felt dizzy and lightheaded and had pins and needles. The crew also recorded that Mr F's vital signs were normal apart from high blood pressure.

When Mr F arrived at hospital, staff left him on a stretcher in the corridor outside the emergency department's resuscitation area because no cubicles were available. Mr F's condition suddenly deteriorated and staff moved him to a cubicle, where he stabilised.

Doctors admitted him and monitored him throughout the night and the next morning, but sadly he died later that day.

What we found

The care and treatment the GP and the practice provided for Mr F was in line with recognised quality standards and established good practice.

The care and treatment at the Trust before Mr F's sudden downturn fell so far below standard that they amounted to service failure. However, this did not contribute to Mr F's death.

The Trust did not investigate Mrs F's complaint thoroughly. That was maladministration, which led to an injustice to Mrs F.

Putting it right

The Trust apologised for the injustice.

It agreed to prepare an action plan that described what it had done to learn lessons from this investigation.

Organisations we investigated

A GP practice

University Hospitals Coventry and Warwickshire NHS Trust

Location

West Midlands

Region

West Midlands

Summary 372/August 2014

Failure to provide appropriate bowel care and nutrition reduced a patient's chance of survival

Ms R complained about the bowel care given to her mother, Mrs P. She also complained that doctors in A&E did not diagnose that Mrs P had had a stroke. Ms R believed that a stroke led to Mrs P's death.

What happened

Mrs P went to A&E after she had a fall. Staff X-rayed her and gave her a walking frame before discharging her home.

A few weeks later, Mrs P was admitted to hospital with pneumonia, dehydration and acute confusion. A scan of her head showed a previous stroke. Her condition worsened and she was assessed as having some form of dementia.

Trust staff found that Mrs P had a bowel perforation, probably caused by diverticulitis (a condition where bulges develop in the bowel wall and become infected and inflamed). Doctors decided not to operate, but to treat her conservatively, with intravenous antibiotics. Mrs P continued to deteriorate and clinicians put her on a care pathway for dying patients before her death.

What we found

The care given when Mrs P went to A&E was appropriate, so we did not uphold this part of the complaint. There were no neurological concerns that would have made stroke management appropriate, and a stroke was not the most important factor in Mrs P's death.

However, while the decision to treat Mrs P's bowel perforation conservatively was appropriate, there was a lack of surgical advice on how to manage the treatment. There was a lack of discussion about Mrs P at a senior level, and poor care from junior doctors.

Mrs P's nutrition and fluid needs were not met. Staff updated food charts sporadically, did not complete malnutrition screening risk assessments, and did not record oral fluid intake on the fluid charts. There was little input from dieticians, and no evidence of senior management discussions about Mrs P's nutritional needs.

While we could not say that there would have been a different outcome for Mrs P had the failings in care not happened, they significantly increased the risk of a poor outcome. Mrs P would have had a better chance of survival if the failings had not occurred.

Putting it right

The Trust apologised to Ms R, and paid her £1,500 compensation for the distress caused by the failings in her mother's care. It also put together an action plan to show how it had learnt from its mistakes so that they should not happen again.

Organisation we investigated

The Newcastle Upon Tyne Hospitals NHS Foundation Trust

Location

Tyne and Wear

Region

North East

Summary 373/August 2014

Lost medical records

Ms W complained about the care and treatment she received while in hospital, and about the attitude and conduct of some staff members.

What happened

Ms W was admitted to hospital very unwell. Staff undertook a procedure that Ms W believed caused her permanent damage. She was also worried about other aspects of her care and treatment such as medication and the conduct of nursing staff.

What we found

There was evidence of failings in the care and treatment Ms W received and poor conduct on the part of one nurse. However, we concluded that the Trust had taken the appropriate action to put things right.

We were unable to substantiate one aspect of Ms W's complaint because the Trust could not provide the relevant medical records.

Putting it right

The Trust apologised to Ms W for the fact that its error in losing some records meant that she could not receive a full response to part of her complaint.

Organisation we investigated

Royal Free London NHS Foundation Trust

Location

Greater London

Region

London

Summary 374/August 2014

Failure to discuss mother's transfers with the family

Mrs A complained that her mother, Mrs Y, was medically unfit for transfers to both a ward and to a community hospital.

What happened

Mrs Y was transferred from an intensive care unit to a standard ward, and later from the ward to a community hospital. Sadly, she passed away in the community hospital soon after. Mrs A felt that the transfers were inappropriate and contributed to Mrs Y's death.

What we found

Mrs Y was clinically fit for both of the transfers, and there was no evidence that these contributed to her death.

However, the Trust did not discuss Mrs Y's transfer to the community hospital with Mrs A. Mrs A was upset as she only found out about this after her mother had been transferred.

Putting it right

The Trust wrote to Mrs A to apologise that staff did not talk to Mrs Y's family about her transfer soon enough.

Organisation we investigated

Gloucestershire Hospitals NHS Foundation Trust

Location

Gloucestershire

Region

South West

Summary 375/August 2014

Patient had to wait almost 12 hours for an out-of-hours visit

Mr B has long-standing medical conditions and has regular chest infections. On a Saturday in late 2013 he had a sore throat, cough and a fever and needed help.

What happened

Mr B called NHS 111 at 2.30pm. Shortly afterwards he received a call back from a triage doctor at an out-of-hours service. It classed Mr B as a routine case and told him that a GP would visit him at home within six hours.

Mr B telephoned to find out what was happening at about 9pm, 10pm and 11pm. At midnight the out-of-hours service called Mr B to say that a doctor was on his way. The GP arrived at about 2am.

Mr B telephoned to complain about the delay in being seen. The out-of-hours service explained that it had been an exceptionally busy day and apologised.

What we found

It was reasonable to class Mr B's case as routine. The attending GP carried out an appropriate examination and diagnosis. We also found that it was acceptable for the out-of-hours service to say that the out-of-hours doctor would arrive within six hours. This is in line with national guidance, and Mr B's case was not urgent. So we took no action on this part of the complaint.

The explanation for the delay in the doctor arriving was understandable. However, the out-of-hours service did not keep Mr B updated about what was going on. It also did not deal with the fact that Mr B had to wait a further two hours after it told him that a doctor was on the way.

In addition, the out-of-hours service did not tell Mr B what it was doing to improve things. We upheld this part of the complaint.

Putting it right

The out-of-hours service apologised to Mr B, particularly for the further two-hour delay, and for the upset it had caused. It told Mr B what it was doing to improve things.

Organisation we investigated

Partnership of East London Co-operatives (PELC) Limited

Location

Greater London

Region

London

Summary 376/August 2014

Appropriate clinical care poorly explained

A trust provided appropriate clinical care but did not explain it in a way that was easy to understand.

What happened

Mrs A was taken to A&E suffering complications after a total knee replacement. Staff stopped the medication that Mrs A was taking to prevent deep vein thrombosis (DVT) and three days later she suffered a stroke.

Mrs A's husband felt that the stroke was related to stopping the medication and complained to us. Mr A also complained about a number of other aspects of Mrs A's nursing and personal care and the quality of the Trust's responses to his complaint.

What we found

The decision to stop the medication to prevent DVT was correct. This medication is believed to cause as many problems as it might solve and its use to prevent strokes is not recommended. The medication would only be used to prevent strokes in patients who also suffered from an irregular heart rate, which Mrs A did not. We were also able to confirm that the Trust was correct in saying that the type of stroke Mrs A had was not one that could have been caused by stopping the medication.

The concerns expressed about nursing and personal care had already been discussed directly between Mrs A and the Trust, and Mrs A had agreed that her concerns had been addressed to her satisfaction.

However, the Trust's response to the complaint about Mrs A's stroke was not presented in a way that either Mr or Mrs A could reasonably be expected to understand. A number of unexplained clinical terms were used and this meant that a lay person would not understand what the Trust said.

Putting it right

The Trust wrote to Mr and Mrs A to apologise for the poor quality of its written response.

Organisation we investigated

Buckinghamshire Healthcare NHS Trust

Location

Buckinghamshire

Region

South East

Summary 377/August 2014

Patient not referred to multidisciplinary team

Mrs V complained that the Trust failed to adequately investigate her husband's symptoms. She was also unhappy about how the Trust handled her complaint.

What happened

In spring 2012, Mr V's GP referred him to the Trust because he had been vomiting for two weeks and had unexplained weight loss. Doctors carried out a number of investigations but were unable to diagnose what was wrong. In autumn 2012, Mr V was admitted to the Trust with a severe infection. His condition rapidly deteriorated and he died the following day.

What we found

The Trust conducted appropriate and timely investigations, and referred Mr V, where necessary, to the vascular department. A vascular surgeon made appropriate arrangements to review Mr V following his admission in autumn 2012.

However, whilst under the care of the vascular department, a junior doctor failed to refer Mr V's care to the multidisciplinary team. We could not say, even on the balance of probabilities, that Mr V's care would have differed had he been referred to the multidisciplinary team, but knowing that her husband was not referred when he should have been was upsetting to Mrs V.

The Trust appropriately responded to Mrs V's complaint.

Putting it right

The Trust had already acknowledged the failing identified in this case, and we recommended that it apologise to Mrs V for the service failure.

It assured Mrs V that the junior doctor involved had learnt from this case, and told her how it would ensure doctors did not make similar mistakes.

Organisation we investigated

Chelsea and Westminster Hospital NHS Foundation Trust

Location

Greater London

Region

London

Summary 378/August 2014

Surgery caused permanent damage

Mr A underwent a surgical procedure, and afterwards suffered from unexpected facial pain and numbness.

What happened

Mr A complained to the Trust about the outcome of his operation. The Trust responded that his symptoms were an unexpected and rare complication of the surgery.

What we found

A surgeon had performed the surgery incorrectly, causing damage to a nerve, and this led to some of the pain and the numbness that Mr A experienced. There is no cure for these symptoms and Mr A could expect to have them for the rest of his life.

The Trust had failed to address and remedy this in its handling of the complaint.

Putting it right

The Trust paid Mr A £6,500 to remedy the injustice he had suffered.

Organisation we investigated

Barts Health NHS Trust

Location

Greater London

Region

London

Summary 379/August 2014

Failure to properly assess patient's condition

Mrs Y's GP referred her to hospital with breathing difficulties. However, a junior doctor at the hospital did not adequately assess her and made an unsafe diagnosis. This was a missed opportunity to refer her sooner.

What happened

Mrs Y had been suffering with breathlessness and difficulty breathing and her GP had been investigating whether her asthma was the cause. After a change in her asthma drugs did not have any effect, Mrs Y was referred for an urgent hospital admission at the Royal Hampshire County Hospital (the Hampshire Hospital – managed by Hampshire Trust).

Staff carried out tests to exclude the possibility of a pulmonary embolism. The tests included a chest X-ray, a test to measure the electrical activity of the heart (an ECG) and a full blood count but none of these showed anything abnormal. Mrs Y was discharged the same day. Mrs Y's GP then referred her to the Hampshire Hospital's chest clinic.

In the following months Mrs Y received care from both the Hampshire Trust and the University of Southampton Trust, but consultants were unable to determine the cause of her illness until it was too late and Mrs Y died.

What we found

The care given by the GP practice was in line with established good practice. The care provided by both Trusts was also in line with established good practice. We did not uphold these aspects of the complaint.

However, we found a number of failings in Mrs Y's initial appointment at the Hampshire Hospital. The clinical history lacked detail about her asthma, and there was no information about whether her symptoms changed throughout the day; whether she experienced night-time symptoms; the type of medication she was on or whether she had previously had severe asthma attacks. In addition, the junior doctor did not measure Mrs Y's peak flow, which would have been central to an assessment of her condition and in line with asthma guidelines.

Although the oxygen level in Mrs Y's blood was reduced, the junior doctor did not measure her blood gases, which was also not in line with national guidance. It was not safe to assume asthma and anxiety were the causes of Mrs Y's symptoms, and the junior doctor should have discussed her case with a senior doctor, but he did not do this.

All these mistakes amounted to service failure. An opportunity was missed to refer Mrs Y for appropriate review sooner, although we concluded that it was more likely than not that she would still have died. We also found an injustice to her family, as they will never know if that would have made a difference.

Putting it right

The Hampshire Trust apologised to Mrs Y's mother Mrs D, who brought the complaint to us, and paid her £1,000. It agreed to prepare an action plan to show what it had done to stop these failings happening again.

Organisations we investigated

University Hospital Southampton NHS Foundation Trust

Hampshire Hospitals NHS Foundation Trust

Location

Hampshire

Region

South East

Summary 380/August 2014

Health organisation poorly handled request for exceptional funding

A primary care trust (PCT) and clinical commissioning group (CCG) refused Mr L exceptional funding for three sessions of treatment at a specific hospital, despite recommendations from Mr L's consultant.

What happened

Mr L's GP made an exceptional funding request to the PCT for three sessions of specialist treatment at a specific hospital. The PCT refused it because it considered that the service at his local hospital was appropriate for Mr L's needs.

Despite a further application with representations from Mr L's specialist consultant, who suggested that the service at his local hospital was not appropriate, the PCT maintained its position.

The Wiltshire Clinical Commissioning Group (CCG) continued to agree with the PCT's position despite the further information from the consultant. Mr L complained of lengthy delays and sought an apology for the delay, the confusion and lack of flexibility he experienced.

What we found

There were failings by the PCT and the CCG in how they handled Mr L's request for funding, and the manner in which they then dealt with his complaint.

Putting it right

Following our report, the CCG apologised for its failings. It paid Mr L £500 in recognition of the distress and frustration caused arising from the poor handling of his requests for funding and the failure to give him a properly considered decision.

Organisation we investigated

Wiltshire Clinical Commissioning Group (CCG)

Location

Wiltshire

Region

South West

Summary 381/August 2014

Significant failings in care of cancer patient

There were significant failings in Mrs Y's care after she was diagnosed with ovarian cancer. The two Trusts involved acknowledged their failings but did not offer a personal remedy to her family.

What happened

Mrs Y was admitted to University College London NHS Foundation Trust (UCLH Trust) in autumn 2009 for treatment following a diagnosis of advanced ovarian cancer. Staff discharged her but she was admitted to Barnet and Chase Farm Hospitals NHS Trust later that same day after she fell at home. Mrs Y remained at Barnet Trust awaiting transfer back to UCLH Trust for further cancer treatment. During this a time she had problems with her bowel function and neutropaenia (a low level of infection-fighting white blood cells). However, the transfer to UCLH Trust did not take place and Mrs Y died at Barnet Trust the next month.

What we found

There were several significant failings in Mrs Y's care by both Trusts. Both Trusts had acknowledged those failings and put in place actions to prevent similar failings happening again. However, both Trusts failed to offer Mrs Y's family a personal remedy for the injustice they were caused by the failings in her care. This failure to offer a personal remedy was maladministration and was a further injustice to Mrs Y's family.

Putting it right

The Royal Free London NHS Foundation Trust (previously Barnet Trust) and UCLH Trust wrote to Mr Y to acknowledge, and apologise for, the maladministration identified and the impact that it had on him and on Mrs Y's family.

The Royal Free London NHS Foundation Trust and UCLH Trust paid compensation to Mrs Y's family of £2,500 by way of personal remedy for the injustice of distress caused to them by their failings in her care. Additionally, the Royal Free London NHS Foundation Trust and UCLH Trust paid a further sum of £500 to Mrs Y's family for the further injustice of distress caused by not providing them with a personal remedy. We asked the two Trusts to provide half the money each.

Organisations we investigated

University College London NHS Foundation Trust

Royal Free London NHS Foundation Trust. (Barnet Trust has since been taken over by Royal Free London NHS Foundation Trust).

Location

Greater London

Region

London

Summary 382/August 2014

Trust failed in its care of cardiac patient

The Trust did not organise adequate follow up when it discharged Mrs A, a cardiac patient. After she was readmitted, it failed to refer her to another specialist, delaying necessary surgery and depriving her of the best possible opportunity to survive.

What happened

In summer 2011 Mrs A was diagnosed with a serious heart condition and underwent surgery at the Trust the following month. Before her discharge, her consultant cardiologist said that she needed close follow up by her local team of cardiologists. However, staff did not make a referral.

In autumn 2011 Mrs A went back to the Trust as an outpatient for a routine appointment. She was admitted for treatment as her condition had deteriorated. Clinicians caring for her agreed she needed to see the consultant cardiac surgeon in his outpatient clinic. However, he was on leave and staff did not look for another surgeon, so Mrs A was not seen until later in the year, by which point she was accepted for urgent surgery. Sadly, Mrs A did not survive the surgery.

Mrs A's daughter Mrs D made a complaint to the Trust.

What we found

There were failings in the way Mrs A was discharged after surgery with no follow up arranged, and also in her discharge after a second admission. There was also a failure to consider or arrange a referral to an alternative surgeon.

Although we did not conclude that Mrs A's death was avoidable, we believed that she was deprived of the best possible opportunity to survive surgery and her family were distressed by this. The inappropriate discharge and inadequate follow up left Mrs A unsupported when her condition deteriorated, and this was also distressing for her and her family.

There were also failings in the way the Trust handled the complaint. Responses were delayed, updates did not have enough detail and there were inadequate messages in some responses. We concluded that this added to Mrs A's daughter's distress.

Putting it right

The Trust acknowledged its failings and apologised to Mrs D for them. It prepared an action plan which set out how it will improve its services. The Trust paid Mrs D £1,000 for the distress she suffered.

Organisation we investigated

Leeds Teaching Hospitals NHS Trust

Location

West Yorkshire

Region

Yorkshire and the Humber

Summary 383/August 2014

Mental Health Trust fails in two aspects of basic nursing care

A trust did not properly monitor or manage an elderly patient's weight or hygiene when he spent over two months on a mental health ward.

What happened

Mr C had a number of physical and mental health issues, including type 2 diabetes, congestive cardiac failure, heart disease and kidney disease.

Mr C had periodic contact with the Sussex Partnership NHS Foundation Trust's community mental health team (CMHT) from late 2008 onwards.

In winter 2011, Mr C collapsed at his home. Clinicians treated him for acute renal failure, a respiratory infection and gout. After a few weeks, he was transferred to the Trust's psychiatric hospital so staff could review his mental health. Mr C remained there for just over two months, until he had to be transferred to another acute hospital because his physical health was deteriorating. Mr C died five days later.

Mr C's daughter Ms F complained that the CMHT failed to adequately intervene in her father's case or do enough to help him get support for around two years. She also complained about communication and the quality of his nursing and medical care while he was in the psychiatric hospital. Ms F said her father's health did not improve during that period and all the problems greatly reduced his quality of life.

What we found

The Trust did not handle the complaint about Mr C's care reasonably. It did not provide sufficient detail about the two different periods of care. There was some lack of clinical evidence but most importantly, two basic failings in nursing care went unacknowledged and not put right: his weight gain and his personal hygiene.

Mr C's weight was not adequately monitored. Though his weight chart was incomplete, it shows that Mr C gained over 10kg in the two months after his admission. There is little to indicate that staff responded to that appropriately. They did not complete a food chart and there was no evidence of weekly weight monitoring, regular review of his care plan or a referral to a dietician.

In addition, staff did not review Mr C's hygiene care plan regularly. Staff should have updated this after every episode of care but there were no entries for over two months. This demonstrates poor record keeping and implies that Mr C did not receive sufficient support with his personal hygiene.

It is quite conceivable that these two failings reduced Mr C's quality of life. His weight gain would not have helped his physical health, particularly as it could have worsened his pre-existing conditions. We did not find that Mr C's weight gain had a direct and specific impact on his chances of survival.

Putting it right

As a result of our investigation, the Trust agreed to apologise for its failings and their impact on Mr C and his family. It will also reflect on the learning it needs to take from this complaint. It will submit a written plan to ensure that record keeping, complaint handling, weight and hygiene monitoring and management failings do not happen again.

Organisation we investigated

Sussex Partnership NHS Foundation Trust

Location

West Sussex

Region

South East

Summary 384/August 2014

Trust failed to diagnose and treat stroke

Mr K complained that his wife had suffered a stroke, but the Trust diagnosed that she had suffered a transient ischaemic attack (symptoms of a stroke that last less than 24 hours). He was concerned that, because of this misdiagnosis, his wife did not receive any treatment for her stroke, or support when she got home.

What happened

Mrs K went to hospital and was diagnosed in the emergency department as having suffered a transient ischaemic attack. She was discharged and given an outpatient appointment a month later. Mrs K subsequently died, but not as a result of the care provided.

What we found

Mrs K was incorrectly diagnosed with a transient ischaemic attack as she had had a stroke and should not have been discharged home. She did not receive appropriate care and support.

Putting it right

The Trust apologised for the injustice caused by the failings we identified and paid Mr K £1,000 in recognition of his distress.

It produced an action plan to prevent the same thing happening again.

Organisation we investigated

East Sussex Healthcare NHS Trust

Location

East Sussex

Region

South East

Summary 385/August 2014

Hospital failed to take enough action after patient's fall

Mrs Y complained she was not told her mother, Mrs C in her nineties, had fallen out of bed in hospital. She was shocked to see her mother's heavily bruised face when she visited. She was also not told when her mother was discharged to a nursing home.

What happened

Mrs C was admitted to hospital from her nursing home with a chest infection. She was confused and partially sighted. She fell out of bed into the gap between the wall and the bed when a health care assistant was changing her bedding. She suffered severe bruising to her face as a result. The hospital did not tell her daughter, Mrs Y, about the fall. When Mrs Y visited her in hospital, she was shocked and distressed to see the bruising on her mother's face.

The hospital failed to tell Mrs Y that her mother had been discharged from hospital to a nursing home. The hospital also gave Mrs Y incorrect information about funding arrangements, and failed to tell her that her mother was granted fast-track funding (NHS funding for patients with a rapidly deteriorating condition that may be terminal).

What we found

The Trust failed Mrs C because she should have been nursed by two members of staff, as set out in her falls care plan. This may have prevented her falling out of bed. The Trust had taken some action in response to this, including raising the issue with the member of staff involved, but did not go far enough. The Trust needed to do more to make sure that staff follow falls care plans.

The Trust failed again when it did not tell Mrs Y about her mother's fall and did not record Mrs C's injuries in her hospital discharge paperwork. Not telling Mrs Y that her mother had been transferred was also a failing, as was giving Mrs Y wrong information about her mother's fast-track funding.

There was evidence that the Trust had taken some steps to address the failings. It introduced electronic incident reporting; used ward meetings to tell staff about informing relatives when patients fell; discussed discharge completion summaries at governance meetings, and audited discharge checklists.

Putting it right

The Trust apologised to Mrs Y for failing to take enough action in relation to her mother's fall out of bed.

It produced an action plan that demonstrated that it had learnt lessons from this case, in particular in relation to staff following falls care plans.

Organisation we investigated

University Hospital Southampton NHS Foundation Trust

Location

Southampton

Region

South East

Summary 386/August 2014

Failings in care were recognised and put right

Mr P received inadequate care whilst a patient. His daughter Ms K complained and the Trust took action to improve its service.

What happened

Mr P was admitted to hospital in autumn 2011 with known chronic obstructive pulmonary disease and a urinary tract infection. He had been on home oxygen and had a 'do not attempt resuscitation' order in place.

He had shortness of breath, a two-day history of confusion, was coughing up sputum, and had a pressure sore on his buttocks.

Mr P was found to have pneumonia and died soon after he was admitted.

His daughter, Ms K, raised a number of complaints about Mr P's care. The Trust found failings in how his medication was given and recorded; that a score that measured Mr P's pressure sore was not reassessed; that a mattress was incorrectly labelled for disposal when it was safe to use, and that there were delays in the responses to Ms K's complaint.

What we found

We concluded that the Trust conducted a thorough and open investigation. The Trust accepted the failings in Mr P's care and, having done so, put reasonable measures in place to make sure improvements were made. It gave us evidence to show the actions it had taken.

Ms K was concerned that the care her father received contributed to his death. We did not find this.

Organisation we investigated

Sheffield Teaching Hospitals NHS Foundation Trust

Location

South Yorkshire

Region

Yorkshire and the Humber

Summary 387/August 2014

Trust did not give patient reasonable care

Falls in hospital are likely to have contributed to Mrs D's poor progress and eventual death.

What happened

Mrs D was admitted to hospital and placed on one-to-one nursing care because she was at risk of falling. She fell twice whilst she was in hospital, sustaining a fracture as a result of the second fall. Her health deteriorated and she died just over three weeks after the second fall.

What we found

The Trust took the complaint seriously and conducted a serious incident report. It acknowledged failings to give the planned one-to-one nursing care and supervision, apologised and put in place an appropriate action plan.

There was a delay in carrying out the X-ray that identified a fracture, and a failure to acknowledge that Mrs D's falls contributed to some extent to the deterioration that led to her death. There were unrecognised failings with regard to record keeping.

However, given Mrs D's frailty and general health, we could not say with confidence that she would not have died if she had not fallen.

Putting it right

The Trust apologised to Mrs D's family and took steps to put things right.

Organisation we investigated

Buckinghamshire Healthcare NHS Trust

Location

Buckinghamshire

Region

South East

Summary 388/August 2014

GPs failed to consider deep vein thrombosis

Mrs E, Mr E's wife, complained that the GPs failed to assess him adequately

What happened

Two GPs visited Mr E at home on consecutive days. Mr E had been suffering pain in one of his legs for several weeks and had not left his chair for two weeks. He died from a pulmonary embolism (a blood clot in one of the arteries in his lungs), following a deep vein thrombosis, (a blood clot in a vein) on the day after the last GP visit.

What we found

Both GPs failed to adequately assess Mr E or provide or arrange the further investigations and treatment that he needed. We found there was a strong probability that, even if the failings had not happened, Mr E would still have died. However, Mrs E will never know whether her husband would have survived if the failings had not occurred.

Putting it right

The GPs have already put in place measures to demonstrate that they have learnt from the complaint. They have taken action to make sure that the same situation does not happen again.

The GPs apologised for their failings and paid Mrs E compensation of £2,000.

Organisation we investigated

A GP practice

Location

North Yorkshire

Region

Yorkshire and the Humber

Summary 389/August 2014

Cancer patient gets lost in the system

Mr S's family complained about delays in diagnosing and treating his kidney cancer.

What happened

Mr S went to A&E as he had blood in his urine. He was sent to a urology clinic for tests. At the clinic, a scan showed he had a mass on his left kidney. Mr S was not told about this but was sent for an urgent CT scan, which took place shortly afterwards. A follow-up appointment was not made for Mr S at that time, and, unaware of any problems, Mr S went on holiday.

The printed report of Mr S's CT scan went astray and did not reach his consultant urologist. As no follow-up appointment had been made, no one was prompted to either chase the CT scan results or review them on the Trust's patient information system.

When he returned from holiday Mr S contacted the hospital for his results, but was told he was not on the system. It was only after repeated attempts that he finally got a message to his consultant urologist, who tracked down the CT scan report and arranged to see Mr S urgently. By the time the consultant urologist saw Mr S and told him of the scan's findings, it was almost two months since the scan was performed.

Mr S had his kidney removed two months later, but a follow-up scan taken the next year showed that his cancer had spread to his lungs. Despite chemotherapy, Mr S died a little under a year later.

What we found

There were unnecessary delays in diagnosing Mr S's cancer and in arranging surgery to remove his kidney. Mr S had 'fallen off' the cancer pathway.

However, even if Mr S had received more urgent treatment, it would not have extended or saved his life. There were no failings in how the possibility of recurrent cancer was investigated.

The Trust's complaint responses were generally to a good standard, but there were excessive delays.

Putting it right

The Trust apologised to Mr S's family and paid them £1,000 compensation.

It agreed to prepare an action plan to show what it has done and plans to do, to prevent the failings happening again.

Organisation we investigated

Wrightington, Wigan and Leigh NHS Foundation Trust

Location

Greater Manchester

Region

North West

Summary 390/August 2014

Concerns about a lack of care and treatment on a gynaecology ward and poor complaint handling

Ms B complained that she shouldn't have been discharged five days after her miscarriage, and that there were delays in her treatment, unnecessary procedures, and a lack of care.

What happened

Ms B was admitted to hospital after suffering a miscarriage. She understood that she would have an operation but this did not happen. Her infection and urinary retention were treated with antibiotics and catheterisation and she was discharged after five days. Ms B had to be readmitted the next day and received further antibiotics, to which she felt she had an allergic reaction. She was concerned about the time it took to organise a kidney scan and about being catheterised a number of times. She was discharged with a catheter in place and told that a district nurse would visit her at home to provide catheter care. However, the nurse did not arrive.

Ms B complained to the Trust and was concerned about the delay in responses and an error in her medical records.

What we found

The treatment with antibiotics, catheterisation and pain relief was appropriate when Ms B was first admitted to hospital. There was no need to perform an operation. The hospital was correct to discharge Ms B as her observations were normal.

There was no evidence that Ms B suffered an allergic reaction to antibiotics when she was later readmitted to hospital, and the timing of the kidney scan was reasonable. Ms B's catheter care was correct and all care and treatment was clinically reasonable.

Ms B was told to expect a visit from a district nurse after discharge but this did not happen because Ms B was outside the Trust's catchment area. This caused Ms B concern and the Trust passed on to us its sincere apologies for this.

The Trust highlighted this issue to all ward matrons and asked them to make sure that staff follow instructions in the discharge summary and are aware of guidelines about district nurse visits where the patient is outside the catchment area.

The Trust's response to the complaint failed to notice an important correction in the records, and did not act in accordance with its complaints policy. There were delays in acknowledging and responding to the complaint.

Putting it right

The Trust apologised to Ms B and paid her £200 in recognition of the upset and concern she suffered as a result of its overall handling of the complaint.

Organisation we investigated

Croydon Health Services NHS Trust

Location

Croydon

Region

South East

Summary 391/August 2014

Hospital unreasonably delayed operation

Mrs M, in her eighties, waited nearly a week for surgery after she fell at home and fractured her hip.

What happened

Mrs M complained about the length of time she had to wait for surgery and about the way her complaint was subsequently handled. The Trust explained some of the reasons for the delay in surgery but did not acknowledge any failings in the care it had given. It apologised for the way it had handled Mrs M's complaint and explained how it had improved.

What we found

There were some reasonable explanations for the delay in Mrs M's surgery. However, several aspects of her care did not comply with relevant guidelines and best practice. There were also failings in the content of Mrs M's medical records, which lacked sufficient detail.

While we found failings in the way the Trust handled Mrs M's complaint, it had already taken reasonable steps to put things right in this area by apologising and sharing information about improvements it had made.

Putting it right

The Trust paid Mrs M £500, apologised for the failings we identified in her care and treatment and drew up an action plan to address those failings.

Organisation we investigated

Shrewsbury and Telford Hospital NHS Trust

Location

Shropshire

Region

West Midlands

Summary 392/August 2014

Avoidable death of young man following road traffic accident

Mrs T complained to us that her son would not have died following a road traffic accident in 2008 if he had received appropriate care from the ambulance crew.

What happened

Mr P, who was in his early twenties, was involved in a road traffic accident with a car while on his motorbike. He suffered extensive facial injuries. An ambulance crew from Great Western Ambulance Service NHS Trust, consisting of a paramedic and an emergency care assistant arrived on the scene and were there for about 20 minutes. The journey to hospital took approximately five minutes. Sadly, by the time Mr P arrived at the hospital, his heart had stopped beating, and he was pronounced dead shortly after.

What we found

Overall, apart from the crew's initial assessment of Mr P, which seemed in line with established good practice given the circumstances, the rest of the ABCDE (Airway Breathing Circulation Disability Exposure) assessment was completely inadequate.

Mr P's airway was obstructed at some stage and during the five-minute ambulance journey to the hospital his airways became 'full of blood'. We concluded that his airways became obstructed by blood while he was in the ambulance. Given the absence of any record to the contrary, it is more likely than not that no, or insufficient, attempts were made to clear Mr P's airways during those five minutes. This clearly fell significantly below what should have happened, and amounted to service failure.

Our emergency medicine adviser said that when Mr P suffered a cardiac arrest in the ambulance, the ambulance should have stopped and the emergency care assistant should then have joined the paramedic in the back to help with resuscitation. This did not happen.

We concluded that the service failure directly contributed to Mr P's death, because one of the failings was that there were no or insufficient attempts to clear or assess his airways while he was in the ambulance. Had the paramedic crew given Mr P appropriate care, his death could have been avoided.

Mrs T has lived with the grief of losing her son and believing that he could have been saved. There is no doubt that this has been a source of profound distress for her, caused by the service failure we identified.

Putting it right

The Trust (now South Western Ambulance Service NHS Trust) apologised to Mrs T and paid her £15,000 in compensation. This Trust has taken over from Great Western Ambulance Service NHS Trust, which provided the service at the time of the events. So, rather than asking this Trust to provide an action plan for failings it was not responsible for, we asked it to give a statement that described how its service would make sure that incidents such as this one are learnt from today. It has done this.

Organisation we investigated

Great Western Ambulance Service NHS Trust (now South Western Ambulance Service NHS Trust)

Location

Swindon

Region

South West

Summary 393/August 2014

Private treatment sought after unnecessary delays

Mrs B claimed that delays in appointments, support and treatment led to unnecessary pain resulting in her seeking private treatment.

What happened

Mrs B complained that a consultant rheumatologist misdiagnosed her with vitamin D deficiency and stopped her medication, causing a flare up in her arthritis. Mrs B asked to transfer her care to a different consultant but appointments were cancelled or delayed. After a scan, Mrs B had to wait ten months for the results which confirmed that she qualified to receive specialist biological therapy. Mrs B received the medication three months later but said she had experienced excruciating pain for over a year for which she had to seek private treatment. She said she had had no support from the Trust during this time.

What we found

While it was not unreasonable for the first consultant to consider that Mrs B's symptoms were due to side effects of her medication and Vitamin D deficiency, the consultant could have staged the medication withdrawal over a longer period of time, warned Mrs B of the possibility of a flare up of her arthritis, and given access to support in the event of this happening.

There were unreasonable delays in rebooking Mrs B's appointments when they were cancelled. There was also a delay of over a year in providing the specialist biological drug therapy to Mrs B, which prolonged her pain and suffering.

Putting it right

The Trust apologised to Mrs B and paid her £3,500 for financial and non-financial loss. The Trust agreed to draw up an action plan to address the failings we identified.

Organisation we investigated

Barking, Havering and Redbridge University Hospitals NHS Trust

Location

Essex

Region

East

Summary 394/August 2014

Patient left in pain by poor dental care

Mr L complained about how long it took for him to receive effective dental care in prison.

What happened

In spring 2013, Mr L damaged a tooth and asked for an appointment to see the dentist. A dentist saw him the following month. The dentist took X-rays and thought Mr L had gingivitis (inflamed gums). He prescribed antibiotics and made a note to review Mr L when the course was complete. Mr L continued to experience pain. He saw another dentist in early summer. The second dentist took out one of his teeth. After this Mr L had no more pain.

What we found

The care Mr L received at his appointment in spring 2013 was inadequate. Relevant guidance says it is not appropriate to treat gingivitis or a broken tooth by prescribing antibiotics alone. If Mr L had received effective treatment at the first appointment, his dental problem would have been dealt with sooner and he would not have been left in pain for so long.

Putting it right

The organisation that provides dental care at the prison apologised to Mr L for the failings in his care and paid him £200 in compensation for the avoidable pain he experienced.

Organisation we investigated

Custodial Dental Services Ltd

Location

South Yorkshire

Region

Yorkshire and the Humber

Summary 395/August 2014

Trust failed to explain care pathway for patient with heart problems

When Mrs A developed a serious heart condition, the Trust failed to explain to her why it needed to carry out tests and observations first to assess whether she was suitable for heart surgery that carried a significant risk.

What happened

Mrs A developed constrictive pericarditis (a tightening of the membrane covering the heart). She was told by the registrar that when the results of her scan were in, she would be referred straightaway to a surgeon. Instead the Trust carried out many tests and reviews, including a period of 'watchful waiting' before going ahead with the surgery.

What we found

While there were no failings in the actual clinical care provided by the Trust, there were failings in communication with Mrs A, and record keeping. There were also failings in the way the complaint was handled.

Putting it right

The Trust apologised to Mrs A and acknowledged the failings we found. The Trust also put a plan in place to learn lessons from the failings to make sure they didn't happen again.

Organisation we investigated

North Bristol NHS Trust

Location

Bristol

Region

South West

Summary 396/August 2014

Failure of Trust to convert referral to 'urgent' led to delays in diagnosing and treating liver cancer

Mr B should have had his GP referral converted to an urgent referral in line with guidance.

What happened

Mr B was losing weight and suffered from indigestion, and after an endoscopy was referred by his GP to the Shrewsbury Trust in autumn 2012. The Trust marked the referral as urgent for an appointment within four weeks. Mr B was seen in clinic in winter 2012, where a mass was found in his abdomen and he was referred for an urgent CT scan. The scan was carried out a month later, and Mr B was diagnosed with cancer early in 2013, following a liver biopsy.

Mr B was referred to University Hospitals Birmingham. He died in summer 2013.

What we found

The Shrewsbury Trust did not follow National Institute for Health and Care Excellence referral guidelines for suspected cancer when it considered Mr B's referral. This meant that Mr B was not transferred on to the cancer pathway, which would have meant access to early scans and appointments. This delayed multidisciplinary team discussions, oncology referrals, the diagnostic liver biopsy and ultimately the diagnosis and treatment of his liver cancer.

We did not find that Mr B's death could have been avoided, but there was a lost opportunity for his symptoms to be better controlled. This meant he could have tolerated any side effects more easily during the last months of his life. This clearly caused significant distress to both Mr B and Mrs R, his partner.

We did not see any failings by the Birmingham Trust relating to the management of his treatment.

Putting it right

The Trust apologised that Mr B's referral was not converted to a two-week wait referral. It also completed an action plan to ensure that patients who are not referred under the two-week wait are put on the cancer pathway at the right time, if this is necessary.

Organisations we investigated

Shrewsbury and Telford Hospital NHS Trust.

University Hospitals Birmingham NHS Foundation Trust.

Location

Shropshire

Region

West Midlands

Summary 397/August 2014

Trust put right problems with complaint handling but not with chest pain procedures

Mrs S complained to the Trust about inadequate care when she went to a minor injuries unit with chest pain and palpitations.

What happened

Mrs S said that an ECG was taken and she was told that it was normal, when she could see that it showed a rapid and irregular heartbeat. She said a doctor did not come to see her and a nurse told her she would need to be admitted for more tests. Mrs S knew that this was not the correct action for the problem she had. She felt that the unit could not provide her with safe care so she discharged herself.

Mrs S complained to the Trust and said its first investigation into her complaint was unsatisfactory and had to be repeated, by which time the staff involved could not remember what had happened. Mrs S said the Trust had not done enough to put right either the problems in the care she received or in handling her complaint.

The Trust agreed with Mrs S that the first investigation was inadequate, and it carried out a further, more detailed and robust investigation. The second investigation identified a number of concerns. These included that the minor injuries unit did not have a clear protocol for managing patients with chest pain, and that the medical cover should be reviewed because there could be delays in getting a doctor to review patients.

The Trust produced an action plan setting out a number of ways in which it would improve the procedures for the minor injuries unit and complaint handling.

What we found

We felt that the Trust had done enough to put right the problems with the complaint handling. It had identified the need for a second investigation and had carried this out. It had improved its procedures and had learnt from Mrs S's complaint. However, we agreed with Mrs S that the Trust had not done enough to put right the problems with the care she received. This was because we found that the revised protocol for patients attending the minor injuries unit with chest pain was still not robust enough.

Putting it right

We recommended that the Trust explain how it will make sure that patients attending the minor injuries unit with chest pain or another acute medical problem are managed appropriately. The Trust agreed.

Organisation we investigated

Southern Health NHS Foundation Trust

Location

Hampshire

Region

South East

Summary 398/August 2014

Trust did not explain the implications of terminal genetically inherited illness to patient and her family

Trust failed to recognise poor communication with a patient and her family, which meant they sought the information from another Trust.

What happened

Mrs W was diagnosed with Huntingdon's disease. When the Trust gave her husband her diagnosis, staff merely told him about it and gave him a print of a webpage about the disease.

Mr W asked for a meeting with a suitably qualified clinician to explain the progression of the disease, the prognosis and also the genetic implications for Mrs W's children. The Trust did not organise this for several months. Mr W was forced to seek the information he and his family needed from another trust after his GP referred him for a second opinion.

When Mr W complained to the Trust, it did not initially accept that its communication was flawed. Instead, it insisted that it provided a consultancy-only service to the satellite hospital Mrs W had been admitted to, and therefore was not responsible for explaining the diagnosis. Mr W had to write to the Trust five times before it acknowledged its failings.

What we found

We found that the Trust had eventually recognised the flaws in its communication with Mr W after Mrs W's diagnosis, and during the complaint handling process. However, we could not see what action it had taken to address this.

Putting it right

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

It also paid Mr W £250 in recognition of its poor handling of his complaint.

Organisation we investigated

The Walton Centre NHS Foundation Trust

Location

Merseyside

Region

North West

Summary 399/August 2014

Failings by Trust meant that a patient was denied his wish to die at home

Mrs M complained about the Trust's care and treatment of her husband in 2012. In particular, she complained that the Trust did not honour Mr M's wish to die at home.

What happened

Mr M's previous experiences of admissions had left him with a deep concern about dying in hospital and he had asked his family to honour his wish that he should die at home.

When his family realised that Mr M was very close to death, they asked the hospital to arrange to send him home. Mrs M said that the senior sister was not supportive of this plan and repeatedly raised concerns that the family would not be able to cope.

By midday on the day of his death, everything was ready for Mr M to be at home. The senior sister made arrangements via the ward clerk for an ambulance to take Mr M home at 6pm that evening. Unfortunately, the ambulance did not arrive until after Mr M's death at 8.20pm.

Mrs M complained that the senior sister had obstructed Mr M's dying wishes. The Trust denied that the senior sister hindered Mr M's discharge but it accepted miscommunication over the ambulance.

What we found

There was no evidence that the senior sister had put barriers in the way of Mr M's discharge.

Although the Trust had apologised for miscommunication in connection with the ambulance booking, it had, in a meeting with Mrs M, moved away from accepting responsibility.

The Trust said that it was not possible to arrange urgent transport in these circumstances, but we discovered that this was not true. We felt that it was probable that, had greater urgency been given to the ambulance request, Mr M would have been transferred in time to die at home. This was an injustice that could not be remedied.

Mrs M also explained that she and her children had suffered a great deal of distress because they could not honour Mr M's wishes. They were waiting at home and so were not able to be at his bedside when he died. They had all planned to say goodbye and to spend special time with him. This caused deep distress to the family, which could have been avoided if greater urgency had been placed on the transport request.

We did not feel that the Trust went far enough in acknowledging responsibility for what happened or the injustice that arose as a result. In the circumstances, an apology alone was insufficient remedy.

Putting it right

The Trust apologised to Mrs M for its failure to make urgent arrangements for Mr M's transfer home, and acknowledged the injustice caused by this failure.

It paid Mrs M £1,000 for the distress caused to her.

Organisation we investigated

University Hospital Southampton NHS Foundation Trust

Location

Southampton

Region

South East

Summary 400/August 2014

GP practice failed to investigate symptoms of diabetes in a 15-month-old baby

A GP practice treated Baby V for asthma, but did not investigate his diabetes symptoms. This led to clinical complications that needed an emergency admission to hospital.

What happened

Baby V went to the practice on a number of occasions for coughs and wheezing, and the GP prescribed him prednisolone. Baby V then started to urinate excessively and to be unusually thirsty. His parents mentioned their concerns about diabetes but the practice did not address these symptoms. Baby V later developed diabetic ketoacidosis (a severe lack of insulin) which resulted in his emergency admission to hospital.

Baby V's parents complained that their concerns about their son exhibiting symptoms of diabetes were ignored. They said that the prednisolone given was so excessive as to have contributed to Baby V's diabetes and that the practice failed to treat his respiratory symptoms appropriately.

What we found

The practice acted reasonably in its care and management of Baby V's respiratory symptoms. The dosages of prednisolone were both clinically indicated and within accepted parameters. The use of prednisolone was not responsible for Baby V developing type I diabetes.

The practice failed to properly investigate the symptoms of diabetes in line with expected standards. This resulted in a lost opportunity to diagnose and treat Baby V's condition which then resulted in Baby V developing a significant clinical complication.

Putting it right

The practice apologised to Baby V's parents and provided them with written assurances that the appropriate tests for diabetes would be conducted in future. They also paid Baby V's parents £1,000 in recognition of the distress and suffering caused by the clinical complications that arose from the practice's failure to follow clinical guidelines.

Organisation we investigated

A GP practice

Location

Lancashire

Region

North West

Summary 401/August 2014

Baby not given best chance to survive

Failure to adequately assess a pregnant woman with vaginal bleeding meant that her baby was not given the best chance, however small, of survival.

What happened

Mrs M was 22 weeks pregnant and suffered vaginal bleeding and pain in her lower abdomen. She went to A&E in winter 2012 where her urine was tested and she was told she had a urine infection. She was discharged into the care of her GP.

During the day Mrs M's symptoms worsened and she went back to A&E. She was later transferred to the maternity ward where she was found to be in advanced labour. Her contractions stopped the next morning but she stayed in the hospital for several days. She was then transferred to another trust's hospital. When she arrived, doctors discovered that her baby had died.

Mrs M complained about the care and treatment received on both visits to the Trust's A&E, and also about the way it responded to her complaints.

What we found

When Mrs M first went to A&E, doctors did not assess her condition adequately or arrange the investigations and treatment she needed. Although the doctors took her history, some of the key information was inaccurate.

They also failed to carry out an internal examination and this meant that their decision to discharge her was not based on all the relevant information. Mrs M was seen by an inexperienced doctor who was new to the team. The Trust's own policy said that Mrs M should have been seen by an experienced member of the obstetrics/gynaecology team. The care and treatment Mrs M received fell far below what it should have been.

Lastly, the Trust took an unreasonably long time to respond to Mrs M's complaint, did not keep her updated and did not provide reasons for the delays.

The Trust acknowledged that, had doctors taken an accurate history when Mrs M first arrived in A&E, she would have been seen in the labour suite straight away.

We could not say that Mrs M's baby would have survived if her care had been different. But what we could say was that her baby would have stood the best chance, however small, of surviving. We recognised that this was an added distress for Mrs M and her partner, and an injustice to them.

We also found that Mrs M suffered distress because of the Trust's handling of her complaint.

Putting it right

The Trust apologised for its failings and put together an action plan that showed learning from its mistakes. It paid Mrs M £750 to acknowledge the impact these failings had on her and her partner.

Organisation we investigated

University Hospitals of Morecambe Bay NHS Foundation Trust

Location

Lancashire

Region

North West

Summary 402/August 2014

Trust's poor care delayed terminal cancer diagnosis

Ms V had a previous history of cancer and her GP referred her to hospital for tests. But these were delayed, which meant it took longer than it should have done to diagnose her cancer.

What happened

Ms V was referred to hospital by her GP after persistent pain in her lower back and leg. The hospital arranged for her to have a scan and discharged her. A week later she was readmitted to hospital and a number of tests, including the MRI scan were done, but there were delays in them taking place.

Doctors did not talk to Ms V about the possibility that she had cancer, but they said that she might need to consider moving to a care home when she was discharged. Her family complained that Ms V's personal hygiene needs were not properly met by nursing staff and that doctors were insensitive about mentioning the care home.

What we found

Although the initial assessment of Ms V's condition was reasonable, there were unreasonable delays in carrying out the necessary tests and scans to find out what was causing her symptoms. Doctors should have discussed with her at an early stage the possibility that Ms V's condition was being caused by cancer.

As a result of the Trust's failings, Ms V's terminal diagnosis was delayed by as much as three weeks. This meant she remained in hospital for too long and was denied the possibility of spending her final weeks with her family at home.

Ms V's hygiene needs were also not adequately met during her time in hospital, which compromised her dignity.

We did not find that it had been inappropriate for a doctor to have discussed with Ms V her views about moving to a nursing home.

Putting it right

The Trust apologised to Ms V's family for the injustice she experienced. It acknowledged service failure and maladministration and prepared an action plan to explain what it had done to learn lessons from the complaint.

Organisation we investigated

Peterborough and Stamford Hospitals NHS Foundation Trust

Location

Lincolnshire

Region

East

Summary 403/September 2014

Man with heart problems was discharged from hospital after tests, but died before his operation.

Ms H complained that her father, Mr H, should not have been discharged from the Trust because he was not well enough. It then took too long for him to get an appointment at another hospital, and he died before his heart operation could take place.

What happened

Mr H had breathing problems and tests showed one of his heart chambers was very weak. He was treated for heart failure, and then tests at Gloucestershire Hospitals NHS Foundation Trust found all three of his blood vessels supplying the heart muscle were severely blocked. After the tests, Mr H became very unwell and was admitted to hospital overnight. His cardiologist felt he needed a heart operation.

According to Ms H, Mr H was told he would have to wait two to three weeks for his operation if he stayed in hospital, or six to eight weeks if he was discharged and had the operation as a planned procedure. Mr H was discharged and his cardiologist wrote to a cardiac surgeon at University Hospitals Bristol NHS Foundation Trust, emphasising the need to prioritise Mr H's assessment for the operation because his condition was severe.

It was several weeks before University Hospitals Bristol NHS Foundation Trust received this letter, but when a cardiac surgeon saw Mr H, he arranged a scan to find out if Mr H was suitable for the operation. Mr H's operation was finally scheduled for 17 weeks after he was referred by the cardiologist. Mr H died from heart disease before he heard about the date for the operation.

Ms H said that she was left not knowing whether her father would still be alive if the operation had taken place within six to eight weeks. This had caused her significant upset.

Ms H wanted the Trusts to take action so that other patients or relatives would not go through the same distressing experience.

What we found

Mr H's condition was complex. There is no guidance or accepted good practice about whether he should have stayed in the Gloucestershire hospital for the operation, and so the decision to discharge Mr H was reasonable.

However, there was a lack of documentation about what Gloucestershire Hospitals NHS Foundation Trust told Mr H about the operation and his options before he was discharged. Also, there was an unnecessary delay in the arrangements for the tests needed before a decision could be made about surgery because the cardiologist did not speak to the surgeon. Overall, despite these shortcomings, we did not find the care and treatment was so poor as to be service failure.

The actions of University Hospitals Bristol NHS Foundation Trust were in line with national guidance that no one should wait longer than 18 weeks for treatment following referral to a specialist. Mr H's operation was scheduled for 17 weeks after his cardiologist referred him to the surgeon.

We did not uphold the complaint about either Trust.

Organisations we investigated

Gloucestershire Hospitals NHS Foundation Trust

University Hospitals Bristol NHS Foundation Trust

Location

Gloucestershire

Bristol

Region

South West

Summary 404/September 2014

Poor care given to patient prone to constipation

Mrs C's family were concerned that failings in her treatment may have led to her death.

What happened

Mrs C's family complained to the Trust because they said she was not given proper care and treatment for her constipation. They say they were unhappy about many aspects of her care, including that they had to ask for extra fluids for her.

Mrs C died and the family wanted the Trust to investigate their complaints.

What we found

There were several failings in Mrs C's care and treatment. The Trust did not complete a plan to monitor Mrs C's bowel, did not give her an enema when it was prescribed, constipation medication when she needed it, or extra fluids.

These failings added to Mrs C's constipation and consequent pain and indignity. But we did not find that they contributed to her death.

There were several failings in the Trust's communication, both between members of staff and with Mrs C's family. The nursing staff did not promptly raise concerns with medical staff about Mrs C's constipation and her medication. The Trust also did not discuss with Mrs C's family its decision not to give her planned blood tests.

There were failings in the Trust's complaint handling because it initially did not respond to all the issues the family had raised. Also, the Trust had estimated that it would send a written response to the family within 25 days, but it took three months, and the Trust did not let the family know this.

Putting it right

The Trust apologised for its failings, and agreed to put in place an action plan to stop the same things happening again.

Organisation we investigated

Heart of England NHS Foundation Trust

Location

West Midlands

Region

West Midlands

Summary 405/September 2014

GP failed to properly assess patient who died soon afterwards

Mr C's GP made an incorrect diagnosis, but there was not enough evidence for the GP to reach a firm conclusion.

What happened

The GP visited Mr C because he was suffering pain in his side and was feeling sick. The GP thought that Mr C had a urinary tract infection or a musculoskeletal problem. He didn't refer him to hospital. However, about 12 hours later, Mr C died from a ruptured abdominal aortic aneurysm (a widening of the main vessel in the abdomen, which risks leaking blood and/or rupturing).

What we found

We partly upheld Mr C's wife's complaint. The GP did not take Mr C's blood pressure and pulse, or consider the possibility that he was suffering from an abdominal aortic aneurysm.

Although Mr C had symptoms relating to his condition, there was insufficient evidence to indicate that the GP should have referred him to hospital urgently.

The failings in the GPs assessment, therefore, did not contribute to Mr C's death.

Putting it right

The GP agreed to discuss our report with the partners at his practice and to put in place an action plan to make sure these mistakes are not repeated.

Organisation we investigated

A GP practice

Location

Greater London

Region

London

Summary 406/September 2014

Out-of-hours service failed to spot that a patient needed to go to hospital immediately

Mrs R complained that a GP from an out-of-hours service failed to diagnose a serious spinal condition and advised her to wait until her GP practice opened in the morning.

What happened

Mrs R phoned the out-of- hours service in the early hours because she was worried about her symptoms, which included back pain, left-sided leg pain and numbness in her hip and leg.

The out-of-hours GP discussed pain relief, reassured her about the cause of her symptoms and said that she could contact her GP practice in the morning. He did not advise her about the possibility that she had a serious spinal condition that can cause paralysis and incontinence if not operated on within a specific time frame. Mrs R said his advice delayed her referral to hospital for surgery.

Mrs R was later diagnosed with and operated on for the spinal condition. After surgery, she experienced distressing symptoms that affected her mobility, ability to work and quality of life. Although she is still affected to some extent, her symptoms have since improved.

Mrs R was unhappy about how the out-of-hours service and its GP responded to her complaint. She did not think that it acknowledged that the GP had not considered the correct diagnosis and the impact of that on her. Nor did she consider that the out-of-hours service had apologised properly or taken sufficient action to stop a similar thing from happening again.

What we found

Mrs R was not advised, as she should have been, about the possible diagnosis of a serious spinal condition. Also, the advice to contact her GP practice in the morning lacked an appropriate sense of urgency. The care given was not in line with General Medical Council guidance, and as a result, Mrs R had surgery later than might have been the case. However, we did not find that the distressing symptoms that she experienced after her surgery were caused by the care provided.

Although the responses to Mrs R's complaint went some way to acknowledging failings in care, the out-of-hours service did not give the full and frank acknowledgement and apology that Mrs R was seeking and deserved.

We partly upheld the complaint.

Putting it right

The out-of-hours service apologised to Mrs R for its failings and paid her £600. It also agreed to draw up an action plan to address its failings.

Organisation we investigated

An out-of-hours GP service

Location

Northumberland

Region

North East

Summary 407/September 2014

GP practice took a patient off its list without giving him a written warning, and handled his complaint about this poorly

A GP practice used a zero tolerance policy to remove a patient without prior written warning, which was against its contract.

What happened

The practice said that Mr D was aggressive and shouted at one of its GPs during a consultation. It wrote to Mr D five days later to say that it was removing him from its practice list. It said that this was in line with its 'zero tolerance' policy.

What we found

The Practice should not have removed Mr D without first giving him a written warning. Under the practice's contract, the only circumstances in which it could remove a patient without giving notice (zero tolerance) were if the patient was violent or threatened violence and the police were called, or if it was not practical for the practice to give a warning. Neither of these circumstances applied in this case.

The practice delayed responding to Mr D's complaint and its actions and delays in this caused him distress, anxiety and inconvenience.

We partly upheld the complaint. Although we found service failure and maladministration, we did not agree with the full extent of the injustices claimed by Mr D.

Putting it right

The practice agreed to apologise to Mr D, to pay him £150 and to draw up an action plan to stop the same mistake happening again.

Organisation we investigated

A GP practice

Location

Greater London

Region

London

Summary 408/September 2014

Failings in care at the end of an older patient's life

Mr B's son complained that doctors and nurses did not tell him how seriously ill his father was; did not give his father proper nutrition; left medication by his bedside which he should have been given; and took no action when his father's denture went missing.

What happened

Mr B had advanced Parkinson's disease, which caused him to have problems swallowing. He ate a special diet to reduce the risk of choking on his food.

Mr B was admitted to hospital three times towards the end of his life. The first time, his denture went missing. The second time, he had pneumonia caused by inhaling food and he gradually recovered. Mr B was readmitted for a third time a few days later, again with pneumonia. He deteriorated and died soon after.

What we found

The Trust did not deal with Mr B's son's compensation claim for the missing denture properly or arrange for a replacement denture. Mr B could still eat without his denture, but his dignity was compromised. During the second hospital admission, Mr B was not given several doses of his essential medication for Parkinson's disease. This caused him stiffness and soreness, and made his swallowing problems worse. During the second and third hospital admissions, doctors and nurses did not tell Mr B's son (or other family members) clearly that Mr B was likely to die soon, even if he temporarily recovered from each bout of pneumonia.

While the decisions about food and drink were complex and difficult in this case, doctors and nurses did not make sure that Mr B was given enough food and drink. In particular, he was left without nutrition over a bank holiday weekend. The lack of food and drink did not reduce Mr B's chances of survival or hasten his death, but it caused him unnecessary discomfort in his final few weeks and days, and distressed his family.

The Trust did not explain the clinical team's caring plan for Mr B to Mr B's son, and this caused him more anxiety and distress.

Putting it right

The Trust apologised to Mr B's son for its failings and paid him £1,500 compensation. It also agreed to prepare an action plan to stop the same mistakes happening again.

Organisation we investigated

East and North Hertfordshire NHS Trust

Location

Hertfordshire

Summary 409/September 2014

Failings found in care given to terminally-ill patient

Mr H complained about the care given to his mother who was terminally ill.

What happened

Mrs G was terminally ill. She had hearing loss, which meant the telephone was not an accessible way for her to communicate.

Her son, Mr H, was unhappy about the medical centre's communication with his mother. He said its telephone system was unsuitable for hearing-impaired patients to book appointments. He also said that one of Mrs G's prescriptions went missing.

Mr H said that the medical centre did not give Mrs G enough information about her terminal prognosis or provide her with suitable end of life home nursing care and support.

Mr H wanted the medical centre to acknowledge that there were failings in his mother's care and to make sure they were not repeated.

What we found

There were no failings in the medical centre's system for booking appointments or in the initial correspondence with Mrs G. The centre was aware that the telephone was not an accessible way for Mrs G to book appointments and adapted its service by writing to her.

The home nursing it provided was appropriate and in line with the relevant guidance.

However, the medical centre did not tell Mrs G about her terminal prognosis or give her information that may have helped her. It did not have an action plan for older and terminally ill patients, and so did not give Mrs G the proper care and support she should have had.

The medical centre also accepted it had mislaid a prescription and it apologised for this. We were satisfied with its response to this.

We partly upheld the complaint.

Putting it right

The medical centre apologised for the failings in this case and prepared an action plan to make sure the mistakes are not repeated.

Organisation we investigated

A medical centre

Location

Northamptonshire

Region

East Midlands

Summary 410/September 2014

Trust did not resolve a woman's chronic shoulder pain although it carried out two operations

Ms A eventually had three operations in twelve months to treat chronic shoulder pain. Each operation was needed because the previous ones had not stopped the pain.

What happened

Ms A had a history of shoulder problems and had already had surgery on both shoulders in 2008. In late 2011, her GP referred her to the Trust's shoulder unit because she had pain when she moved her left shoulder. She was seen by a consultant orthopaedic surgeon and had surgery in winter 2011.

Ms A later had a follow-up outpatient appointment and six sessions of physiotherapy. However, she continued to experience pain.

Ms A went back to her GP in early 2012 and, after various attempts (including private therapy) to relieve the symptoms were unsuccessful, she was referred back to the shoulder unit. She had a second operation on her left shoulder in summer 2012.

After three further physiotherapy sessions, Ms A's pain persisted, so she asked the Trust for a second opinion from another orthopaedic surgeon. Ms A later had a third operation on her shoulder in autumn 2012. Further physiotherapy relieved her pain and symptoms.

What we found

Although Ms A's consultant correctly assessed her condition and arranged the investigations she needed, her doctors did not single out whether the problem was due to her shoulder joint or inflammation of the tendon due to calcium deposits.

Significantly, they did not give her an important diagnostic injection that Ms A's consultant had recommended. This meant that clinical decisions about Ms A's first and second operations were not based on all the relevant information. Also, Ms A's follow-up care after her first and second operations was not well organised.

Although Ms A's first operation included surgery to the joint at the tip of her shoulder, the surgeon did not focus completely on this joint. If he had, Ms A's surgery may have solved the problem the first time.

As it was, when Ms A had a second operation, doctors incorrectly concentrated on removing the calcium on the tendon, which meant that the operation did not deal with the underlying cause of her symptoms (the joint at the tip of her shoulder). So a third operation was needed, with the extra pain and discomfort that caused. And, because Ms A's follow-up care had not been well organised, Ms A experienced more distress.

Putting it right

The Trust apologised to Ms A for its failings and agreed to put together an action plan that showed that it had learnt from its mistakes so that they would not happen again. The Trust also paid Ms A £2,000 compensation and reimbursed her over £500 for the private treatment she had had for her pain.

Organisation we investigated

Royal Berkshire NHS Foundation Trust

Location

Reading

Region

South East

Summary 411/September 2014

Trust delayed when it diagnosed cancer

Long delays in diagnosing Mr Y's cancer meant that he did not get palliative care that might have improved the quality of the last few months of his life.

What happened

Mr Y's GP referred him to the Trust to investigate a lump at the base of his neck. A consultant saw him in late spring 2011, but his oesophageal cancer was not confirmed until late summer 2011. Trust staff told Mr Y that his cancer was inoperable and he died in autumn 2011.

Mr Y's daughter complained about unnecessary delays in diagnosing her father's illness, and that the treatment he received during this time, in particular pain relief, was inadequate.

What we found

While the Trust carried out many appropriate investigations, it did not perform some tests that it should have. This, along with long delays in both administration and investigations; misguided thinking about provisional diagnoses; and a lack of monitoring by the cancer team; meant that Mr Y's care was not in line with national standards.

We did not find any failings in the assessment and management of Mr Y's pain.

Putting it right

The Trust acknowledged and apologised for its failings and paid Mr Y's family £500. It also agreed to draw up plans to learn lessons from the complaint so that the poor service is not repeated.

Organisation we investigated

Gloucestershire Hospitals NHS Foundation Trust

Location

Gloucestershire

Region

South West

Summary 412/September 2014

Failure to investigate symptoms delayed diagnosis of a spinal tumour

A neurologist discharged Mrs F without sending her for a scan that would have shown that she had cancer.

What happened

Mrs F had two appointments with a consultant neurologist who referred her back to her GP with no explanation for some of her symptoms. When Mrs F saw a different consultant neurologist five months later, a scan showed a tumour on her spine.

Mrs F had surgery but by the time the tumour was removed, she experienced physical difficulties, particularly with walking, which have not improved significantly since surgery.

What we found

When Mrs F's first consultant neurologist could not explain the numbness she was experiencing, he should have recognised that her symptoms were progressive and arranged for a scan of the whole of her spine. It was not appropriate for him to simply discharge Mrs F back to the care of her GP with a broad invitation to re-refer her if the GP felt it necessary.

If the tumour had been diagnosed earlier, the outcome for Mrs F would probably have been significantly different. Although it is likely that Mrs F would still have been left with some physical problems, they would probably have been less severe.

Putting it right

The Trust and the first consultant neurologist apologised to Mrs F. The Trust paid her £8,000 in recognition of the additional physical difficulties caused by its failure to investigate her symptoms. It also agreed to prepare an action plan to make sure lessons have been learnt.

Organisation we investigated

Basildon and Thurrock University Hospitals NHS Foundation Trust

Location

Essex

Region

East

Summary 413/September 2014

Trust did not provide adequate care and treatment for an older person

Mr V complained that the Trust did not provide adequate care and treatment for his mother, Mrs V, which contributed to her deterioration.

What happened

Mrs V went into hospital with confusion. Staff diagnosed her with a low potassium level. Her breathing was poor and her condition deteriorated. Days later, ward staff noted that Mrs V usually took warfarin and gave her heparin. They transferred her to another ward and found she had a hospital-acquired infection and dehydration. Doctors put Mrs V on a ventilator but she died soon afterwards. Mr V complained to us.

What we found

Doctors did not assess Mrs V adequately or recognise that she was frail and suffering from delirium. There was a delay in treating her severe hospital-acquired infection and dehydration, and staff did not manage Mrs V's medicines appropriately.

Although we did not find that those failings caused Mrs V's death, they contributed to her progressive clinical deterioration. The knowledge that Mrs V received poor care has distressed Mr V.

Putting it right

The Trust acknowledged its failings and apologised to Mr V for the injustice these caused. It also paid him £1,000 compensation and agreed to prepare an action plan to make sure it learnt lessons from the complaint.

Organisation we investigated

The Royal Wolverhampton Hospitals NHS Trust

Location

West Midlands

Region

West Midlands

Summary 414/September 2014

Two trusts failed to properly assess the mental capacity of an older man with mental health problems

Mr S, who had been diagnosed with mental health problems, had treatment from one trust and long-term supportive care from another. However, neither trust assessed his ability to consent. This meant his daughter thought his condition could have been improved.

What happened

Mr S had a long history of psychiatric illness, and his sight was also failing. Doctors referred him to Moorfields Eye Hospital NHS Foundation Trust for treatment, but he refused to give consent for the operation. He had a different operation but his sight continued to deteriorate.

During this time, and over the following 18 months, Mr S was under the care of South London and Maudsley NHS Foundation Trust (the mental health trust), where he began to lose his independence. He was allegedly exploited in the community.

Neither Trust formally assessed Mr S's ability either to consent to treatment, or to manage his finances.

What we found

Both Trusts should have formally assessed Mr S's mental capacity and the mental health trust had many opportunities to do this over a long period of time. However, because we could not say what the result of such an assessment might have been, it was possible that Mr S would have made the same choices. Therefore, we partly upheld the complaints about both Trusts.

Putting it right

The mental health trust apologised to Mr S's daughter and agreed to pay her £1,250 compensation. Both Trusts agreed to prepare action plans to address the failings identified.

Organisations we investigated

South London and Maudsley NHS Foundation Trust (the mental health trust)

Moorfields Eye Hospital NHS Foundation Trust

Location

Greater London

Region

London

Summary 415/September 2014

Could more have been done to ease man's final days?

Mr T's son complained about his late father's nursing and medical care. He believed that the Trust's lack of care led to his father's death.

What happened

Mr T was in his 90s and had a history of bowel cancer and heart disease. He had had two heart attacks in the last few years.

Mr T was admitted to the Trust for observation because he had fallen and was complaining of lower back pain. After he had been in the hospital for 48 hours, Mr T began to vomit. Doctors put this down to a drug he had been given and changed his medication. However, the next day an X-ray showed that his small bowel and stomach were distended and doctors suspected that he had a bowel obstruction.

In the following days, doctors continued to review Mr T and to treat him, but his condition deteriorated. He was diagnosed with an irregular heart rate, hospital-acquired pneumonia and an excess of fluid in the lungs, in addition to the bowel obstruction. Later, Mr T choked on his tea and doctors suspected that he had accidentally inhaled tea into his lungs.

About ten days after Mr T was admitted, he developed shortness of breath and his abdomen became more distended. The doctors' plan included treatment for heart conditions, a CT scan and a senior surgical review. But Mr T died before this could happen.

What we found

There were no failings in doctors' medical management of Mr T.

However, there were failings in recording Mr T's levels of pain, which the Trust has already acknowledged. Nurses did not consider another way of giving him pain relief when he could not, or would not, take medication orally.

At a point when Mr T's condition had deteriorated, there was too much fluid in his blood (as he had become overloaded with fluids), and nurses did not refer Mr T to the Trust's critical care outreach team or to a senior doctor.

While the amount of fluid Mr T had received might have contributed to his heart problems, it was clear by that stage that his heart problems had caused the excess fluid on his lungs and that had led to his death. The fluids in his blood had no significant impact on the outcome for Mr T.

We could not say that, on the balance of probabilities, Mr T would have survived if the failings we had identified had not happened. However, it would have been distressing for his family to see Mr T in pain because nurses did not consider other ways of giving him his pain relief and to see him deteriorate knowing staff were doing nothing to increase his care.

Putting it right

The Trust acknowledged its failings, apologised to Mr T's son and paid him £500. It also agreed to put together an action plan that showed learning from its mistakes so that they would not happen again.

Organisation we investigated

Southport and Ormskirk Hospital NHS Trust

Location

Merseyside

Region

North West

Summary 416/September 2014

Woman will never know whether her father could have lived longer if he had had better treatment sooner

Ms K says that doctors and nurses gave her father poor care and treatment when he was admitted to hospital. We found his heart problems were not treated soon enough.

What happened

Mr P was admitted to the Trust after he fell at home. Doctors recognised that he had an abnormally fast heart rate and an abnormal heart rhythm. He was confused and had several falls at the Trust. After two weeks, Mr P went to a community hospital for rehabilitation. He was readmitted to the Trust just over a week later because his condition had deteriorated. He died a few days after he was readmitted.

What we found

There were failings in nursing care at the Trust, but it had taken correct action to put this right. The medical care was also inadequate because doctors did not record an initial assessment; did not investigate Mr P's confusion; did not properly treat his abnormal heart rhythm; and did not review him sufficiently over the weekends. In addition, a geriatrician did not see Mr P soon enough and doctors did not tell Mr P's family that he was deteriorating.

The poor medical care meant that Mr P's heart condition was not effectively treated for seven days and his diagnosis of delirium was delayed. However, we did not find that the poor treatment contributed to his death.

We partly upheld the complaint.

Putting it right

The Trust acknowledged failings in the medical care provided. It apologised to Ms K and paid her £500 compensation. It also agreed to prepare plans to stop the same mistakes recurring.

Organisation we investigated

Oxford University Hospitals NHS Trust

Location

Oxfordshire

Region

South East

Summary 417/September 2014

Fall in hospital led to fractured hip

A trust's failure to give reasonable care meant that Mr D fell while he was in hospital.

What happened

Mr D went into hospital complaining of hip pain after he fell from a chair at home. Staff diagnosed delirium and treated him successfully, but he fell while unattended and fractured his hip.

What we found

The Trust did not carry out a mobility assessment. As this was not done, Mr D should have received safe support while standing. We cannot say that the fall could have been prevented and the fracture avoided if staff had been with Mr D.

We also saw a failing in that Mr D was placed in a chair after his fall, despite a note that he was complaining about hip pain. It is likely that this caused him additional pain and discomfort.

Although the Trust acknowledged that staff should have carried out a mobility assessment, apologised and took some corrective actions, we felt it could do more to stop similar problems happening again.

Putting it right

The Trust apologised to Mr D, accepted that it was not best practice to put him in a chair after his fall, and paid him £200 compensation. It also took steps to emphasise the need for medical staff to clearly keep details of a patient's mobility management plan in the clinical records. It also found ways to monitor the effect of these improvements.

Organisation we investigated

The Royal Wolverhampton Hospitals NHS Trust

Location

West Midlands

Region

West Midlands

Summary 418/September 2104

Nursing care fell below the expected standard

Ms F complained about elements of the nursing and medical care she received during several admissions to hospital.

What happened

Ms F was admitted to hospital several times over the course of a year. She had difficulty breathing three times and staff gave her intensive oxygen therapy. She complained about hygiene standards, especially in relation to fitting and maintaining cannulas (tubes inserted into her body).

Ms F also complained about her medication control, the haphazard way she was given oxygen therapy and some occasions when her dignity was compromised. She also complained about the way the Trust handled her complaint.

What we found

Ms F received reasonable medical care. However, there were basic errors in the way staff prescribed her oxygen therapy and administered, inspected and cleaned cannulas.

The medication Ms F brought into hospital with her was poorly controlled and some of her nursing records were completed without proper care.

Ms F raised many complaints with the Trust but it failed to identify and investigate each of them.

Putting it right

The Trust acknowledged and apologised for its failings and put together action plans that showed learning from its mistakes so that they would not happen again.

Organisation we investigated

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

Location

Norfolk

Region

East

Summary 419/September 2014

Poor end of life care

Mrs V's daughter complained that her mother had poor end of life care, and the family were not told about a do not resuscitate (DNAR) order.

What happened

Mrs V was terminally ill with non-curable cancer. She went into hospital when she became seriously unwell. The Trust carried out appropriate tests and investigations into her overall condition. The tests showed that the cancer in her liver could not be seen and had shrunk in her lungs. Staff shared this information with Mrs V's family. Mrs V's prognosis had not changed, however, and her condition deteriorated quickly. She died before a priest could see her.

Mrs V's family were understandably distressed. They thought that Mrs V had not been given the right treatment just before she died and that a shortage of staff meant she had not been cared for as well as she should have been.

What we found

Mrs V received good care and treatment even though her hospital ward was not staffed as it should have been. We noted that the Trust had not acknowledged the understaffing on the ward. Mrs V's medical records were not up to standard because there was no clear written plan of what clinical observations should be recorded, and therefore there was no full written record of her observations.

The Trust was wrong not to have discussed the DNAR order with her family, but in general, communication with them about Mrs V's condition was acceptable.

The staff had tried to arrange for a priest to see Mrs V, but we found that she deteriorated so quickly that there was not time. This was not due to any fault of the Trust.

Putting it right

The Trust apologised to Mrs V's family. It agreed to draw up a policy to improve communication about DNAR orders, to explain how it will improve staffing levels, and to make sure that written records meet the relevant guidelines.

Organisation we investigated

North Middlesex University Hospital NHS Trust

Location

London

Region

Greater London

Summary 420/September 2014

Patient discharged from A&E was readmitted later that day

After Mr F's emergency admission to A&E, doctors did not fully assess his condition before they discharged him. He was later readmitted as an emergency.

What happened

A community hospital had been treating Mr F for a chest infection. When he developed breathing difficulties, he went to the Trust's A&E. Doctors suspected he had had a heart attack.

After Mr F had been in A&E for several hours, the Trust decided that he had not had a heart attack and discharged him back to the community hospital. Shortly after he arrived, his condition deteriorated and he was rushed back to A&E, from where he was admitted to hospital

Mrs F complained that Mr F was not properly monitored or assessed during his first A&E visit. She said doctors did not recognise how serious his condition was and nurses did not properly look after him. She blamed the Trust for his deterioration and his subsequent emergency admission, which she said could have been avoided if staff had correctly judged whether Mr F was fit enough to be discharged.

She also complained that the Trust did not tell the community hospital about what investigations and treatment it had given Mr F, or what his treatment plan was after his discharge.

What we found

Nurses at the Trust did not carry out enough tests, and when they found an abnormality, they did not tell the clinician. The clinician did not do a proper risk assessment of Mr F, and this probably caused his deterioration after his discharge.

The Trust did not give the community hospital enough information about Mr F's treatment plan after his discharge.

Organisation we investigated

East Kent Hospitals University NHS Foundation Trust

Location

Kent

Region

South East

Summary 421/September 2014

Failings in care and treatment of a man with sepsis reduced his chances of recovery

Mr C, who had multiple health problems, went to hospital as an emergency. Staff did not recognise the severity of his illness at first and he waited over two hours to be seen by a doctor.

What happened

Mr C, who was in his seventies, went to hospital with an infection. Nursing staff assessed him when he arrived and a doctor saw him nearly two and a half hours later. The doctor suspected that Mr C might have sepsis (a life-threatening condition that arises when the body's response to an infection injures its own tissues and organs) and decided he should stay in hospital. Mr C had his first dose of antibiotics two hours later.

The next day, clinicians started Mr C on a more intensive regime of antibiotics and took advice on treatment from the hospital's microbiologists. Staff then transferred Mr C to the intensive treatment unit. He died the day after that.

The cause of Mr C's death was 'sepsis with multiorgan failure'. The Trust had not identified the source of the infection by the time of Mr C's death, but had found a number of possibilities including a chest infection or an infection in the biliary system (the organs and ducts that produce and transport bile, which helps break down fats in food).

Mr C's daughter, Mrs P, complained about her father's care and also about the information on his death certificate.

What we found

Although Mr C was managed appropriately once he was in the care of the medical team, his initial care did not meet the expected standard. A doctor did not see Mr C for more than two hours, staff did not carry out his physiological observations and clinicians did not give him antibiotics until four hours after he arrived at the hospital. In short, the clinical staff who saw him soon after he arrived in hospital did not recognise the severity of his illness. This reduced his chances of recovery.

The information included on the death certificate was not unreasonable, given the clinical circumstances and the uncertainty about the precise cause of Mr C's sepsis. It is unfortunately not possible to resolve this.

Putting it right

The Trust agreed to acknowledge and apologise to Mrs P for its failings, and to identify ways to improve its service. The Trust also paid Mrs P £1,200 compensation.

Organisation we investigated

Ashford and St Peter's Hospitals NHS Foundation Trust

Location

Surrey

Region

South East

Summary 422/September 2014

Poor communication made patient think something had gone wrong

Mr L developed a deep wound infection after heart surgery. Although this was not life-threatening, he was left scared and depressed because he thought he was at greater risk than he actually was.

What happened

Mr L had heart surgery and developed an infection. The Trust did all the right things to treat the infection, but did not tell Mr L that such cases can take years to clear without affecting a patient's general health.

Mr L complained to the Trust, but its responses did not explain what had happened and why the treatment was correct. When Mr L went to a meeting to discuss his complaint, the consultant walked out. The written response following this meeting was badly written and again the issues were poorly explained.

What we found

Mr L's care and treatment were good and even went beyond what was normally offered. However, the Trust did not explain everything well and this left Mr L concerned about his health. The Trust did not draw up a proper plan for dealing with Mr L's complaint and its responses were hard to understand. The Trust gave some information that did not make sense or fully answer Mr L's questions.

Putting it right

The consultant who had walked out of the meeting had already apologised to Mr L, so we did not recommend any further action on this point.

The Trust apologised to Mr L for its poor complaint handling and agreed to draw up plans to improve its communication and complaint handling.

Organisation we investigated

Plymouth Hospitals NHS Trust

Location

Plymouth

Region

South West

Summary 423/September 2014

Lack of input from surgical team after surgery led to pain and distress

Mrs W complained that after surgery for a kidney stone, she did not get appropriate pain relief and doctors from the urology team did not review her, despite repeated requests. Mrs W also complained that the Trust did not respond fully to her complaint, which left her with unanswered questions, worries about future treatment she might need and concerns that other people might have the same experience she did.

What happened

After Mrs W's surgery, she woke up on the recovery ward in pain. Nursing staff and an on-call anaesthetist gave her pain relief. She stayed in the recovery area because there was no available bed on a ward.

Mrs W's pain got worse. Nursing staff in the recovery area repeatedly asked for someone from the urology team to review Mrs W but were told no one was available. When staff tried to contact the on-call registrar, they were told he was not on site. The on-call urologist saw Mrs W later and called the surgeon who had performed her surgery. Doctors agreed an appropriate treatment plan for Mrs W and staff moved her to a ward.

What we found

There were failings in the urology team's support for Mrs W after her surgery. Although records show that Mrs W had pain relief while she was in the recovery area, urology staff should have visited her to assess and reassure her and the nursing staff caring for her. Mrs W endured pain and distress as a result of this.

The Trust did not fully respond to the issues Mrs W raised, although it insisted it had done so. It refused to respond further.

Putting it right

The Trust apologised to Mrs W for the lack of urology input whilst she was in recovery and for its poor complaint handling. It also paid her £350 compensation to recognise the distress and upset it had caused. The Trust also drew up an action plan to improve its procedures and it shared the lessons from Mrs W's case with nursing staff and the urology team.

Organisation we investigated

Mid Essex Hospital Services NHS Trust

Location

Essex

Region

East

Summary 424/September 2014

Hospital's administrative errors delayed scan

Ms Y went to the Trust in late summer 2011 suffering from blackouts and headaches.

What happened

Ms Y saw an associate specialist in neurology, who thought her symptoms might have been caused by her existing medication. He referred her for a scan. The appointment letter did not reach Ms Y because of a mistake in her address in the Trust's computer system. This did not come to light until she saw the associate specialist again for a review in late 2011.

Ms Y had a scan in early 2012. Clinicians did not see anything abnormal on that scan. She went to A&E two and a half weeks later, with symptoms that were initially thought to be caused by a stroke. After more investigations, including another scan, staff found Ms Y had a cancer of the lymphatic system.

What we found

The care provided by the associate specialist was appropriate. Ms Y's symptoms did not suggest cancer, and he referred her for a scan.

Significant administrative and systems failures meant the associate specialist did not know that Ms Y had not had her scan appointment until later in 2011. We could not say whether these problems delayed the diagnosis of Ms Y's cancer. This was because her symptoms did not suggest that clinicians should look for a tumour in the base of the skull, where one was later found.

There were some shortcomings in Ms Y's care. Clinicians did not identify an abnormality in Ms Y's skull on the first scan. However, it was difficult to see on the scan. Doctors found the abnormality two weeks later, when they investigated further and reviewed the scan. It was unlikely that this two-week delay had a major effect for Ms Y.

We partly upheld the complaint.

Putting it right

We were satisfied that the Trust had already taken action to improve its administrative systems, so we did not make any further recommendations.

Organisation we investigated

Imperial College Healthcare NHS Trust

Location

London

Region

Greater London

Summary 425/September 2014

Two trusts failed vulnerable patient

Mr A and his partner Ms B were left without adequate support in an acute hospital by two Trusts when a crisis team did not arrive. The Trusts did not give alternative support until the next morning.

What happened

Mr A went to Norfolk and Norwich University Hospitals NHS Foundation Trust (the first Trust) with Ms B because he was having suicidal thoughts. He waited a long time for a doctor's assessment, and then waited all night for the crisis team from the neighbouring Trust (Norfolk and Suffolk NHS Foundation Trust – the second Trust) to see him.

During the night, the first Trust did not support Mr A and Ms B adequately, and this caused both of them considerable distress. The second Trust's crisis team did not arrive, although the first Trust telephoned several times.

A mental health nurse assessed Mr A the following morning. The nurse discharged him and recommended he went to his GP surgery to arrange counselling. Mr A was found dead some days later. An inquest reached a narrative verdict.

What we found

The initial triage that the first Trust completed was inadequate. However, the decision to not complete toxicology tests or detain Mr A under mental health legislation was reasonable.

There were shortcomings in the level of support that the first Trust gave Ms B and Mr A overnight. The Trust addressed this by apologising to Ms B and giving staff feedback.

The second Trust's crisis team's failure to come to see Mr A was unreasonable, particularly given the length of time that he waited to be assessed. The eventual assessment and discharge by the mental health nurse was not as comprehensive as it should have been. It was likely, however, that the outcome would have been the same even if the assessment had been thorough and properly recorded.

Putting it right

Both Trusts apologised to Ms B and told her that they had relayed the lessons they had learnt from her complaint to staff.

The first Trust took steps to make sure that complaints involving both Trusts are better managed in future to avoid the delays Ms B experienced. The second Trust agreed to do likewise.

Organisations we investigated

Norfolk and Norwich University Hospitals NHS Foundation Trust

Norfolk and Suffolk NHS Foundation Trust

Location

Norfolk

Region

East

Summary 426/September 2014

Prisoner's complaint about changes to his medication

Mr E, who was in prison at the time, had been taking medication for a number of years. A GP stopped one form of Mr E's medication and reduced another without informing him, causing him to experience withdrawal symptoms and distress.

What happened

Mr E had been taking strong painkillers for a back injury for several years. He was in a prison where Serco Group PLC was responsible for primary medical care and handling medical complaints. Serco contracted the provision of GP care at the prison to a local GP practice.

A GP from the practice noted that Mr E was taking two forms of opiate medication, which was not appropriate. The GP stopped one of Mr E's medications and reduced the dosage of the other without telling him. Mr E then reported several withdrawal symptoms. A different GP saw him a week later, and prescribed the medication that had been stopped. Mr E said that he used heroin during this period to help with his withdrawal symptoms.

Mr E complained to Serco about the change to his medication. Serco sent him separate responses. After the first two responses, Mr E brought his complaint to us. We considered that Serco had not responded reasonably to his complaint and we asked it to respond again. Mr E was unhappy with Serco's third answer and asked us to investigate.

We partly upheld Mr E's complaint.

What we found

The GP did not continue the prescription of one of Mr E's medications and did not tell him the reason for reducing his other medication. Serco then sent Mr E three responses to his complaint that were neither accurate nor reasonable.

While these failings caused Mr E mild back pain, withdrawal symptoms, distress and inconvenience, we saw no evidence that he suffered from severe withdrawal symptoms or that he was required to use heroin as a result.

Putting it right

Serco paid Mr E £250. It developed an action plan to improve its complaint handling.

Organisations we investigated

Serco Group PLC

A GP practice

Location

Nottingham

Region

East Midlands

Summary 427/September 2014

An unreasonable delay in responding to concerns about cataract operation

Mr V had surgery for a cataract. He then had a series of unfortunate complications and lost sight in one eye. Although there were no failings in his clinical care, delays in complaint handling caused him distress and denied him timely answers to his concerns.

What happened

Mr V had surgery at University Hospitals of Morecambe Bay NHS Foundation Trust (the first Trust) to remove a cataract from one eye. He suffered a dropped nucleus, an unfortunate but recognised complication that meant he needed specialist care.

The first Trust transferred Mr V to Royal Liverpool and Broadgreen University Hospitals NHS Trust (the second Trust) the same day. He had to wait several days before he could be treated because his eye was hazy and needed stabilising. He had surgery to remove the cataract but clinicians found bleeding in his eye. After a review, staff discovered that he had a detached retina. He had treatment to try to correct this, but sadly he began to lose sight in this eye.

Mr V complained to the first Trust and waited a number of months for a response. He was dissatisfied with the eventual explanation and asked for a meeting with the Trust. The Trust did not arrange this until almost a year later because of staff availability problems and poor complaint handling.

The second Trust responded to Mr V's complaint promptly. However, neither Trust could fully explain to Mr V where things had gone wrong, so he came to us.

What we found

There were no failings in the clinical care that Mr V received from either Trust, though we identified shortcomings in the first Trust's consent process. The first Trust did not handle Mr V's complaint well and there were considerable delays.

We did not uphold any part of the complaint about the second Trust.

Putting it right

We gave Mr V a clear explanation of what had happened. The first Trust apologised to Mr V for failings in its consent process and complaint handling and agreed to draw up plans to improve these aspects of its service.

Organisations we investigated

The University Hospitals of Morecambe Bay NHS Foundation Trust

Royal Liverpool and Broadgreen University Hospitals NHS Trust

Location

Lancashire

Region

North West

Summary 428/September 2014

Trust failed to give a joint response to a complaint that involved health and social care

Mr R complained that his nephew, Mr D, had inappropriate treatment for his Huntington's disease and that the medical team were unwilling to involve professionals with specialist knowledge of this condition. He also complained about the delay in discharging Mr D and the changes that were made to the discharge plan after arrangements had been put in place. Mr R was also unhappy about the way the Trust handled his complaint.

What happened

In autumn 2011 Mr D went to A&E after a fall at home. Staff noted Mr D had difficulty swallowing when they tried to give him food and drink. They referred him to the speech and language therapy service.

Mr D was malnourished so staff started to give him intravenous fluids because he either refused drinks or had difficulty swallowing. Mr D was often non-communicative and did not co-operate with staff, which was part of his condition. Although the Trust recommended high-calorie liquid feeds and high-energy supplements, Mr D only ate intermittently throughout his stay in hospital.

The next month, the Trust decided that Mr D was medically fit for discharge. Trust staff, social workers, Mr D's representatives, and the manager of the home where Mr D had lived, held a case conference to discuss discharge arrangements. The Trust agreed that Mr D would return to his supported accommodation and that social services would carry out a care package assessment. A discharge liaison nurse would carry out an urgent assessment for nursing home placement if Mr D's condition did not improve after discharge.

Because of disagreements about Mr D's discharge destination, he stayed in hospital for some weeks. The Trust then decided he was medically fit for discharge but his condition was slowly deteriorating because he refused intravenous fluids and would not drink. Staff thought that Mr D's failing condition was made worse by the unfamiliar hospital environment.

Mr D's blood sugar levels fell. He also had pneumonia and was dehydrated, and eventually his blood oxygen levels fell to a dangerously low level. His blood pressure also dropped. Mr D's condition continued to deteriorate and he died soon after.

What we found

The appropriate staff were involved in Mr D's care and were aware of the difficulties he had eating and drinking. Mr D had severe Huntington's disease and was very malnourished on admission. Although they gave appropriate care, staff were unable to make sure that Mr D had enough food and fluids, and they could not stop his condition declining.

There were disagreements about the most appropriate place of discharge for Mr D but there were no faults or omissions in the discharge planning process.

There was fault in the Trust's complaint handling. Mr R was concerned about the involvement of social services as well as the Trust. The Trust told Mr R several times that he needed to fill in a form for it to work with social services. When the Trust eventually sent out what it thought was the appropriate form, members of the team dealing with Mr R's concerns had moved on. The way the Trust dealt with Mr R's complaint meant that he did not receive a co-ordinated response from the Trust and the local authority.

The Trust had earlier assured him that the organisations could give a joint response.

We partly upheld the complaint.

Putting it right

Although we found no fault in the care and treatment the Trust gave Mr D, its complaint handling was flawed. Mr R became frustrated with the complaints procedure and did not get the joint response he expected when he first raised his concerns.

The Trust apologised to Mr R for the way it had handled his complaint and explained what lessons it had learnt. It also paid him £250 compensation.

Organisation we investigated

Sandwell and West Birmingham Hospitals NHS Trust

Location

West Midlands

Region

West Midlands

Summary 429/September 2014

GP practice deferred home visit and failed to monitor diabetic patient in her seventies

Processes at Mrs G's practice broke down, so she did not get an urgent home visit.

What happened

Mrs G had multiple health problems including a heart condition, chronic kidney disease, and type 2 diabetes. Her diabetes was not well controlled so the practice increased her medication, which led to gastric side effects. Ms D, Mrs G's daughter, asked the practice for a home visit. The practice agreed to this, and Ms D asked it to contact her if necessary.

A GP telephoned Mrs G directly because the practice's usual procedure for arranging home visits had failed. Mrs G was confused, and her husband told the GP it was not urgent. Ms D said her parents would not wish to trouble or inconvenience a doctor, but the home visit was urgent. The following day Mrs G collapsed. She was unable to be resuscitated and died at home.

What we found

The decision to defer the home visit was unreasonable as the practice did not carry out a robust assessment because of Mrs G's confused state. The practice had agreed to speak to Ms D; when it could not contact her it should have gone ahead with the home visit as planned. There was a missed opportunity for Mrs G to get the treatment she needed for her heart condition. We could not reach a view on whether Mrs G's death could have been prevented if the visit had gone ahead as planned.

It was unreasonable for the practice to increase Mrs G's diabetes medication without regularly monitoring her kidney function. This possibly played a part in Mrs G's death.

Putting it right

The practice apologised to Ms D. It also changed its procedures to make sure that appropriate supervision arrangements were in place for trainee doctors who are on call and to make sure that the workload for trainee GPs on call is manageable and does not affect patient care. The practice will also audit all diabetic patients who have kidney failure, to make sure that their medication is appropriate and that their kidney function has been adequately monitored.

Organisation we investigated

A GP practice

Location

Halton

Region

North West

Summary 430/September 2014

Failure to communicate with a woman's relatives about end-of-life care

Mr B complained that the Trust did not tell him about the decision to place his wife, Mrs B, on the Liverpool care pathway. He said that he felt he had let his wife down by not asking more questions about her end-of-life care.

What happened

Mrs B was terminally ill in hospital. Trust staff made plans with Mr B for his wife to return home for her end-of-life care, but on the day she was due to be discharged, her condition worsened. The Trust decided to place Mrs B on the Liverpool care pathway, and she died three days later in hospital.

Following media publicity about the Liverpool care pathway, Mr B complained to the Trust. He said that his wife was put on the Liverpool care pathway without consultation with him or their son, and staff did not explain the plans for her treatment.

What we found

Staff did not complete sections of Mrs B's Liverpool care pathway assessment, including the section about communicating the plan for end-of-life care with the patient or their family. While there was some evidence that staff had mentioned the decision to put Mrs B on the Liverpool care pathway to her family, this was not sufficient to make sure that Mr B and her family understood the plans for her end-of-life care.

This led to the injustice that Mr B felt he had let his wife down by not asking more questions or being more involved in decisions about her care at the end of her life.

Putting it right

The Trust wrote to Mr B to acknowledge and apologise for the failure to communicate the decision to place his wife on the Liverpool care pathway adequately. It created an action plan to make sure that clinical staff discuss decisions about end-of-life care adequately with patients and their relatives in future.

Organisation we investigated

East Sussex Healthcare NHS Trust

Location

East Sussex

Region

South East

Summary 431/September 2014

Failure to manage a complication after surgery put patient at increased risk of heart attack

Mr C complained about problems in surgery he had for oesophageal cancer. He believed that the Trust's action may have caused him to have a heart attack.

What happened

Mr C had surgery for oesophageal cancer. After the operation, he developed a complication in which fluid leaks from part of the lymphatic system. Doctors tried to manage the problem conservatively at first. However, this was unsuccessful and Mr C had another operation. During this operation, Mr C had a heart attack. He had treatment and was discharged home the following month.

What we found

There was no fault on the part of the Trust in relation to Mr C's fitness for surgery and his first operation. The Trust carried out appropriate tests on Mr C's heart before surgery. The operation itself was carried out in accordance with standard practice and the surgeons took all reasonable precautions to avoid the complication Mr C developed.

We found fault in how the Trust managed the complication because clinicians managed it conservatively for too long before Mr C's second operation. We could not say if the delay in carrying out the second operation caused Mr C's heart attack, but it put him at greater risk. This was an injustice to Mr C because he will never know whether his heart attack could have been avoided.

There was also fault in relation to Mr C's take-home medication, for which the Trust had already apologised.

Putting it right

The Trust apologised to Mr C and paid him £1,000 compensation. It also prepared an action plan to stop a recurrence of the faults we identified.

The Trust told us that as direct result of Mr C's complaint, it had introduced a new protocol to deal with the complication he experienced.

Organisation we investigated

University Hospitals Birmingham NHS Foundation Trust

Location

West Midlands

Region

West Midlands

Summary 432/September 2014

Significant failings in administration and complaint handling

Miss H had gynaecological surgery at the Trust. After the surgery, her condition came back so she asked whether the surgery had been carried out correctly. She also encountered administrative problems during her period of care and in the complaints process.

What happened

Miss H had surgery to remove an ovarian cyst. The Trust scheduled the surgery for a morning, but it was delayed because the surgical team did not have her medical records.

Miss H also found the attitude of some of the clinical staff to be inappropriate. A small cyst recurred since the surgery, so she queried whether the procedure was carried out appropriately.

Miss H also had follow-up care at the Trust. She received letters from the Trust that showed two different hospital numbers, but although she raised this with the Trust, it delayed correcting it. Miss H had other administrative problems during this period.

After this, Miss H's GP told her that he had not had adequate information about her procedure from the Trust. She also found out that records were missing from her medical notes.

Miss H complained to the Trust. There were a number of delays throughout this process and Miss H did not feel that the responses she received were robust.

What we found

Miss H's surgical procedure was carried out appropriately. These types of cysts can recur and this does not mean that there were errors in the original surgery. We also consider that the Trust addressed Miss H's complaint about staff attitude appropriately.

However, there were repeated administrative and record-keeping failures by the gynaecology department throughout Miss H's time at the Trust.

The Trust's responses to Miss H's complaints fell very far short of an adequate standard, and there were unreasonable delays in responding to her complaints. These concerns have arisen in previous investigations about this Trust, so we considered that there was evidence of systemic problems here.

Putting it right

The Trust agreed to apologise to Miss H for its failings. It also said it would review its handling of her complaint to establish a reason for the delays and poor responses; audit its complaint handling, looking at both the timeliness of complaint responses and the standard of the responses; identify how it could improve its complaint process after the audit; and consider how it would monitor the standard of complaint handling.

It also agreed to review administrative and record-keeping procedures in the gynaecology department to find out why the repeated failures occurred, and identify appropriate improvements in an action plan.

Organisation we investigated

Barts Health NHS Trust

Location

Greater London

Region

London

Summary 433/September 2014

Area team handles complaint badly

Miss D complained that a nurse practitioner did not diagnose a ruptured aneurysm, and that an area team handled her complaint badly.

What happened

Miss D visited her GP with an excruciating headache. A nurse practitioner saw her and diagnosed a migraine. Two days later, Miss D went to her local A&E, where staff found that she had a ruptured aneurysm, a swelling in an artery.

Miss D complained to the primary care trust, (the PCT) which responded to her complaint. When Miss D contacted the PCT with outstanding concerns, it passed her case to the Area Team in spring 2013. The Area Team took over a year to respond to Miss D.

What we found

The nurse practitioner made a reasonable diagnosis on the basis of Miss D's symptoms, which had not indicated that she had a ruptured aneurysm.

There were failings in the Area Team's complaint handling.

Putting it right

The Area Team apologised to Miss D for its failings and paid her £250 compensation. It also agreed to draw up an action plan setting out the action it will take to address the failings we found.

Organisation we investigated

Birmingham, Solihull and the Black Country Area Team

Location

West Midlands

Region

West Midlands

Summary 434/September 2014

Dentist wrongly failed to offer an NHS scale and polish when it was needed

Miss T needs regular teeth cleaning because bacteria can affect her heart condition. Her dentist wrongly told her that she would have to see the hygienist and pay privately for this.

What happened

Miss T went to the dentist and was told she needed a scale and polish. She was only offered the option of having this work carried out privately by the practice hygienist.

She complained to us that she was treated under the wrong dental charge band, communication by the practice was poor and that the dentist did not discuss dental charges with her. Miss T said the treatment given by the hygienist should be available as a band 1 NHS treatment.

What we found

The dentist had not discussed all the options available and had not explained that an NHS scale and polish was available as an alternative to seeing the hygienist. We found communication had been poor.

There was no evidence that Miss T was treated under the wrong NHS band or that the hygienist treatment should have been offered as an NHS treatment, because the practice did not employ an NHS hygienist, only a private hygienist.

Putting it right

The Practice apologised to Miss T and reimbursed her the cost of the hygienist treatment. It also reviewed its policy on scale and polishes to make sure all NHS dentists at the practice offer a scale and polish as an NHS treatment where clinically necessary.

Organisation we investigated

A dental practice

Location

Peterborough

Region

East

Summary 435/September 2014

Inadequate pressure area care and poor complaint handling.

Mrs E complained that the Trust did not investigate her husband's symptoms adequately after he went into hospital in late summer 2010; that the nursing care in hospital in spring 2011 was inadequate; and that the Trust's responses to her complaints were inaccurate.

What happened

Mr E (Mrs E's husband) went into hospital in late summer 2010 because he had collapsed several times at home. Doctors carried out a number of tests, but could not find the cause of his symptoms.

Staff transferred Mr E to another hospital trust for more tests. Clinicians at the other trust diagnosed him with an infection in his spine. In spring 2011, Mr E went back to the Trust. He developed pressure sores during this second admission.

What we found

After Mr E's admission in late summer 2010, the Trust carried out appropriate and timely investigations, and referred Mr E, when necessary, to another trust.

Most of the nursing care Mr E received his second time in hospital was adequate. However, nurses did not give enough pressure area care. The Trust's response to Mrs E's complaint about her husband's pressure sore care was inadequate.

If the service failure had not happened, it is likely Mr E would not have developed pressure sores, and the sores were unlikely to have degraded as much as they did. Mr E also had a long recovery time.

Mr and Mrs E were distressed by their experiences, and this was made worse by the Trust's inadequate complaint handling.

Putting it right

The Trust apologised to Mrs E and paid her £1,000 compensation. It also agreed to develop plans to stop the failings identified recurring.

Organisation we investigated

University Hospitals of Morecambe Bay NHS Foundation Trust

Location

Lancashire

Region

North West

Summary 436/September 2014

Trust managed a lung condition appropriately

Miss B, Mrs N's daughter, complained about how the Trust had managed her mother's chronic obstructive pulmonary disease (COPD), and about her mother's treatment in hospital.

What happened

Mrs N was diagnosed with COPD in 2010. The Trust reviewed her in hospital on a number of occasions in the next 18 months.

Mrs N went into hospital in winter 2011 because clinicians suspected her COPD was getting worse. She had a cardiac arrest but staff successfully resuscitated her. Sadly, she did not regain consciousness and doctors considered that further treatment would not be appropriate. Mrs N died the following morning.

What we found

We did not uphold Miss B's complaint. After Mrs N's diagnosis of COPD in 2010, the Trust adequately managed and treated her condition. We also found that when Mrs N went into hospital in winter 2011, staff gave her oxygen therapy and monitored her oxygen levels appropriately.

After Mrs N's cardiac arrest, doctors told Miss B that they could not give her mother any more treatment. Miss B was concerned that the doctors took this decision on the basis of medical records relating to other patients. However, given that Mrs N's prognosis was very poor, we found the decision not to give further treatment was appropriate.

Organisation we investigated

Hull and East Yorkshire Hospitals NHS Trust

Location

Hull

Region

Yorkshire and the Humber

Summary 437/September 2014

Failure to carry out appropriate tests meant breast cancer went undetected until it was too late.

Ms G complained that the Trust did not carry out appropriate tests when she went to the breast clinic in 2010. She was concerned that this led the Trust to diagnose her with mastitis when in fact she had breast cancer.

Ms G said that in response to her complaint, the Trust had offered assurances that it had acted appropriately, but Ms G felt that it had not been open and honest in its response.

What happened

Ms G saw her GP in spring 2010 because she was concerned about changes she found in her breast. The GP suspected mastitis but sent an urgent referral to the Trust to rule out the possibility of anything more sinister.

Breast clinic staff saw Ms G quickly. They carried out an ultrasound scan and a clinician diagnosed mastitis. The clinician arranged a follow-up appointment for three weeks later. Unfortunately Ms G was unable to get to this appointment and went to the clinic again in early summer 2010.

At this second appointment, a different clinician again diagnosed mastitis. The clinician arranged a three-month follow-up appointment for Ms G, which she did not attend. The same clinician wrote to Ms G later that year, discharging her from the service.

In autumn 2011 Ms G went to her GP again because she was concerned about changes in her breast. Her GP referred her back to the Trust, which diagnosed advanced breast cancer that had spread to her bones, liver and brain. Ms G was told that her cancer was terminal and although treatment was available to prolong her life, the cancer was now incurable.

What we found

The first appointment was conducted appropriately. It was reasonable for the first clinician to diagnose mastitis. The clinician arranged follow up and noted that if the condition did not clear, then further tests should be carried out at the follow-up appointment.

There were failings at the second appointment. Staff should have carried out a mammography, a biopsy or both, but this did not happen. A clinician discharged Ms G from the service with no advice about the potential seriousness of her condition and what she should do if her symptoms did not clear. The Trust gave Ms G and her GP a false sense of reassurance about Ms G's condition when it wrote to Ms G twice with a diagnosis of mastitis.

There were also failings in the way the Trust handled Ms G's complaint. It did not fully investigate and its response did not acknowledge the extent of the failings or their impact on Ms G.

Ms G's cancer would have been detectable in 2010 and the Trust could have diagnosed it at an early stage when Ms G's prognosis would have been much better. It was likely the secondary cancers developed as a result of the failure to diagnose breast cancer.

Putting it right

During the investigation, the Trust gave us details of changes and improvements to its services since the events occurred. We are satisfied that how it monitors patients on the cancer pathway has improved significantly.

The Trust apologised to Ms G and its chief executive offered to meet Ms G to apologise in person for the failings we identified.

The Trust paid Ms G £70,000 for the distress, pain and suffering caused by the failings we identified.

We also shared information about this complaint with the General Medical Council because we were concerned that the second clinician's failure to carry out appropriate tests may present a risk to patient safety.

The full report on our investigation is available to read on our website.

Organisation we investigated

West Hertfordshire Hospitals NHS Trust

Location

Hertfordshire

Region

East

Summary 438/September 2014

Family distressed by failings in nursing care

Nurses did not properly assess a patient's risk of falling or help him with his meals.

What happened

Mr S was admitted to an acute hospital after surgery. He died in hospital a few weeks later. His family complained about several aspects of his care and treatment both at the acute hospital (the Acute Trust) and during a short stay at a community hospital (the Care Trust).

What we found

The doctors and nurses caring for Mr S did what they should have done for the most part. However, nurses at the Acute Trust should have assessed Mr S's fall risk and helped him with his food. It was distressing for his family to witness these failings and we partly upheld the complaint.

We did not uphold the complaint about the Care Trust.

Putting it right

The Acute Trust acknowledged and apologised for its failings and showed evidence that it had learnt from the complaint in order to stop this happening again.

Organisations we investigated

Gloucestershire Hospitals NHS Foundation Trust

Gloucestershire Care Services NHS Trust

Location

Gloucestershire

Region

South West

Summary 439/September 2014

Older patient fell at home after Trust discharged her against her daughter's wishes

Mrs G complained that her mother, Mrs Y, was inappropriately discharged from hospital. Mrs G also complained about her mother's personal care and poor care and treatment in hospital.

What happened

Mrs Y had dementia and was visually impaired. She went into North Manchester General Hospital after a fall at home. Staff treated her, and then doctors decided that she was medically fit to go home. A physiotherapist and an occupational therapist then assessed her as at her usual level of mobility. Staff discharged Mrs Y home.

Mrs Y fell at home and fractured her hip. She went back into hospital, where she had another fall. Staff later discharged Mrs Y home. Mrs Y's general health continued to deteriorate and she died after another hospital admission.

What we found

The Trust's response to Mrs G's complaint was mostly appropriate. It acknowledged her concerns and apologised for some weaknesses in the care and treatment it had given. It also developed an action plan to learn lessons from Mrs G's complaint.

Although we found some shortcomings in doctors' assessment of Mrs Y's medical fitness for discharge, the overall handling of her discharge did not amount to service failure.

We found deficiencies by nurses when they assessed Mrs Y's risk of falling, and in how they planned her care. Staff missed opportunities to plan and deliver more appropriate care. However, this would not have prevented Mrs Y's fall. We also found that the doctors' decision not to scan Mrs Y's head after her fall was reasonable.

There were some shortcomings in Mrs Y's personal care. The Trust apologised for some of these.

There was no maladministration in how the Trust handled Mrs G's complaint.

Putting it right

The Trust agreed to write to Mrs G to acknowledge the failings in falls risk assessment and care planning, to apologise for the impact of these, and to update its action plan to make sure that lessons have been learnt.

Organisation we investigated

Pennine Acute Hospitals NHS Trust

Location

Greater Manchester

Region

North West

Summary 440/September 2014

Patient with broken vertebrae put at risk in A&E

A patient was not initially assessed by a senior doctor, so his treatment was delayed. This led to unnecessary pain, distress and risk of serious injury.

What happened

Mr G complained that the Trust did not properly assess or treat his broken neck when he was admitted to A&E after a highspeed car accident. In A&E, staff removed his neck collar and gave him pain relief tablets.

When staff took Mr G for an Xray, his bed was bumped against a door frame, and this caused him great pain. Mr G then tried to stand but was unable to do so, and collapsed. It was at this point that a senior doctor became involved and ordered a CT scan, which showed broken vertebrae.

The Trust then transferred Mr G to another hospital, where the neurology team treated him, and fitted him with a 'halo' spinal injury brace, which he had to wear for 19 weeks.

What we found

The Trust should have treated Mr G's case as a trauma call when he first arrived in A&E. Had this happened, a senior doctor or trauma team would have reviewed him initially and he would have got the right care from the start. Staff should not have removed the neck collar and should have given him stronger, intravenous, pain relief, rather than tablets, which he found difficult to swallow. The Trust should have X-rayed Mr G where he was, rather than in an X-ray unit.

Mr G experienced unnecessary pain and distress because of the Trust's failure to properly assess and treat him. His scan results showed that he had potential instability of the spine. Removing the neck collar put Mr G at risk of displacement. However, these failings did not affect the way he was managed in the longer term, or how long it took him to recover.

Putting it right

The Trust apologised to Mr G and paid him £750 in light of the unnecessary pain and distress he experienced. It also agreed to review its criteria for initiating a trauma call or involving a senior emergency department doctor, and to explain how it will monitor how well the criteria are working.

Organisation we investigated

Northern Lincolnshire and Goole Hospitals NHS Foundation Trust

Location

North Lincolnshire

Region

Yorkshire and the Humber

Summary 441/September 2014

Trust made significant improvements, but we still found failings

Ms A complained about the Trust's response to her concerns about substantial and repeated failures in her mother's care.

What happened

Although the Trust had accepted that there were significant failures in the clinical care it had given Mrs P, Ms A's late mother, and also in its complaint handling, Ms A came to us because she did not believe the Trust had made enough improvements.

The Trust admitted that staff had not acted on a scan and an Xray that both showed a mass which was found to be cancer some months later.

The Trust explained that once staff had identified the error, there were failures in its complaint handling and it did not tell Mrs P about the mistakes it had made. The Trust explained that it had improved its complaints process.

We partly upheld the complaint.

What we found

Although the Trust had improved how it conducted and referred scans, there was still work to do to make sure it had a plan in place to prevent a backlog of unreported scans.

The Trust had not improved its complaint handling or decided how it would deal with cases in which it later found significant failures.

Putting it right

The Trust agreed to put in place a mitigation plan for any increase in unreported scan numbers.

The Trust agreed to give its multidisciplinary team and its complaints team evidence of its improved guidance.

Organisation we investigated

University Hospital of North Staffordshire NHS Trust

Location

Staffordshire

Region

West Midlands

Summary 442/September 2014

Delay in cancer diagnosis meant a patient's family could not spend time with him at the end of his life

The Trust failed to diagnose Mr K's terminal cancer. Once it had found cancer, the Trust did not tell Mr K's family how ill he was, and as a consequence the family missed out on spending more time with him before he died, and he did not have the end-of-life care they would have liked.

What happened

Mr K was admitted to the Trust after a fall. The Trust carried out a scan of his abdomen and diagnosed a hiatus hernia. It treated Mr K for a chest infection and he went home after rehabilitation.

The Trust readmitted Mr K two months later with a suspected stroke. Tests revealed a very large mass in his abdomen and chest, and doctors diagnosed cancer. The Trust told Mr K's family what it had found a week later but unfortunately Mr K's health deteriorated rapidly and he died.

When the Trust answered the complaint, it did not acknowledge that it could have diagnosed the cancer sooner, it did not recognise the impact of its poor communication and it made no improvements to stop this happening again.

What we found

Trust staff did not properly read a scan and so failed to diagnose Mr K's cancer. Although this did not mean the outcome would have been any different, his family would have had a clearer picture of the prognosis, and Mr K's end-of-life experience, and his family's experience of that time, would have been very different.

Poor communication was a factor throughout Mr K's second admission and it affected all of Mr K's end-of-life care. It took away the opportunity for him and his family to spend his last few weeks together at home.

Putting it right

The Trust apologised and paid £1,500 in recognition of the distress caused to the family. The Trust agreed to review the work of the doctors who read the scan, and to produce an action plan to identify what led to the failings and what action was needed to stop a recurrence.

Organisation we investigated

Barts Health NHS Trust

Location

Greater London

Region

London

Failings in trust's mental health care

The Trust allocated Ms B a care co-ordinator in late summer 2011, after appointments with psychiatrists. However, there were shortcomings in Ms B's contact with the care co-ordinator.

What happened

Ms B had no contact with her care co-ordinator until early 2012, when she had another psychiatric appointment. There were then more delays and cancelled appointments before she was seen the next month. Ms B was unhappy about the support and asked the Trust to change her care co-ordinator. A social worker took over the role in spring 2012 but only saw Ms B twice before she left the Trust. Staff did not tell Ms B she had left.

From late summer 2012 Ms B saw a Trust psychologist, and had regular psychology sessions.

What we found

The service Ms B received from her care co-ordinator fell significantly short of what it should have been.

There was a three-month delay in referring Ms B to the Trust's psychology service and she was not seen for another month. The Trust's target for assessment was six weeks.

Ms B said that she had asked to see a psychiatrist for some months during this time but the Trust did not follow up her requests. There were no records of this request. Not noting or acting on such requests was a failing.

Staff had told Ms B that she would get support with mindfulness, a therapeutic technique to calm the mind. Although she eventually had mindfulness training from the psychologist, this was more than a year after the Trust first offered it.

There were also failings in the Trust's complaint handling. It acknowledged that the service had been poor and apologised, but it had not identified all the failings that we highlighted.

Putting it right

The Trust apologised to Ms B for its failings and paid her £300 compensation to recognise the distress she had experienced. It also produced an action plan to address its failings and reviewed its complaint handling arrangements.

Organisation we investigated

Tees, Esk and Wear Valleys NHS Foundation Trust

Location

County Durham

Region

North East England

Summary 444/September 2014

Grieving family distressed by poor complaint handling

Ms L complained about the care and treatment given to her late mother, Mrs M, in the last few months of her life. Ms L said her mother was alcohol-dependent. She said that the practice considered she had 'brought the problems on herself', and did not provide good care. Ms L also said that the practice's poor complaint handling added to her distress, and the practice was not open and honest about what had happened.

What happened

In spring 2013 Mrs M's brother asked the practice for a home visit because Mrs M was very unwell, had been drinking heavily and did not feel able to leave the house.

The practice visited Mrs M at home and arranged an urgent referral to the local hospital because there was a possibility she had a form of gastrointestinal cancer. Mrs M contacted the hospital and cancelled the appointment as she was too anxious to have an endoscopy procedure without general anaesthetic. The practice asked for an appointment for Mrs M to have the procedure under anaesthetic.

During this time Mrs M was having a home detox programme supported by the local substance misuse team. She had withdrawal symptoms, but clinicians considered that these were a normal part of the detox programme.

Staff from the substance misuse team asked the practice for a home visit for Mrs M because of concerns about her deteriorating health. The practice did not visit and Mrs M died soon after.

Mrs M's family complained to the practice. The practice did not provide a written response to the complaint until we asked it to in autumn 2013. Ms L was not satisfied with the response and we agreed to investigate her complaint.

What we found

We had no concerns about the clinical care the practice gave Mrs M. While we could not say that the practice should definitely have visited Mrs M, we felt that staff did not do enough to find out about Mrs M's condition before deciding not to visit.

However, we had concerns about record keeping at the practice. Details of a GP's conversation with staff from the substance misuse team were not recorded at the time but were added to Mrs M's notes nearly seven months later.

The practice was not open and transparent in the way it dealt with Ms L's complaint. Having added a late entry to Mrs M's records, it relied heavily on this entry in its complaint response. The response itself was inaccurate and was not consistent with Mrs M's medical records. The practice should have provided a full written response to the complaint much sooner than it did.

Putting it right

The practice apologised to Mrs M's family that it did not follow up the request from the substance misuse team and that it did not do more to find out about Mrs M's condition on the day. The practice also apologised for its inaccurate complaint response. It paid Mrs M's family £1,000 compensation, and the GP shared our report with her responsible officer.

Organisation we investigated

A GP practice

Location

Staffordshire

Region

West Midlands

Summary 445/September 2014

GP practice did not support carer when she tried to manage her stress

Mrs T's husband has Asperger's syndrome, which can be very stressful for her. She complained that the practice did not help her deal with the stress.

What happened

Mrs T visited the practice on several occasions complaining of stress. When she did not receive the help she needed, she decided to fund therapy privately. She later contacted the practice to ask for funding for this therapy. She then approached the Clinical Commissioning Group (CCG) for funding.

What we found

Over a period of eight months, the practice missed the opportunity to give Mrs T the support that she needed.

We did not uphold the complaint about the CCG.

Putting it right

The practice acknowledged its failings, apologised to Mrs T and paid her £250 compensation. It also agreed to draw up plans to address the failings we identified.

Organisations we investigated

A GP practice

Greenwich Clinical Commissioning Group

Location

London

Region

Greater London

Summary 446/September 2014

Ambulance was delayed, but this did not cause physical harm to mother and baby.

Mrs M started losing blood in late pregnancy and needed an emergency caesarean. Her baby was very poorly, and is now disabled. Mrs M complained that this would not have happened if there had been no delays with the ambulance and at the hospital.

What happened

Mrs M said she had to wait too long for the ambulance, and so lost too much blood. She said this meant she nearly died and it caused her baby's disability. She also complained that the hospital should have decided to deliver her baby when she saw staff earlier in the day, and hospital staff took too long to deliver her baby by emergency caesarean. She felt this contributed to her baby's disability.

What we found

The ambulance took too long to reach Mrs M because of problems in how the Ambulance Trust handled the call and poor staffing. The Ambulance Trust should have acknowledged this in its response to Mrs M's complaint. However, Mrs M did not lose enough blood to affect her health or that of the baby while she was waiting, and we could not link the delay to her baby's disability. We partly upheld the complaint about the Ambulance Trust.

We did not uphold the complaint about the Trust because the care it provided was appropriate and did not contribute to the problems Mrs M's baby had when he was born.

Putting it right

The Ambulance Trust apologised to Mrs M and paid her £500 for the distress she experienced because of the delay.

Organisations we investigated

London Ambulance Service NHS Trust

North Middlesex University Hospital NHS Trust

Location

London

Region

Greater London

Summary 447/September 2014

Mother paid for private autistic spectrum disorder diagnosis to avoid long wait

Ms T was told that her nine-year-old child would have to wait about a year for an assessment to confirm whether or not she had an autistic spectrum disorder. Ms T decided to pay for a private assessment.

What happened

Ms T's daughter was referred to child and adolescent mental health services at the Trust in early summer 2013. An initial assessment identified that she needed a full autistic spectrum disorder diagnostic assessment.

Ms T understood the assessment would take place in autumn 2013 but, when autumn came, she found that the wait was about a year. Ms T was concerned that, without a diagnosis, her daughter and the rest of the family could not get the support they needed. She complained and asked the Trust to sort out the situation.

Ms T paid over £2,000 for a private assessment. Her daughter received an autistic spectrum disorder diagnosis in spring 2014. Ms T did not tell the Trust.

In early 2014 the Trust upheld Ms T's complaint and apologised for the length of the waiting time. It told her what it intended to do to address the problem.

The Trust recruited an additional member of staff to reduce the waiting time, but it did not tell Ms T about this. The Trust offered Ms T an initial assessment appointment earlier than she had been led to expect, but she turned it down because the private assessment was nearly complete by this stage.

Ms T complained to us. She wanted the Trust to pay the cost of the private assessment and to reduce the wait for other children.

What we found

Mrs T chose to pay for an assessment. The Trust was under no obligation to reimburse the cost of private treatment which it did not know about and did not agree to fund.

The waiting time was far longer than the three-month wait specified in relevant guidelines from the National Institute for Health and Care Excellence.

The Trust should have been clearer in its communications. It should have told Ms T what the situation was from the start. It should have told her what it was doing internally and externally to reduce the wait. This would have enabled her to make a fully informed choice.

If both parties had communicated better, an alternative way forward might have been found which did not involve Ms T paying over £2,000.

Putting it right

At the time she chose to pay for private treatment, Ms T was not aware that there was any prospect of the wait being reduced. She was in a very difficult and distressing position. She was worried that the ongoing delay in getting help would have long-term consequences for her daughter.

The Trust took reasonable steps internally to address the waiting time. It is also taking reasonable remedial action with partners and commissioners to address capacity issues in the system.

The Trust paid £500 to Ms T in recognition of the impact of its poor communication.

Organisation we investigated

Coventry and Warwickshire Partnership NHS Trust

Location

West Midlands

Region

West Midlands

Summary 448/September 2014

Care home room was not fit for purpose

Mrs G complained her husband's room in a care home was not fit for purpose. She also complained about the Trust's district nursing services and the continuing care team. Mrs G was concerned about how her complaint was handled.

What happened

Mrs G contacted the district nurse to ask for respite care. The district nurse assessed Mr G's needs and sent a fast-track continuing care assessment to the continuing care team. The continuing care team arranged for Mr G to be admitted to the care home the same day.

Mrs G visited Mr G at the care home the next day. Mr G's room smelled strongly of urine, and it was cold because staff had opened the window to try to get rid of the smell. Mrs G decided to take Mr G home because she was worried about his health and the risk of infection.

What we found

The care home used a room that was not fit for purpose. There were also failings in how the care home handled the complaint. Its responses were contradictory and it did not send a further response as it had agreed.

We found no failings by the Clinical Commissioning Group or the Trust.

Putting it right

The care home apologised to Mrs G and paid her £750 compensation. It also agreed to prepare an action plan to address its failings.

Organisations we investigated

County Durham and Darlington NHS Foundation Trust

A care home

Darlington Clinical Commissioning Group

Location

Darlington

Region

North East

Summary 449/September 2014

Trust did not fail to diagnose a heart problem but could have communicated better

Mrs E complained that the Trust failed to implement an appropriate care plan for a heart condition, or adequately monitor her, for more than two years. She complained that, as a consequence, the Trust failed to identify a number of serious medical conditions that she was suffering from. She said that this denied her the opportunity to have elective surgery and, instead, she became unexpectedly unwell and needed emergency surgery.

What happened

In late 2009 Mrs E's GP referred her to the Trust's cardiology department because of a significant family history of aneurysm, a swelling in the wall of an artery. Mrs E had several tests and staff referred her to a clinical genetics service. She had more tests in early 2011 and early 2012 and had a 24 hour blood pressure monitor in the middle of 2012.

In late 2012 Mrs E suffered an aneurysm. She needed emergency surgery the following day.

What we found

The Trust monitored Mrs E reasonably and did not miss any clear signs that could have helped to prevent her emergency surgery.

However, the Trust should have reported the test results more comprehensively. Staff should have given Mrs E lifestyle advice and offered her more face-to-face appointments with a consultant. While we could not link these failings to Mrs E's distressing experience, she would have felt better if she could have asked more questions.

Putting it right

We did not make any formal recommendations to the Trust. However, we highlighted the shortcomings we had found and asked it to consider them carefully.

Organisation we investigated

Pennine Acute Hospitals NHS Trust

Location

Greater Manchester

Region

North West

Summary 450/September 2014

Failure to follow local procedures when handling a funding request

A woman complained about her local clinical commissioning group's (CCG's) handling of a request for funding for surgery.

What happened

Ms B's GP applied to the local CCG for funding for an operation she needed because she did not meet the usual criteria for NHS funding. The CCG considered Ms B's case at a panel and decided that there was no exceptional reason to grant funding.

Ms B later complained to us about the procedure the CCG used. She noted that the CCG had not followed its published procedures and she felt the panel was not independent. Ms B also complained about the CCG's handling of her complaint.

What we found

The CCG did not follow its local published procedures because it did not invite Ms B to make a personal statement or attend the panel. The CCG's complaint response was inadequate as it did not acknowledge the failure to follow due process and did not provide an appropriate remedy for this.

We did not uphold the complaint about the independence of the CCG's panel, or the further complaint about a decision to close Ms B's complaint when her consent had not been received within a specified time.

Putting it right

The CCG apologised to Ms B. It also reviewed the patient information leaflet to make sure it fully reflects the CCG's procedure for handling funding requests.

Organisation we investigated

North, East, and West Devon CCG

Location

Devon

Region

South West

Summary 451/September 2014

Poor care, communication and involvement of patient in her own care planning

Ms J complained about a lack of continuity in her mental health care, and about the Trust's understanding and empathy. She was also unhappy with how the Trust handled her complaint.

What happened

Ms J had been under the care of the community mental health team for some years. She received care and support through the care programme approach, which assessed, reviewed and planned her care with her. In 2010 Ms J started to raise concerns about the crisis team and their lack of support when she went into crisis. Her care had been ongoing since this time and she had continued to raise complaints with the Trust about the lack of continuity, lack of support in a crisis, poor communication, staff attitude, and services she has been offered.

What we found

Ms J's care lacked continuity and she was not fully involved in her care planning. The Trust did not recognise these failings during local resolution. This distressed Ms J and made her feel isolated because she felt she was not getting appropriate care. Despite these failings, the attitude and behaviour of staff involved in Ms J's care was appropriate and we found no fault in how the Trust handled Ms J's complaint.

Putting it right

The Trust apologised to Ms J and agreed to complete an action plan to address its failings.

Organisation we investigated

Leicestershire Partnership NHS Trust

Location

Leicestershire

Region

East Midlands

Summary 452/September 2014

Older patient died in hospital when his wish was to die at home

Mrs C complained to the Trust that her husband received poor care and treatment and that staff did not respond properly to his deteriorating condition.

What happened

Mr C had terminal cancer complicated by heart problems, including heart failure. He went into hospital with breathing problems. Doctors diagnosed that he had fluid on his lungs and mild kidney problems. They arranged scans and continued to give Mr C diuretics. His condition deteriorated and he did not recover. He died in hospital.

What we found

Mrs C said that her husband's wish had been to die at home or in the care of a hospice. However, a breakdown in communication meant staff did not follow up this request. Doctors and nurses failed to escalate the deterioration in Mr C's condition to a suitably senior doctor. That said, earlier intervention would not have changed the outcome for Mr C.

We found shortcomings by the Trust, particularly in the lack of information it gave Mrs C about the seriousness of the downturn in her husband's condition. This meant she and her family lost the opportunity to be with Mr C when he died.

We found maladministration in the way the Trust handled Mrs C's complaint.

Putting it right

The Trust apologised to Mrs C and paid her £250 for the injustice caused by Mr C dying alone in hospital. It also agreed to prepare an action plan to make sure that lessons were learnt about complaint handling.

Organisation we investigated

York Teaching Hospitals NHS Foundation Trust

Location

York

Region

Yorkshire and the Humber

Delayed response to postoperative complications

Mr S complained that one of his dental crowns was damaged during an operation on his hand. Mr S said this caused him agitation, pain and embarrassment.

What happened

Mr S complained to the Trust and asked for £300 to replace the damaged crown. The Trust replied that it had got his consent for the operation and that his records noted that he had fixed crowns on his teeth. The Trust said it gave patients a standard information sheet that noted the risks of anaesthetic, one of which was dental damage, and Mr S should have received one. Because dental damage was rare, it would not be routinely discussed with patients unless there were particular risk factors that made it more likely to occur (such as difficult airway management or poor dentition). The Trust had not identified any particular risks in Mr S's case and said that having a crown did not significantly increase the risk of damage. Furthermore, it said that had he been specifically consented for this, it would not have reduced the possibility of dental damage.

The Trust said that Mr S's laryngeal mask was inserted by a trainee but overseen by a consultant anaesthetist and that there was no damage during insertion or when staff removed the mask. The Trust apologised that there was no record that staff told Mr S about dental damage before the operation. However, if he had been told about this, dental damage would not have been avoided. Overall, it said that the damage was an unavoidable and non-negligent complication of anaesthesia.

What we found

The Trust's comments that dental damage is a rare complication were reasonable. But its comments that Mr S was not at a higher level of risk were unreasonable: patients with crowns, bridges, veneers, or implants on a front tooth are at greater risk of dental damage.

There was no evidence that the Trust gave Mr S any information before the operation to fully explain the risks, and the preoperative paperwork was not properly completed. That meant we could not confirm if staff discussed risks. This poor record keeping, along with a lack of clarity about which anaesthetist or anaesthetists were present, meant we could not say if Mr S's dental injury was unavoidable. Overall, the Trust's response to Mr S's concerns was unreasonable and there were problems in its record keeping.

Putting it right

The Trust paid Mr S £250 compensation and agreed to tell us how it will maintain the quality of its written records.

Organisation we investigated

Gloucestershire Royal Hospital NHS Trust

Location

Gloucestershire

Region

South West

Summary 454/September 2014

Man's fall in hospital delayed further medical treatment

When Mr L fell in hospital and fractured his hip, the Trust apologised but did not offer a financial remedy.

What happened

Mrs B's father, Mr L, went into hospital for bladder treatment. While in hospital, he fell out of bed and fractured his hip. He had an emergency hip replacement, which delayed the treatment he went into hospital for. He fell again after his hip operation but fortunately was not hurt. When the Trust discharged Mr L from hospital, it had still not treated the original problem and he needed another operation later that year.

Mrs B complained and the Trust apologised that her father had fallen. It accepted that staff had not taken Mr L's dementia into account when they assessed his risk of falling. The Trust told Mrs B that she would need to take legal action if she wanted compensation. She complained to us instead.

What we found

We could not say that Trust staff could have prevented Mr L's fall, even if they had carried out the proper assessments in line with national standards. However, we saw no evidence to reassure us that staff had assessed or mitigated his risk of falling. This delayed Mr L's treatment and caused him additional distress and discomfort.

Putting it right

The Trust paid Mr L compensation of £1,250.

Organisation we investigated

Barts Health NHS Trust

Location

London

Region

Greater London

Summary 455/September 2014

GP practice's failings did not contribute to cancer patient's death, but trust's complaint handling was poor

Mr D complained that the GP practice did not refer his wife for investigation of her symptoms, which later turned out to be cancer. He also complained that an oncologist did not arrange to monitor the cancer after radiotherapy was complete. Mr D said that the Trust did not give a reasonable standard of care and treatment when his wife was in hospital, and that its complaint handing was poor.

What happened

Mrs D had a number of medical conditions, including a serious lung problem. She visited the practice on nine occasions in 2009 with symptoms such as coughing and wheezing. Mrs D then went into hospital with shortness of breath and a worsening cough. Doctors diagnosed that she had lung cancer that had spread to her lymph nodes, and an oncologist arranged a course of palliative radiotherapy. A scan then revealed that the cancer had spread to her liver and spine and she started chemotherapy. She was discharged from hospital and died.

What we found

The practice delayed referring Mrs D for further investigations. However, we did not find that this delay limited her treatment options or contributed to her death. We therefore partly upheld the complaint about the practice. We found no service failure in the care and treatment given by the oncologist or the hospital where Mrs D was an inpatient. We did not uphold these complaints. However, the Trust's complaint handling was poor.

Putting it right

The Practice and the Trust agreed to prepare action plans to explain how they intend to learn lessons from the failings we identified. The Trust also apologised for its failings and paid £250 compensation.

Organisations we investigated

A GP practice

East Lancashire Hospitals NHS Trust

Location

Blackburn with Darwen

Region

North West

Parliamentary and Health Service Ombudsman

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